United Nations CERF Central Emergency Response Fund

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

RESIDENT/HUMANITARIAN COORDINATOR	**Renata Lok-Dessallien**

REPORTING PROCESS AND CONSULTATION SUMMARY

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

Several after action review exercises were conducted by OCHA to inform the report. The first one was conducted in Yangon with the recipient agencies, implementing partners and cluster/sector coordinators on 29 August 2016. A similar exercise was conducted with partners and relevant stakeholders in Myitkyina, Kachin on 6 September 2016. In Rakhine State, an invitation for an AAR was sent on 1 September 2016; however, it was not very successful with only two agencies attending the exercise. The results of the AAR exercises were shared with HCT members and recipient agencies to inform their specific reporting process and have been used to inform this report.

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 ☐

The draft report was shared with all HCT members, as well as all sector and cluster coordinators for their comments on 21 October 2016. All comments have been integrated into the final document.

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

YES ☒ NO ☐

The final version of the report has been shared with CERF recipient agencies, members of the HCT and cluster/sector coordinators.

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: US$ 257,086,573[1]		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF (*UFE: $5,367,651; Floods Rapid Response: $10,405,409*)	15,773,060
	COUNTRY-BASED POOL FUND (*Myanmar Humanitarian Fund*)	5,020,963
	OTHER (bilateral/multilateral)	111,410,010
	TOTAL	**132,204,033**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 08-Sep-15			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	15-UF-CEF-103	Child Protection	500,000
UNICEF	15-UF-CEF-104	Water, Sanitation and Hygiene	400,000
UNICEF	15-UF-CEF-105	Sexual and/or Gender-Based Violence	196,240
UNICEF	15-UF-CEF-106	Nutrition	299,841
FAO	15-UF-FAO-027	Food Security	500,000
UNFPA	15-UF-FPA-033	Sexual and/or Gender-Based Violence	405,000
UNFPA	15-UF-FPA-034	Health	482,178
UNHCR	15-UF-HCR-051	Shelter	497,561
IOM	15-UF-IOM-032	Health	517,489
WFP	15-UF-WFP-061	Food Security	1,172,706
WFP	15-UF-WFP-062	Nutrition	196,636
WHO	15-UF-WHO-039	Health	200,000
TOTAL			**5,367,651**

[1] 2015 Myanmar HRP requirements after update to include requirements for 2015 floods response ($67.5 million).

TABLE 3: BREAKDOWN OF CERF UFE (2nd Round 2015) FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies implementation	3,156,640
Funds forwarded to NGOs and Red Cross / Red Crescent for implementation	2,149,802
Funds forwarded to government partners	61,209
TOTAL	**5,367,651**

HUMANITARIAN NEEDS

In 2015, significant humanitarian needs continued in Myanmar. Inter-communal violence in Rakhine State, and unresolved conflict in Kachin and Shan States, have impacted an estimated of 536,400 people. Of these people targeted for humanitarian assistance under the 2015 HRP, some 202,569 are internally displaced persons living in camps (116,183 in Rakhine State and 86,386 in Kachin and Shan States). The number of displaced persons in villages in Rakhine was 14,969; and other displaced persons in host families or other individual accommodation was 8,158 in Rakhine State and 12,684 in Kachin State respectively. Displaced people living in camps or camp-like situations remained dependent on humanitarian assistance to meet their basic needs largely due to continued restrictions on movements and limited access to livelihood opportunities. The protracted displacement also had adverse effect on the host communities, straining already scarce resources. The number of crisis affected people in communities housing/surrounding by internally displaced persons was 120,000 persons (100,000 persons in Rakhine and 20,000 in Kachin State). The number of non-displaced crisis-affected people in Rakhine reached 177,290 individuals and 731 resettled displaced persons in Kachin State. Among those displaced persons, the most vulnerable population were: 1) children (-18 years old) 20,992 male, and 20,693 female in Rakhine State; and 19,505 male and 19,490 female in Kachin State; 2) displaced women living in camps in Kachin 41,186 and 39,171 women in Rakhine; 3) elderly living in camps (+60) 3,136 male (2,058 in Kachin and 1,078 in Rakhine) and 4,194 female (2,888 in Kachin and 1,306 in Rakhine). The situation was further compounded by the countrywide floods that affected over nine million people across the country.

After more than four years of conflict in Kachin and Shan States, 100,000 people remained displaced and sporadic fighting and displacement continued. More than half of the displaced population live in areas beyond Government control where access remains restricted. In Rakhine State, about 140,000 people remained displaced following outbreaks of violence in 2012. Discriminatory laws, policies and practices, which place severe restrictions on movement and access to basic services, cause particular hardship and lead to a high level of dependency on humanitarian assistance. Camp housing and facilities were constructed as a temporary measure and require repairs. Continued provision of food, education and nutrition and protection services remain needed in the camps. By the end of 2015 approximately 25,000 displaced persons benefited through owner-driven individual housing schemes, a key step to ending displacement.

In addition to aforementioned humanitarian needs, Myanmar was hit by devastating floods and landslides in 2015. According to the Government, 38,000 houses were totally destroyed and 315,000 were heavily damaged. Over 1.4 million acres of farmland were inundated, and 841,000 acres destroyed. The long-term socio-economic effects will continue to be felt by communities, increasing their vulnerability to trafficking, gender-based violence and child labour.

II. FOCUS AREAS AND PRIORITIZATION

The Humanitarian Country Team's (HCT) response strategy was based on a series of consultations on prioritization. Humanitarian priorities were identified through the consultative process followed to develop the 2015 Myanmar Humanitarian Response Plan involving NGOs, UN agencies, donors and government. Sectors based the priorities on sector-specific assessments, multi-sector assessments, and on-going humanitarian action. CERF funds were requested to support the critical gaps in the humanitarian response and to meet the basic needs of the people living in the remote areas and restricted access as well as the more difficult operating environment, often receiving less attention in Rakhine, Kachin and Shan States.

The critical gaps identified include:

- Improve access to quality medical services
- Construction and maintenance of shelters
- Strengthening protection of conflict-affected people including sexual and gender based violence, trafficking, etc.

- Reduce negative coping mechanisms
- Support vital and underneath nutrition programmes
- Maintenance of water and sanitation facilities in hard to reach areas

The response covered all vulnerable groups, including displaced people, host communities, ethnic and indigenous groups and other affected communities. Based on the consultations, the response strategy targeted the following beneficiaries per cluster/sector:

Cluster/Sector	Female	Male	Total
Health	11,547	4,896	16,443
Food Security	76,735	69,415	146,150
WASH	10,759	11,688	22,447
Protection	39,509	39,994	79,503
Nutrition	2,704	2,496	5,200
Shelter	965	860	1,825

CERF funding complemented existing financing mechanisms such as the Myanmar Humanitarian Fund (MHF), formerly known as Emergency Response Fund (ERF), to ensure the most efficient use of available resources to meet life-saving needs.

III. CERF PROCESS

In June 2015, the HCT initiated a series of consultations on prioritization. It reviewed a number of HCT documents including the latest HCT-endorsed list of HCT priorities; the latest ICCG-endorsed list of Sector/Cluster priorities; the HCT recommendations based on the first Quarterly Monitoring Report for 2015; an analysis carried out by OCHA of funding levels and trends; and the results of an OCHA Accountability to Affected People Survey carried out in May-June 2015. Based on this, OCHA presented the HCT/ICCG with three options for consideration when prioritizing use of CERF and MHF funds.

During the first two weeks of July 2015, in parallel to the consultations held with HCT/ICCG members, OCHA initiated consultation with donors on their views on prioritization. Concurrently, some Clusters/Sectors leads proactively started consultations in order to gather preliminary views and priorities by Cluster/Sector members and partners. During this period, the second Quarterly Monitoring Report for 2015 was finalized and this was also used as a key document to inform decisions about humanitarian needs, gaps and priorities.

On the basis of this series of consultations, the RC/HC approved the Prioritization Strategy Summary and that all proposed activities should be part of the overall 2015 Humanitarian Response Plan. Following this, Sectors/Clusters presented their requests based on the Prioritization Strategy Summary, while considering also the CERF life-saving criteria, operational capacity and access to deliver in the timeframe indicated.

On 27 July during a HCT meeting, the RC/HC agreed on allocations by sectors/clusters for the CERF and the indicative amounts for the MHF as follows:

Sector	CERF UFE (2nd Round 2015)	MHF Standard Allocation	Total	%
Health	1,200,000	800,000	2,000,000	26%
Food Security	1,600,000		1,600,000	21%
Protection	1,100,000	100,000	1,200,000	15%
WASH	400,000	450,000	850,000	11%
Nutrition	500,000	300,000	800,000	10%
Education		750,000	750,000	10%
Shelter	500,000	100,000	600,000	8%
TOTAL	5,300,000	2,500,000	7,800,000	100%

Factors that were considered to strategically focus this CERF request were HRP cluster/sector identified priority needs and activities to be implemented in 2015, cluster/sector needs assessments and consultation with humanitarian partners. The main framework used during the prioritization of the CERF request was the 2015 Myanmar HRP and its quarterly monitoring report. The 2015 HRP was additionally oriented by the 2015 Humanitarian Needs Overview, the Statement on the Centrality of Protection in Humanitarian Action, endorsed by the Inter-Agency Standing Committee (IASC) Principals in 2013, and the United Nations "Human Rights Up Front" Plan of Action.

In the 2015 Humanitarian Needs Overview, the following four key humanitarian issues in Myanmar were listed: (1) the prolonged displacement resulting from on-going inter-communal tensions and unresolved armed conflict; the fact that local communities in conflict-affected areas are severely affected; and serious protection concerns in these areas that need to be addressed; (2) the unequal and inadequate access of crisis-affected people to basic services and livelihoods opportunities, particularly in Rakhine State; (3) the challenges in finding durable solutions for the displaced, including the fact that the camps in Rakhine and Kachin were established as temporary ones with shelters designed to last for only two years; and (4) the importance of enhancing the resilience of communities and preparing for new emergencies, taking into consideration the fact that Myanmar is one of the countries at highest risk of natural disasters in South-East Asia.

Based on this, the HCT agreed on the HRP strategic objectives outlined above to assist displaced and crisis-affected people as well as non-displaced people in host/surrounding communities affected by the crises. Any prioritization of projects, including for the purpose of allocating funds from the Central Emergency Response Fund (CERF) or the country-based Myanmar Humanitarian Fund (MHF), were based on a consideration of whether or not the proposed projects are in line with one or more of these three strategic objectives.

In line with the 2015 Myanmar HRP, the CERF proposals considered cross-cutting and people-centred approach in particular focusing on: 1) Gender - identifying and responding to the different experiences, needs, abilities and priorities of women, girls, boys and men affected by crisis; developing targeted interventions to promote gender justice; working with men to support increased involvement and decision-making for women; and mainstreaming gender-equality at every stage of the Humanitarian Programme Cycle. 2) Conflict-sensitive and "Do No Harm" approaches; and, 3) Accountability to Affected Populations.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR[2]

Total number of individuals affected by the crisis: 536,400

Cluster/Sector	Female			Male			Total		
	Girls (< 18)	Women (≥ 18)	Total	Boys (< 18)	Men (≥ 18)	Total	Children (< 18)	Adults (≥ 18)	Total
Child Protection	34,070	450	34,520	34,577	373	34,950	68,647	823	69,470
Food Security	26,661	50,778	77,439	26,287	45,193	71,480	52,948	95,971	148,919
Health	4,221	5,356	9,577	6438	1,203	7,641	10,659	6,559	17,218
Nutrition	6,230	0	6,230	5,224	0	5,224	11454	0	11,454
SGBV	2,309	5,452	7,761	1,831	3,567	5,398	4,140	9,019	13,159
Shelter	490	473	963	469	393	862	959	866	1,825
WASH	8,821	8,829	17,650	7,449	6,645	14,094	16,270	15,474	31,744

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

BENEFICIARY ESTIMATION

Child Protection

Beneficiary numbers for child protection were measured through registration for services on adolescent programming. Double counting was avoided as agencies are working in geographically different areas—both camps and communities—as evidenced by the 4W matrix. Case management figures are taken from the child protection information management system where cases are registered and followed. There may exist a small yet insignificant percentage of cases that fall within both adolescent programming and case management services. Adults participating in child protection groups are registered through an initial registration process and after attendance at monthly meetings. Access to services is counted through population coverage of a camp, as such the Camp Coordination and Camp Management (CCCM) data has been used to count the number of children who have access to youth services and case management services.

Water, Sanitation and Hygiene

Beneficiary numbers were determined through camp and project records, which indicated the number of people who benefited from the WASH services administered through the CERF grant. While the initial target for Save the Children International (SCI) was 9,666 people, by the project end a total of 14,508 had been reached. Similarly, while only 16,446 people were initially targeted through Metta Development Foundation (Metta), a total of 17,236 were reached by project end. In all, against a combined target of 22,447 a total of 31,744 were reached or 41% more people than planned (9,297) with at least one of the planned activities.

Shelter

The number of individuals affected by the crisis was calculated according to figures from the Shelter Gap analysis conducted in July 2015 by all the CCCM/Shelter Cluster members. Disaggregated data per sex and age come from the Camp Profiling Round 4. On the basis of these figures, the beneficiaries who would benefit from shelter activities thanks to CERF funding have been selected on priority needs.

Food Security

Actual beneficiary figures were collected at village level at the time of distribution (livelihoods activities implemented by FAO). Specifically, family registration cards containing demographic information of each beneficiary family were reviewed and recorded by IPs. The CERF funded project reached a total of 21,607 individual beneficiaries (3,300 households), out of which 11,237 are women and around 9,662 are boys/girls under 18 years old. All beneficiaries are inhabitants of Northern Rakhine State (Maungdaw and Buthidaung Townships).

The grant also contributed to the life-saving food assistance to the most vulnerable populations (WFP intervention) in Rakhine State supported by multiple donors for the reporting period from October 2015 to June 2016. Mixed commodities purchased with CERF and other grants were jointly and/or separately distributed to flood-affected populations contingent on different lead times for procurement and delivery of various commodities, timings of the contribution confirmation and operational requirements. Therefore, it was not feasible to trace the exact number of direct beneficiates supported by CERF grant only as part of a large multi-donor action. Instead, WFP has reported the average number of people reached with CERF and other contributions per month during the reporting period.

Health

Regarding the UNFPA project, the CERF-funded project reached a total of 9,893 (8,302 female and 1,591 male) direct beneficiaries from IDP and host communities in Waingmaw and Mogaung Townships including in hard-to-reach areas, exceeding the set target population of 8,298 (5,975 female, 2,323 male) by 19%. In addition, health education sessions were broadcast through radio to communities across various Townships, including Waingmaw, Mogaung, Myitkyina, Mohnyin, Hopin, Bhamo, Shwegy, Mansi.

The initial WHO proposal targeted 24 villages, with 9 IDP camps and 15 host communities in Government Controlled Areas in Kachin State. This number was decreased to a total of 20 villages, 8 IDP camps and 12 host communities. The estimation of beneficiaries was calculated based on a baseline survey to avoid double counting. The challenge is the fluctuating number of IDPs in the camps. Usually the number of IDPs is increasing, because people from some villages, who were not affected by violence but isolated from their home community, subsequently fled from their village due to perceived security reasons.

IOM estimated the beneficiaries of its intervention based on 2015 referred cases in the hospitals of the targeted areas. There was no double counting of beneficiaries given that direct support was provided on an individual basis. The challenge in the estimation of beneficiaries especially for referral support activities is not having a consistent number of beneficiaries as the activity deals with medical conditions and other methodologies were used in estimating persons seeking health care with emergency medical condition in a specific time frame such as hospital and health center data of the previous year.

Nutrition

The beneficiaries receiving treatment through the CERF funding for severe acute malnutrition (SAM), implemented by UNICEF and WFP, was estimated per the quantity of Ready to Use Therapeutic Food (RUTF) cartons procured and provided to the sub-implementing NGO—Action Contre la Faim (ACF). With CERF funding, a total of 4,148 RUTF cartons were procured by UNICEF, and based on the average consumption of 135 sachets per SAM child, it is estimated that the 4,148 cartons of RUTF allowed treatment of SAM in approximately 4,608 children. For Moderate Acute Malnutrition (MAM), all new, existing and discharged cases were recorded. A total of 2,027 children were reached through WFP's MAM treatment programme, and 9,427 children were reached through the prevention programme. Of those reached through the prevention programme, 6,651 children were enrolled in the Therapeutic Feeding Programme Follow-Up (TFP-FU) and 2,776 children in the Blanket Supplementary Feeding Programme (BSFP). However, as all children who received SAM treatment through ACF's Outpatient Therapy Programme (OTP) were referred to the TFP-FU, they are not counted towards the overall total number of children reached through both the SAM and MAM programmes. If kept separate however, WFP through Malteser reached a total of 11,454 children.

Sexual and/or Gender-Based Violence

Beneficiary numbers for child protection (UNICEF project) were measured through registration for services on adolescent programming. Double counting was avoided as agencies have worked in geographically different areas—both camps and communities. Case management figures are taken from the child protection information management system where cases are registered and followed. There may exist a small yet insignificant percentage of cases that fall within both adolescent programming and case management services. Adults participating in child protection groups are registered through an initial registration process and after attendance at monthly meetings. Access to services is counted through population coverage of a camp; as such the Camp Coordination and Camp Management (CCCM) data has been used to count the number of children who have access to youth services and case management services.

Beneficiary numbers for the UNFPA Gender-Based Violence (GBV) programme were estimated through the careful reconciliation of both CCCM data and detailed needs assessments which have been conducted over the past 12 months by UNFPA in collaboration with other protection agencies as well as through data collated from the existing primary health care services, which are being provided in the targeted communities. Different methodologies were used to reach target numbers of beneficiaries and data was collected in such a way as to avoid double counting. Beneficiaries were measured through registration upon receiving commodities (such as dignity kits) participation in information and knowledge groups, awareness raising on GBV prevention through outreach work and case management data systems. While participation in events such as International Women's Day on 8th March is a strong measure of the success of prevention programme, the numbers of participants are not included in order to avoid double counting given that many of them would already have been reached through awareness sessions in the outreach component of the programme. Double counting is also avoided as agencies are working in different camps and communities evidenced by the 4W matrix. Monthly reporting of GBV data, including case management reporting and the number of people trained was put in place to protect the integrity of the data collected and to adjust as required in cases of possible double counting.

TABLE 5: TOTAL DIRECT BENEFICIARIES REACHED THROUGH CERF FUNDING[3]

	Children (< 18)	**Adults** (≥ 18)	**Total**
Female	82,802	71,338	154,140
Male	82,275	57,374	139,649
Total individuals (Female and male)	**165,077**	**128,712**	**293,789**

[3] 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

Child Protection

In summary, the CERF funding contributed to gap-filling services for children and adolescents in Kachin and Rakhine States and supported the expansion of grassroots child protection services that contribute to the prevention and response of violence and abuse towards conflict-affected children. The development of adolescent's life skills served to ensure adolescents are empowered to have more control over their own protection. In addition, the increased coverage in case management systems supported a response to survivors of abuse on a larger scale, reaching the most vulnerable.

In Rakhine State, as a result of CERF funding the Child Protection sector expanded its community-based child protection response to cover all forms of violence and abuse against children. The CERF funding added to the expansion of Child Protection Groups (CPGs) in communities in Maungdaw District in northern Rakhine State as well as in Pauktaw and Sittwe Townships, with an additional seven CPGs in communities. In addition, CERF funding has supported improving the quality of existing CPGs in Sittwe, Pauktaw and Myebon. The CPGs are responsible for reporting cases to trained case workers or the Department for Social Welfare (DSW) social workers (where available) and are also trained on identifying signs of abuse, child friendly approaches, awareness raising for prevention of abuse, and how to refer individuals using the guiding principles of case management – confidentiality, safety, dignity and best interest of the child. The development of the CPGs and expansion of case management have increased communities' understanding of child protection and have led to increased reporting of cases. During the period of the CERF funding, CPGs have referred 206 cases to case workers.

Through the development of a more formalised system of case management, case workers responded to 1,817 protection cases including response to family reunification, sexual and gender based violence (SGBV), risky migration, physical violence, early child marriage, neglect and trafficking. Responses included support to access services, psychosocial support through group activities of family mediation or referral to specialised services such as medical or legal referral. The number of trained field case workers increased by 16 allowing for more coverage to the underserved Pauktaw camps and northern Townships in Rakhine. An inter-agency training took place in May to ensure that case workers are appropriately trained on principles and standard operating procedures that are in line with the minimum standards of child protection ensuring a more coordinated approach to case management. Case management services are now accessible to a population of 68,647 children. CERF funding also contributed to the coordination and implementation of a life skills programme which supported 2,252 out-of-school and vulnerable adolescents to learn skills that will allow them to better protect themselves within their homes, communities or places of work.

Teams took extra time to seek communities' advice on how to discuss issues of reproductive health and relationships. An adolescent round table was held in August in Yangon to share techniques between 11 child protection agencies to develop new strategies for addressing the challenges presented in the contexts of Rakhine and Kachin.

Water, Sanitation and Hygiene

The "Emergency WASH services for IDPs in Hard to Reach Areas of Kachin and Northern Shan" project commenced in November 2015 under the leadership of UNICEF and agreements were signed with SCI, who sub-granted to Wun Pawng Ninghtoi (WPN), and to Metta.

Activities focused on supporting maintenance of WASH facilities in hard-to-reach locations within Government Controlled Areas (GCAs) and Non-Government Controlled Areas (NGCAs). The project contributed to a reduction in morbidity due to contaminated water, lack of usable latrines, and poor hygiene practices. It helped to address critical WASH needs for a total of 31,744 people, including children, women and men of both displaced population and host communities. Over 40% more people than planned were reached with at least one output under this project (9,297 people). Populations reached for different outputs varied as per differing identified needs for water (27,883), sanitation (30,689) and hygiene promotion (26,617).

The activities completed with CERF funding included:

- WASH: 27,883 people continued to access equitable and sustainable water supplies. Activities included rehabilitation (23) and replacements (14) of WASH infrastructure as follows: three spring catchments with gravity networks and nine water storage tanks were constructed; one water storage tank was renovated; a water distribution piping system serving three camps was strengthened; 312 water tests were conducted at the household level and at public water collection points; 378 WASH committee members received O&M training and toolkits; four tube wells, two dug wells, three water tanks and one hand pump were constructed; nine water supplies were rehabilitated; four overhead water tanks were constructed.

- Sanitation: 31,744 people continued to access safe sanitation facilities through the following activities; 283 latrines were newly constructed and 317 latrines were repaired; 329 existing latrines were de-sludged and another 44 latrines decommissioned; 80 waste bins were installed; 54 people attended Solid Waste Management training and 34 campaigns were held on the topic; 727 waste bins were provided both at the household and community level; and 5,170 metres of drainage were constructed.
- Hygiene promotion: the WASH cluster collectively agreed to not distribute kits based on lessons learnt and feedback received suggesting that hygiene kits were being sold in the local markets. In place of this activity, the program was able to reach 26,617 people through the following activities 18 bathing spaces were newly constructed and four bathing spaces repaired; 33 hand-washing facilities were newly constructed; 23 Hygiene Promoter trainings were conducted; 246 FGDs were conducted on hygiene knowledge and practice; 58 hygiene awareness banners were placed in communal locations; 643 hygiene awareness sessions were held; and a Knowledge Attitude and Practices (KAP) survey demonstrated that approximately 83% of the overall population were practicing safe hand washing at the end of the project.

Health

As part of this UNFPA health project, basic SRH services were provided through mobile clinics to a total of 9,893 (8,302 female and 1,591 male) beneficiaries, exceeding the set target of 8,298 (5,975 female, 2,323 male) by 19%, including IDPs as well as non-displaced communities across 38 villages in hard to reach areas of Waingmaw and Mogaung Townships. Mobile clinics provided a full range of RH services with a variety of activities including health education sessions on reproductive health issues, distribution of clean delivery kits, ante-natal care and family planning services as well as referral to higher health facilities for further treatment. 5,431 clean delivery kits were distributed through the mobile clinics to pregnant women, to the Township Hospitals, Rural Health Centres and Sub Centres of the Government Health Structures. At the community level, 631 clean delivery kits were distributed directly through the mobile clinics. A total of 3,236 participants (2,578 female and 658 male) attended reproductive health (RH) education sessions. A total of 68 women were referred to the higher level health facility for further lifesaving treatment such as caesarean section, safe blood transfusion and further treatment as needed due to complication during pregnancies. This service delivery was closely coordinated with State Public Health department and provided with assistance from Health Assistants from the field. The CERF grant was also used to refurbish 44 government health facilities (RH Units of 2 Township Hospitals, 6 Station Health Units, 1 Maternal and Child Health Clinic, 8 Rural Health Centres and 27 sub centres) which included the provision of reproductive health commodities, labour beds as well as an upgrade of the facility including the provision of septic tanks, incinerators and the repairing roofs. In collaboration with Public Health and Clinical Departments, a 3 day workshop on "Clinical management of Rape and Orientation of Gender Based Violence" was held successfully with 30 government health staff (21 female and 9 male) from 6 Townships.

The WHO intervention has increased the chances of survival of 2,380 women of reproductive age (72% of targeted 3,296 women of reproductive age) and 1,251 girls and boys under five (128% of targeted 976 girls and boys under five) in the targeted areas through increased access to reproductive, maternal and child health care services and increasing the capacity and knowledge of service providers. The underachievement of the target for women of reproductive age and overachievement of the target for girls and boys under-five are due to changes in the numbers of target communities. The number of target communities in the original proposal was 24 communities (9 IDP camps and 15 host communities), which was reduced to 20 communities (8 IDP camps, and 12 host communities). In the first interim report it was requested to make this change as a change in budget meant that addressing the needs for all 24 targeted communities was not possible. In addition, 1,362 pregnant and lactating women (PLW) (248% of targeted 550 PLW) and 765 girls and boys under five (78% of targeted 976 girls and boys under five) are empowered through women's circles with life-saving knowledge and practices. The overachievement of the target for PLW and underachievement of the target for girls and boys under-five are due to changes in the numbers of target communities in line with the CERF funds received. This indicator was not adequately reviewed. 252 PLW (129% of targeted 195 PLW) received antenatal care services. These lactating women received antenatal care for better health care support during their pregnancy. The overachievement in antenatal care services is due to an increase in the actual number of pregnant women provided with the service. The total number of beneficiaries increased from 244 to 378 because of the number of pregnant women who require antenatal care is always in flux and in this case was greater than the original number estimated in the proposal.

Other achievements of the WHO project have been:

- 113 PLW (68% of targeted 166 PLW) initiated breastfeeding within 1 hour of delivery. The underachievement of breastfeeding initiation after delivery is due to the difficulty in households understanding and moving away from the known traditional midwife practices. This project aims at changing behavioural practices and thus requires an extended period to affect change.
- 49 pregnant women (114% of targeted 43 pregnant women) and 58 children under five (114% of targeted 51 children under five) who faced complications were referred in a timely manner to the nearest government hospitals. The overachievement in patient referral is due to higher actual number of patients who required referral support.
- 363 male family members (79% of targeted 460 male family members) engaged in health awareness raising activities.

- 252 PLW (129% of targeted 195 PLW) and 927 children under five (119% of targeted 780 children under five) had access to maternal and child health care services. The overachievement in the access to maternal and child health care service is due to an increase in number of actual beneficiaries.
- 47 TBAs and Assistant Midwives (235% of targeted 20 TBAs and 20 AMWs respectively) were trained on basic emergency obstetric and neonatal care. The overachievement in number of TBAs and AMWs trained was due to participation of all TBAs and AMWs in the project area.
- 100 out of 126 postnatal visits were made by a midwife within 48 hours. The proposal indicates expected deliveries to total 212 but it only totalled 126 deliveries. For this reason, the 47% achievement rate is on "expected", not actual deliveries. For actual deliveries a postnatal visit target of 79% was achieved.
- The government health staff from the Township Health Department including 1 Township Medical Officer, 1 Health Assistant (HA), 1 Township Health Nurse, and 33 midwives were trained to provide consistent and responsive MNCH services (including schedulable outreach activities) for the selected IDP camps and host communities. The monitoring of the training is conducted by the Government Township Health Department. Through supportive supervision and technical inputs by the Township Health Department staff in the field, the department provides on the job capacity training and support in critical areas supporting Reproductive Health.
- 104 out of 126 actual deliveries were assisted by skilled birth attendants. The indicator in the proposal measures the achievement percentage out of 212 targeted deliveries and thus can be misinterpreted. Looking at actual deliveries, 83% of deliveries were assisted by skilled birth attendants.
- 4 township level coordination workshops were held with the township health department to strengthen coordination of the health care activities. One Training of Trainers (TOT) was held for 99 key township health department staff on IYCF and GMP (44 midwives, 4 HA, 1 trainer, 5 LHB, 32 OHS and 4 PHS).

Regarding the IOM project, 3,694 persons received emergency referral support in the township and station hospitals, 263 health care staff were provided with orientation on referral mechanisms, and 3 townships were supported with the establishment of township referral mechanisms. Health facility functional assessments were undertaken in 74 health care facilities and 16 health care facilities were provided with critical, life-saving medical and non-medical supplies (4 hospitals and 14 RHC) to equip them with resources in providing emergency health care services to vulnerable populations and 100 basic health care staff were provided with Sexual and Reproductive Health (SRH) kits. The emergency referral with focus on maternal and child health, and major life threatening emergencies as well as SGBV referrals support to all targeted townships supported a total of 3,694 persons, which include cost of treatment, meals, lab investigations, transportations. A total of 1,924 persons received emergency referral support on treatment; of which 951 were Emergency Obstetric Cases (EMOC), 446 were Emergency Child Cases (ECC) and 517 were "Other Medical Life Threatening Emergency Medical Cases" for both Buthidaung and Pauktaw.

A coordinating mechanism, protocol and referral criteria were established in collaboration with the Township Health Medical Officer. The referral mechanism was developed in the three target areas. Furthermore, a standardized cost was also agreed on by all health partners including the THD to avoid any discrepancy in supporting emergency patients in Buthidaung. Extension of support for emergency referrals was made up to Station Hospitals in Pauktaw and Buthidaung. In Pauktaw, a total of 3,694 persons received support on transportation, meals, cost of treatment, lab investigations from October 2015 to September 2016 covering both emergency referrals from Pauktaw Township Hospital and Kyauk Taung Station Hospitals. Providing financial support for patients needing to access emergency care is essential in particular for the most vulnerable members of a community especially for those living in hard to reach areas, and for whom health expenditures precipitate catastrophic costs.

IOM conducted orientation sessions with the Township and Station Hospital staff relating to emergency referral criteria, mechanism and criteria. Discussions were made during the sessions on ensuring coverage of the whole population. Awareness sessions were also provided to community leaders related to emergency referral mechanism as this was seen as an important aspect as well to involve the community leaders in the referral mechanism. Referral forms, flyers and copies of referral criteria were distributed to the BHS staff and CHW/AMW in each township. During the monthly coordination meetings, the IOM team also conducts 1-2 hours sessions with the BHS staff and serve as venue for additional awareness and discussions on challenges faced during the referral pathway. A total of 263 were provided with orientation sessions in Buthidaung and Pauktaw.

An assessment of health facilities was conducted in January and February to assess the capacity of the health facilities to deliver emergency health care services to the population in Pauktaw and Buthidaung. A total of 2 township hospitals, 2 station hospitals, 8 rural health centers and 42 sub-centers were assessed by the field team in both areas to look at human resource, medical and non-medical supplies, services provided and other needs.Both Pauktaw and Buthidaung had a history of insecurity in this region due to conflict and multicultural context. Difficult communication is mainly accountable for communication gaps and delay in disseminating information which cause delays on emergency referrals. With the CERF funding support, barriers were decreased through supporting on distribution of

medical and non-medical items to 16 health care facilities minor rehabilitation of 4 hospitals (Kyaw Taung Station Hospital and Pauktaw Township Hospital in Pauktaw, Taung Bazaar Station Hospital in Buthidaung and Sittwe General Hospital in Sittwe received minor rehabilitations i.e. repair of roofs and ceiling which was damaged by the previous Cyclone in 2015), incinerator repair, water supply to the hospital and some minor painting, hand washing stations at the Child Ward of Sittwe General Hospital. Through this support to the health care facilities, the population in the targeted township was able to access emergency health care services in the hospitals which was not accessible before and has increased the number of inpatients and emergency referrals. Furthermore, a total of 263 health care staff were provided with orientation on emergency referral criteria and pathway in two areas.

Support was provided to the Township Health Department and State Health Department in collecting data and information relating to vulnerable populations access to emergency health referrals for Buthidaung and Pauktaw. A monthly report was shared to the Township Health Department, State Health Department and Health Cluster emergency referrals supported persons in the target areas. Under the State Health Department, a State Health Operations Coordination Room/Unit (SHOC) was created by the SHD to coordinate all emergency health related needs and activities in all Rakhine State. IOM collaborated closely with SHOC and received requests of support for emergency referrals on transportation of patients from Township Hospital to Sittwe General Hospital.

Support to the implementation of early warning and response system (EWARS) took several months as this is led by the Ministry of Health in collaboration with the State Health Department and WHO. The delay was due to development of EWARS forms and roll out of training at the State Health level and then to township level. In July 2016, the first training was conducted by MOH/WHO at the State Health Department for all Township Health Medical Officers. The EWARS training on the township level wherein BHS staff will be trained for collection and reporting is yet to be planned by the State Health level. It was only initiated as a pilot EWARS to NGOs/health partners working on IDP camps wherein EWARS is implemented and reported back to the Health Cluster in collaboration with the State Health Department. The township wide EWARS has yet to be systematized and train the Basic Health Staff.

Support to critical reproductive health interventions including promoting adequate clinical care for SBGV and provision of critical reproductive health commodities was given in collaboration with UNFPA on GBV referral pathway for Buthidaung and Pauktaw. IOM worked closely with UNFPA in the distribution of RH kits in the township level for 100 midwives. Orientation was provided by UNFPA in the use of the RH kit which consists of CDK kits and post rape kits in the township level and BHS staff.

Sexual and/or Gender-Based Violence

The UNFPA GBV project achieved its objective of making "women and girls feel safer because they receive improved access to targeted services, can safely access GBV psychosocial support, and live in communities with increased awareness on the consequences of GBV" (CERF project title). A total of 6,459 beneficiaries (target: 4,156) were reached by the CERF GBV programme including 4,556 females (target: 2,234) and 1,903 males (target: 1,922). The project reached and exceeded the female target, in part due to the expansion of the project beyond the original target areas in order to provide emergency assistance in response to flooding in other areas in Northern Shan State (NSS) (Kyaukme and Hsipaw, South of Lashio). The number of males reached fell just below the target by approximately 1%, however this is not of critical programmatic concern given the primary focus of the programme was to provide GBV response services for women and girl survivors or those at risk of GBV. In addition, the men in this region are more transient as they are more likely than women to be working in locations away from the camps or host communities or are traveling back to their places of origin regularly.

Women and girls have improved access to GBV services, in particular psychosocial support (PSS)/case management and medical referrals within the targeted communities provided by trained IDP case workers and health providers who have received Clinical Management of Rape (CMR) training from UNFPA. This capacity building was also coupled with the distribution of Post-Rape Kits through the health clinics and Dignity Kits. Women and girls also participated in awareness raising sessions on GBV, post-rape treatment and the reporting of Intimate Partner Violence and appropriate community interventions in response to GBV. Men and boys also participated in GBV awareness raising activities. International Women's Day activities were also held on the 8th of March to raise awareness about GBV in communities.

In line with best practice programming principles, a post project evaluation workshop was held with implementing partners, relevant local organisations and health staff. A SASA! Scoping exercise in Kachin and NSS for future GBV prevention implementation was also completed under this project. Both the final evaluation report and scoping study are now being utilized in the design of continuing programmes and adaption of SASA! in the region with additional resources leveraged as a consequence of the CERF UF project.

In addition to the key programmatic responses, the CERF UF project also contributed to the introduction of concrete GBV protocols and referral pathways to ensure clinical management of rape and emergency response teams are available in case of emergency as well as a GBV response roster with trained PSS and Case Management workers from different agencies and with various language capacities. A dedicated GBV coordination mechanism was also initiated in September 2016 through the establishment of the UNFPA-led NSS GBV Working Group to improve coordination between organizations working on GBV as well as engagement with government authorities.

More generally, the NSS humanitarian community is more aware of the existence, prevalence and dynamics of GBV in the region as a consequence of this project with IEC materials also having been developed to facilitate community discussions to raise awareness on GBV, while health staff have a greater capacity to respond to the needs of women and girls affected by violence.

In Kachin, UNICEF intervention supported a gap in service provision for case management and gender based violence (GBV) activities including the service provision of five women's and girls' centres as part of a wider case management programme inclusive of boys, combined with psychosocial support through adolescent and Child Friendly Spaces (CFS) programming, and were situated in some of the hardest to reach conflict-affected areas. UNICEF and Plan were able to expand their scope of work to additional communities increasing the number of CPG's who were trained to refer child protection cases to their local case managers. CPG's referred 26 cases during the project period for specialised support by case managers, including cases of suspected trafficking, early child marriage and suspected recruitment into armed groups. In Kachin, the adolescent life skills package was implemented to support IDP children.

Shelter
UNHCR's project contributed to the improvement of the protection and living conditions of the beneficiaries. With CERF funding, 365 new shelters and kitchen attached have been built.

Food Security
The CERF grant supported FAO emergency activities to increase crop and vegetable production for self-sustenance and better nutrition. FAO through its implementing partner, the Department of Agriculture, delivered agriculture inputs (seeds and fertilizer) and organized trainings on basic agriculture practices for 12,784 individuals from 1,700 households. Seeds (i.e. 15.75 MT paddy seeds, 30 MT cowpea seeds, and 0.6 MT vegetable seeds) and 42.5 MT of fertilizer were procured and distributed for quick food production, better nutrition, and income generating activities. Trainings were delivered between December 2015 and January 2016 and focused on topics such as: seed selection, germination test, seed bed preparation and land preparation, systematic plantation and transplantation, weed control, using chemical and organic fertilizer, basic picking and harvesting at minimum waste, and reducing post-harvest losses. In addition, the CERF grant allowed FAO to contribute to increasing animal production, improving access to a balanced diet containing high quality animal proteins through small scale, low input livestock production making use of spare capacity in household labour force. FAO provided livestock through its implementing partner, the Livestock Breeding and Veterinary Department (LBVD). The project supported 1,600 households with 2,800 goats and 200 pigs as well as basic animal health and production training on treatments of swine, goat diseases, and general animal health. Pigs and goats were distributed to beneficiaries to generate complementary and rapid revenues that allow covering basic needs, diversifying livelihoods and improving access to a balanced diet containing high quality animal proteins through small scale, low input livestock production, making use of spare household labour force. The training aimed not only to improve basic knowledge of good animal husbandry, but also to lower the mortality rate of animals distributed. The training also aimed to improve beneficiaries' knowledge on good household nutritional practices for better use of available food resources as well as general knowledge of animal diseases and vaccines.

On the other hand, with CERF funding complemented by other donors, WFP had procured 1,199 MT of mixed commodities (378 MT of rice, 307 MT oil and 514 MT of Fortified Blended Food (FBF)) and in partnerships with Action Contre la Faim (ACF), Action for Green Earth (AGE), CDN, Myanmar Health Assistant Association (MHAA), Myanmar Heart Development Organization (MHDO), Plan International, Save the Children International (SCI), Malteser International (Malteser) and MHDO provided life-saving food and nutrition assistance to an average number of 127,312 IDPs, the most food insecure people and malnourished children. The CERF funds substantially helped increase WFP's outreach to malnourished children under the age of five. The total number of children aged 6 – 59 months assisted through the project reached 32,592 for the whole of Rakhine State. As a result of WFP activities, supported by CERF, food consumption of the targeted beneficiaries has improved over the assistance period.

Nutrition
CERF funding for the nutrition intervention in Rakhine State enabled the treatment of approximately 4,608 children with SAM, exceeding the initial programme target. In Maungdaw and Buthidaung Townships, ACF implemented nine Outpatient Therapeutic Care (OTC) and two Stabilisation Centres. Detection of malnutrition relied on attendance by caretakers to conduct passive screening and on referrals by community volunteers (Super Community Caretakers (SCCT)). Close collaboration and engagement with community leaders, Traditional Birth Attendants (TBA) and the Traditional Healers (TH) was established to raise awareness on malnutrition related topics and services offered, and to further engage them in the prevention, detection and referral of potential malnutrition cases. Treatment provided by ACF staff reached the international SPHERE standards for SAM: cure rate > 75%, death rate < 10% and defaulter rate <15%. However, the defaulter and non-respondent rates were high in the OTP (14.9% and 9.0% respectively). ACF is currently carrying out an analysis to better understand the causes to better address these issues in follow-on activities. It is expected that the most likely causes were sharing and selling of RUTF due to chronic food insecurity in the two targeted townships, as well as ACF's limited staff capacity to implement

home visits to all children with SAM per the criteria. Future interventions will likely require investing more in community mobilisation work and multi-sectoral interventions in order to address challenges and improve the continuous utilisation of OTC services.

CERF funding also contributed to addressing the needs of children with Moderate Acute Malnutrition (MAM). The CERF-funded MAM programme was managed by WFP and implemented through Malteser, and resulted in the treatment of a total of 2,027 MAM children 6-59 months. The unit costs of the Fortified Blended Foods (FBF) distributed for the MAM treatment were lower than expected, and as such an additional 45.89 metric tons (MT) of Wheat Soya Blend (WSB)++ was procured (107.61 MT planned vs. 153.5 MT purchased). In addition to those who received MAM treatment, 9,427 children 6-59 months were reached through prevention programs. These included 6,651 children receiving follow up rations after completing SAM treatment (TFP-FU), as well as 2,776 children who were enrolled in the BSFP for prevention of acute malnutrition. TFP-FU and BSFP children U5 received three kg of WSB++ per month (or 100 gram per day). The performance indicators of the MAM programme showed average results: the cure rate (60%) was lower than the SPHERE standard of 75%, while the defaulter rate (18%) is above the recommended threshold of 15%. This may have been due to the fact that the MAM treatment program was newly set up by Malteser in the project area at the end of 2015.

CERF's ADDED VALUE

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

Child Protection
With CERF funds, UNICEF and CFSI were able to start up a child protection programme in Maungdaw in Rakhine state where there were no other child protection actors at the time. This was essential to providing lifesaving support through community-based child protection mechanisms and psychosocial programming to populations who were affected by restrictions on movement and access to services.

Water, Sanitation and Hygiene
UNICEF received approval of CERF funding two weeks after its proposal submission date on October 2nd. Partnership agreements were signed on 11th December and 25th November for SCI and Metta respectively after which date both partners had internal resources to begin activities while awaiting fund transfers. Delays in signatures were related to all partners being heavily involved in 2015 flood response activities during the month of November. CERF funds were transferred and distributed to partners within a month thereafter. Due to the short timeframe of the project and difficulty in recruiting staff for short duration contracts, there were some delays in the project. Thus some portions of WASH assistance reached beneficiaries faster than others.

Health
For the WHO project, there was a delay in the delivery of assistance because of a delay in the transfer of funds from the WHO to Plan International Myanmar, a lack of a pre-existing MoU between the Ministry of Health and Plan International Myanmar, and a delay in procurement of nutritional commodities by Plan International Myanmar.

UNFPA identified IP who had secured a MoU with Minister of Health and Sport to work in the affected region in order to expedite assistance.

The IOM CERF funded project provided a rapid delivery of assistance in response to the urgent health needs of the population in Rakhine State and was able to address the critical gap and key priority of the vulnerable populations. There were multiple barriers to accessing emergency health care service and the CERF funding enabled breaking down some of these barriers especially in supporting emergency referrals on transportation, cost of treatment, meals, etc. Furthermore, supporting the health care facilities with medical and non-medical supplies and minor rehabilitations, coupled with capacity building of health staff has greatly impacted the communities through delivery of quality health care services to the target beneficiaries.

Sexual and/or Gender-Based Violence
According to UNFPA, CERF funding led to fast delivery of assistance through i) the provision, prepositioning and distribution of Dignity Kits and Post-Rape Kits in a timely manner and ii) mobilization of qualified staff to respond to GBV emergencies in Northern Shan State.

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This was essential to providing lifesaving support through community-based child protection mechanisms and psychosocial programming to populations who were affected by restrictions on movement and access to services.

Shelter
The fast approval of this CERF UFE grant allowed UNHCR to immediately start the implementation in coordination with its partners.

Food Security
As per FAO comments, the CERF funding led to immediate assistance delivered to conflict and flood-affected communities during the 2015 winter sowing season (agriculture component) and 2016 summer season (livestock component). Agricultural inputs were distributed between the beginning of November and first week of December, allowing farmers to grow rice paddy, cowpeas and vegetables during the winter cropping season. In addition, FAO was able to provide affected communities with livestock (goats and pigs) together with the animal feed and required vaccines between May and June 2016. Distribution during the 2016 summer cropping season allowed landless people to benefit from the restocking of small livestock for breeding.

Regarding WFP's intervention, while most of the other funds for Rakhine were resitricted to the delivery of food commodities that are part of the basic food basket (rice, oil, pulses, salt), CERF's contribution also included a nutrition component to deliver Fortified Blended Food (FBF). This enabled WFP to respond quickly to the sudden increased demand for FBF in Rakhine. Finally, to cover the rice requirements (as per the proposal), WFP used funds from other donors which were exclusively aimed at procuring rice, oil, pulses and salt.

Nutrition
The supplies for SAM and MAM treatment were procured by UNICEF and WFP as soon as the funds were made available. Supplies were procured internationally and took some several months to arrive in Myanmar. Once received, supplies were provided to ACF and Malteser. ACF had a pre-existing Outpatient Therapy Programme (OTP) and thus was able to immediately provide assistance to children with SAM. Conversely, as Malteser started a new programme, it took a few months to set up the operation, including training staff, renovating Supplementary Feeding Programme (SFP) sites, and organising community awareness activities to ensure uptake of services by the community. For this reason, the MAM programme was a bit slower to provide support than the pre-existing SAM programme.

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

Child Protection
CERF funds helped to fill gaps in services for an underserved population – adolescent boys and girls. Without the provision of activities and developing skills to empower the adolescents, there were reports of adolescents being involved in negative coping mechanisms, such as using drugs and alcohol, taking risky migration routes in search of a better life, self-harm, early child marriage, child labour and recruitment into armed groups. In Kachin, with the departure of IMC (key GBV actor) CERF funding helped to continue lifesaving services to support survivors of GBV through maintaining women's and girls' centres as well as linking these services to wider child protection case management systems and referral mechanism through CPG's.

Water, Sanitation and Hygiene
As the funding was applied to the protracted crisis in Kachin and northern Shan States, UNICEF initially utilized its own funding sources to ensure time-critical needs were met. CERF funding, however, contributed to enabling a response where needs existed in hard-to-reach areas that were not covered through other funding sources.

Health
According to WHO, CERF funds helped put in place the timely provision of maternal and new born care through antenatal care, patient referral, lactation training and trainings to community volunteers and government health staff.

[4] Time-critical response refers to necessary, rapid and time-limited actions and resources required to minimize additional loss of lives and damage to social and economic assets (e.g. emergency vaccination campaigns, locust control, etc.).

The distribution of clean delivery kits under this CERF funding was a key response to the time critical needs of pregnant women affected by conflict, providing the needed assistance for safe delivery in the final stages of pregnancy. As per UNFPA's comments, under this funding, 631 clean delivery individual kits were distributed to ensure availability of RH services among the affected population directly through mobile clinics.

IOM indicated that there were several situations wherein the hospitals received life threatening cases that needed referral to a tertiary hospital. However, the patient and family had no means to transport by boat from the township to Sittwe General Hospital and even the township health department had no funds or boat to transport the patient. Through CERF funds, the patients of these critical cases were able to access urgent medical treatment to a tertiary hospital.

Sexual and/or Gender-Based Violence
UNFPA considers that CERF funds helped respond to critical needs through i) frequent awareness sessions about the 72-hour timeframe intervention in case of rape and ii) services in place in all targeted camps on a 24/7 basis where they were not previously available.

UNICEF indicates that CERF funds helped to fill gaps in services for an underserved population – adolescent boys and girls. Without the provision of activities and developing skills to empower the adolescents, there were reports of adolescents being involved in negative coping mechanisms, such as using drugs and alcohol, taking risky migration routes in search of a better life, self-harm, early child marriage, child labour and recruitment into armed groups. In Kachin, with the departure of IMC (key GBV actor) CERF funding helped to continue lifesaving services to support survivors of GBV through maintaining women's and girls' centres as well as linking these services to wider child protection case management systems and referral mechanism through CPG's.

Shelter
Without the funds provided by CERF, UNHCR would not have been able to implement any shelter construction to this extent, due to a shortage of funds and other priority commitments by UNHCR.

Food Security
FAO recognizes that the timely distribution ensured a maximized impact of seeds distribution with higher yields. All targeted activities were implemented on time according to the growing season. The population of Northern Rakhine State has been struggling to restore agriculture-based livelihoods due to shortfalls of quality agricultural inputs, thus limiting agriculture production and income generation. This has left many households reliant on food aid for their subsistence. The population has been receiving basic food items, but has missed the inputs necessary to produce fresh food. The project focused on improving nutritional intakes and increasing income through distribution of agricultural inputs and livestock. Without CERF funded assistance these populations would not have been able to access the inputs needed to produce fresh food for their subsistence nor have the necessary support to rebuild their livelihoods and eventually reduce reliance on food assistance.

For WFP, continued food assistance to IDPs, the most food insecure people and children vulnerable to malnutrition, contributed to containing conflict, thus maintaining stability in the conflict affected areas. Based on the relief Post Distribution Monitoring (PDM) conducted by WFP in June 2016, 90.4 % of those who received relief assistance in Rakhine indicated an adequate level of food consumption. The identification of increased vulnerability for malnutrition of children under five years was very time critical. CERF funds helped to provide the underfunded life-saving assistance for most vulnerable populations in Rakhine State. Thanks to CERF, WFP was able to quickly respond to the increased demands for FBF in Rakhine.

Nutrition
As reported by UNICEF and WFP, while CERF funding significantly helped address the needs of children with SAM in the targeted areas, the funding only contributed to a small portion of the overall needs in the northern part of Rakhine State and for a limited period of time though needs remain. CERF funding also enabled treatment of children with MAM in northern Rakhine, where prior to the CERF funding no actors provided this treatment. As untreated MAM cases present an increased risk of mortality and morbidity and likely result in further deterioration of the nutritional status of children, CERF funding therefore served as a preventative measure.

Despite concerted efforts of humanitarian agencies over the last few years, including the CERF Underfunded Grant, the northern part of Rakhine State continues to suffer dismal rates of food insecurity and access to basic social services.

The most recent Standardized Monitoring and Assessment of Relief and Transitions (SMART) Nutrition survey conducted by ACF among children aged six to 59 months (2015) showed alarming prevalence of Global Acute Malnutrition (GAM) in Buthidaung (15.1 per cent) and Maungdaw (19 per cent), well above the critical WHO threshold of 15 per cent.

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

Different opinions are expressed by the recipient agencies and sectors. Please see below a summary:

- Regarding **Child Protection**, CERF funds did not help UNICEF in the resource mobilisation from other sources.
- However, UNICEF indicates that the CERF Grant helped to mobilise funding from DFID and OFDA for the **WASH** sector.
- For the **health** sector, WHO indicates that CERF funding did not contribute to mobilize external and additional funds. The WHO country office in Myanmar received the South East Asia Regional Health Emergency Funds from its regional office in India. Plan International received its internal funds. UNFPA was able to utilize the project funded by CERF with Myanmar Medical Association (MMA) as the implementing partner to mobilize additional funding from Finland and Sweden to link the current sexual and reproductive health interventions. In addition, the life-saving activities included in this CERF-funded project were implemented through a well-coordinated approach building upon local capacities, allowing IOM to mobilize and capitalize on local available resources in response to critical needs in Rakhine State. It has also helped secure additional mobilization of resources – and varying levels of support from MOH, humanitarian partners and local authorities.
- Regarding the **SGBV** sub-sector**,** UNFPA admits that additional and subsequent funding was awarded to UNFPA and their IPs: i) women and Girls First (funding from Sweden, Finland, UK, Italy and Australia to UNFPA); ii) IRC received complementary funding from ECHO and BPRM to increase network capacity for GBV emergency response and PSS within 10 Townships with a Lashio-based office.
- UNHCR indicates that the additional funding received for **shelter** activities was not linked with CERF UFE grant. The latter came indeed very late in the year (UNHCR funding cycle is 1st January to 31st December) in order to contribute to improve resource mobilization efforts.
- Taking into consideration the **food security** sector, CERF funds assisted FAO's fundraising efforts. FAO made reference to the CERF funding in a successful application to the Japanese Embassy for funding in 2016 in Rakhine and Chin states. The Japanese Government has funded an intervention of USD 4.5 million that covers flood affected areas in Rakhine and Chin States with the objective of improving household food security and increasing resilience to floods and cyclones in conflict and natural disaster prone areas. However, WFP admits that CERF grant did not help the organization to mobilize additional funds.
- Finally, UNICEF and WFP recognize that additional resource mobilisation in the **nutrition** sector did not occur as a result of CERF funding. The nutrition sector faced a financial gap, which CERF funds partially helped to address for a short period.

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

Child Protection
As per UNICEF's comments, the CERF funding enabled the coordination of adolescent programming across 11 child protection agencies reaching youth in conflict affected areas and areas of protracted emergency. The programmes have helped children who are out of school, or who have no access to secondary education, to continue learning basic numeracy and literacy and to understand dangers they may face, such as dangers during migration, stranger danger, risks with alcohol and drugs as well as how to have healthy relationships. The CERF funding also supported the development of grassroots case management systems and the development of the child protection information management system, enabling the sector to collect data on child protection issues which will in turn support evidence based programming.

Water, Sanitation and Hygiene
As the WASH Cluster coordination mechanism was already fully established at the time CERF funds were received, it cannot be said that the funds necessarily improved coordination in what was already perceived to be an effective cluster. However, with the addition of the CERF funds, UNICEF recognizes that there were additional needs for coordination which the cluster function effectively met.

Health
Regarding the WHO project, the emergency responses were implemented in collaboration between WHO, Plan International Myanmar, Kachin State Government, State Health Department and other humanitarian partners in Kachin State under the leadership of the Health Cluster. Technical and financial support through the CERF created more space for improved humanitarian coordination. In relation to the UNFPA intervention, CERF funding improved the coordination between UNFPA and State Health Departments and also with MMA for effective service provision and referral systems through the introduction of regular coordination meetings and ad hoc meetings as required. IOM also recognizes that thanks to CERF support, the coordination amongst the humanitarian community was strengthened and responded to critical needs for the displaced population and vulnerable communities. In many instances, the field team collaborated with other partners such as UNFPA, WHO, ICRC, MSF and other local NGO's working in the same areas.

Sexual and/or Gender-Based Violence
UNFPA indicates some coordination improvements were achieved through the support of CERF initial funding: i) active participation of GBV coordinating agencies in all Lashio-based coordination meetings led by OCHA, including with other Protection and Health partners (UNHCR, MSF, ICRC, DRC); ii) initiation of the GBV WG in NSS led by UNFPA; iii) initiation of the GBV Emergency Response roster to support the deployment of trained case workers and health workers in emergencies; and iv) development of close collaboration with NSS-based local Women's Groups and Youth Groups

Shelter
UNHCR recognizes that the coordination between CCCM/shelter/NFI cluster members increased as they had to work in close coordination in the identification of needs, programming and implementation. However, the other grants being for very different sectors and geographical areas, most of the activities were carried out relatively independently one from another and the coordination between the humanitarian community did not reach momentum.

Food Security
FAO indicates that through the implementation of the CERF funded project, information sharing within the Food Security Sector (FSS) has been strengthened allowing for improved coordination between humanitarian organizations. The FAO team participated, and actively shared information, during response coordination meetings and workshops with humanitarian agencies (UNDP, UN OCHA, WFP) and government bodies in Yangon, Rakhine State as well as at local level. In addition, WFP recognizes that a multi-sectoral, integrated and coordinated approach is pivotal to tackle food and nutrition insecurity. WFP, in its role of FSS co-lead, contributed to strengthening inter- and intra-cluster coordination collaboration while also fostering synergies with other partners' interventions. The seven UN organizations and their partners receiving the CERF funding cooperated closely at all times including through sector/cluster meetings and the After Action Review meeting held on 29 August 2016.

Nutrition

As per UNICEF and WFP's comments, the two sub-implementing partners, ACF and Malteser, had to coordinate to ensure effective collaboration between the SAM and MAM programme to discuss mutual referrals of beneficiaries from SFP to OTP and vice versa.

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

Please find below some relevant comments from some recipients agencies:

- **WHO:** CERF contributed to provide emergency health care services to displaced populations in Kachin State by addressing Maternal Mortality and seeking early treatment in response to illness in the under-five population.

- **UNHRC:** CERF has added value to the humanitarian response by filling some of the gaps, which would have remained significant otherwise. The relevance of the UFE modality has been indeed to cover activities that were not receiving sufficient attention from donors.

- **UNFPA:** CERF funds for health and GBV projects. The CERF-funded health team worked closely the with the GBV team, providing technical assistance and resources to improve awareness and knowledge on health needs and available services among GBV survivors.

Conversely, CERF funding enabled Health programming to be utilized as an entry point to approach GBV, as a sensitive issue to GBV interventions and implement a multispectral response to GBV survivors. Overall, the initial CERF funding in Shan State greatly contributed to the humanitarian response by increasing other humanitarian actors' awareness of needs related to GBV issues and of GBV interventions in emergencies.

- **FAO:** The CERF allocation strengthened FAO's capacity to quickly respond to the needs of flood- and conflict-affected populations through diverse actions that not only focused on the distribution of inputs, but also on delivery of capacity building trainings that were crucial in building community resilience. The CERF grant was key in improving agricultural livelihoods in difficult areas of Northern Rakhine State affected by ethnic conflict. The allocation allowed the delivery of timely support to address the immediate needs of affected communities as well as the underlying causes of food insecurity. The project contributed to the enhancement of the agricultural production, an increase in the number of livestock, and also allowed for income generation and improvement of nutrient-intake through quality foods as part of beneficiaries' diets. From the capacity development perspective, the project increased farmers' capacities in the area of agriculture production practices and livestock management. CERF funding has also allowed for the implementation of the full food security approach as stated in the FAO - WFP partnership programme.

- **WFP:** Since the CERF proposal included a nutrition component, WFP was enabled to procure additional FBF. To the contrary, funds which were restricted to the delivery of commodities of the basic food basket (rice, oil, pulses, salt) did not allow doing so. Thus, WFP could timely assist 32,592 malnourished children under-five years in Rakhine State.

- **IOM:** Through CERF allocation, it was able to effectively support a rapid delivery of emergency assistance in response to the urgent health needs of the population in Rakhine State and was able to address the critical gap , reduced barriers in accessing emergency health care of the key population

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT

Lessons learned	Suggestion for follow-up/improvement	Responsible entity
The recipient organization did not inform about changes in project targets and budget in advance. Greater common understanding of the procedures is required.	Provide comprehensive training to recipient organizations on the CERF, particularly standard operation procedure on project modification/revision, including how to manage changes in project targets, the need to arrange a no-cost-extension, budget revision etc.	CERF Secretariat OCHA HFU
Time-critical interventions began promptly, thanks to the rapid disbursement of CERF funds.	Keep up this momentum to promote early action and respond to time critical needs	CERF Secretariat
Benefit of timely provision of funds for emergency reponse	Should be continued	CERF Secretariat
Intervention and support from local actors (CBOs, local groups) have been key in the implementation of this CERF programming	CERF Secretariat should encourage applicants to establish networks with these local groups for sustainability and efficiency purposes	CERF Secretariat HCT
CERF Underfunded process took place concurrently with: • MHF Standard Allocation • CERF Rapid Response • MHF Reserve Allocation	During an emergency consider delaying underfunded calls to give sufficient administration time to ensure quality and timeliness	CERF Secretariat

Reporting process should be disseminated to agencies prior to implementation for detailed information of data collecting	Continuous coordination between CERF Secretariat and recipient agencies to ensure consistency of data collection and reporting	CERF Secretariat OCHA HFU
CERF funding enabled a fast delivery of direct response to the beneficiaries and targeted communities including the government counterparts and enabled targeting more beneficiaries than planned.	Funds should be allocated to organizations that directly deliver response to target beneficiaries for an immediate impact and response to the affected populations and more cost effective resource mobilization.	CERF secretariat
Humanitarian response in rural contexts should consider the main sources of livelihoods of the affected population and their capacities to withstand a shock. Support to the affected population to restore their livelihood by increasing their resilience is not only one of the "CERF life-saving criteria" for the grant allocation but is progressively becoming a consolidated practice in humanitarian responses that should be considered by CERF secretariat.	Food assistance (in kind and through vouchers / electronic vouchers or cash) represents the first necessary support during humanitarian crisis with acute problems of food security. It is equally important that in the rural context, resumption of agricultural activities can start at the same time as food assistance, and possibly in the same areas and covering the same number of beneficiaries, in order to increase food availability locally and reduce dependency on food aid. Humanitarian operators are progressively acknowledging the relevance of addressing the capacities of the individuals and the communities to better withstand natural disasters. Although humanitarian assistance is meant to address the immediate and lifesaving needs of affected population, humanitarian donors and pooled fund mechanisms (such as CERF) should also promote interventions that can increase resilience of individual communities to withstand recurrent disaster.	CERF secretariat HCT Food Security Sector
Compared to funds restricted to providing food commodities of the minimum food basket, the CERF funding allowed for the inclusion of the nutrition component which was very helpful to respond to the increased number of malnourished children in northern Rakhine State.	Consideration of future funding proposals combining relief assistance with nutritional support, which is critical. Advocacy with donors showcasing the benefits of flexible funding. Specifically in an unstable and rapidly changing context unrestricted funds are valuable to avoid gaps in addressing the rapidly changing needs of vulnerable people.	CERF Secretariat HCT
The duration of the no-cost extension depends on each agency's request. Some agencies found the NCE request process more complicated because it needs to be prepared one month before the end of the project.	Better advocacy / clear guidelines should be given to implementing partners on NCE	CERF Secretariat OCHA HFU
Lack of access to Non-Government-Controlled Areas posed a lot of challenges in project implementation. As fund recipients, some UN agencies could not access NGCA to monitor the project implementation.	Third-party monitoring approach should be considered for project monitoring in hard-to-reach / inaccesible areas for UN Agencies or international IPs	CERF Secretariat UN Agencies

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Multisectoral approach of the CERF underfunded allocations with strong coordination among sectors have been effective in 2015-2016	This coordinated and multisectoral approach should be continued for future allocation	HCT
The lack of MoUs between some implementing partners and relevant Government entities caused a delay in the implementation of the project.	Ensure that recipient agencies identified implementing partners ready to operate and implement the project. Internal due diligence process should be undertaken by recipient agencies.	UN Agencies
Delays in transfer between the HQ recipient agency and the Country Office	Accelerate and streamline the fund transfer process.	UN Agencies
Some activities could not be implemented by implementing partners because delay in the request/approval of no-cost extension.	Improve project management by recipient agency and accelerate the process of no-cost extension request.	UN Agencies OCHA HFU CERF Secretariat
Initial implemention plans related to some activities needed a modification to respond to the lack of local capacity. Local partner staff had limited skills and insufficient knowledge of international standards in humanitarian intervention.	Build capacity of local sub-implementing partners in emergency response and project cycle management, within a gender and inclusive approach.	UN Agencies
Some specific interventions only serve IDP communities while host communities have a similar degree of need.	Expand some interventions to host communities in collaboration with local authorities.	UN Agencies
Staff movement was often suspended due to security restrictions and armed conflict.	Ensure active advocacy on acces and increased safety and security trainings for staff.	RC/HC HCT UNDSS
Difficult transportation during the rainy season.	Include risk analysis and mitigation activities during the CERF application process.	UN Agencies
Activities initially planned cannot be implemented due to the lack of context analysis during the application process.	Develop more qualitative context analysis, including community-based engagement, during the application process.	UN Agencies
Limited actors in some key response sectors in some very hard-to-reach areas with limited services.	Promote a proper mapping of local capacity through the different response sectors and across the country, with focus in the hard-to-reach areas with limited services.	ICCG
Combination of UN agencies, international partners and local actors, including some Government entities at different levels facilitated a faster project implementation and a stronger response.	Ensure proper coordination and partnership with international partners and local actors, including some Government entities at different levels, particularly those running sensitive, complex programmes which can be very helpful in case of an emergency UN intervention with CERF funds.	HCT UN Agencies
Challenge to implement key activites in local in communities due to time constraints and limited awareness of population.	Raise awareness at different levels to emphasize importance of specific emergency activites (i.e. screening and treating children).	UN Agencies

A stand-alone emergency sector response is insufficient to address the persistent / recurrent situations, which need longer-term and integrated multi-sector approach.	Scale up implementation of multi-sectoral programmes to prevent emergency situation (i.e. malnutrition) in a sustainable way.	RC/HC HCT / UNCT UN Agencies
Coordination between recipient agency and implementing partner was delayed in beginning phase of project due to change in staff roles and responsibilities and unclear lines of communication.	Clarify lines of communucation, delegation of authority and handover and division of responsibility.	UN Agency Implementing Partner
Fast delivery of direct response to the beneficiaries and targeted communities including the government counterparts and enabled targeting more beneficiaries than planned.	Funding envelopes should take into consideration delivery capacity of recipient agencies for an immediate impact and response to the affected populations and more cost effective resource mobilization.	RC/HC HCT
Delivery of trainings along with the emergency response was well received by beneficiaries (i.e. livelihood project). This increased knowledge, provided the opportunity to help ensure the highest and longest-lasting value gained from these interventions.	Opportunities to expand local capacities of vulnerable groups when delivering emergency response / development interventions should be explored and implemented whenever possible to help ensure support is comprehensive and sustainable.	HCT / UNCT
Lack of cooperating partners in some complex context (i.e. Rakhine State) remains a challenge when implementing life-saving activities.	Continue advocacy with the Government for more access of NGOs in the affected areas.	RC/HC HCT
Disbursement to UN agencies was quite quick, but transfer of funds to IPs took time, leading to some NCE requests.	Recipient UN agencies should identify IPs before emergency periods in order to have agreements and be able to facilitate a quick transfer of funds.	UN Agencies
Inputs from sub-national level colleagues in the design, implementation and M&E for cross-sectoral projects are needed.	Organize twice a year regular refresher / orientation sessions with partners, integrating practical aspects for the CERF application process and management and implementation. This could be organized also before any specific CERFallocation.	OCHA HFU UN Agencies Implementing Partners
Any change (reprogramming of activities or budget), including no-cost extension (NCE) should be communicated to OCHA in its early stage to provide the right guidance on the process to follow (i.e. NCE at least four weeks before the finalization of the project).	Monitor progress of CERF funded projects, as part of cluster/sectors/ICCG coordination meetings, including joint field monitoring missions, where possible, in order to identify challenges to be addressed, e.g. the need for a NCE.	UN Agency Implementing Partner OCHA HFU

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-103	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Child Protection		☒ Concluded
4. Project title:	Addressing immediate protection needs of conflict-affected children in Rakhine State		

7.Funding

a. Total funding requirements[5]:	US$ 1,670,000	d. CERF funds forwarded to implementing partners:	
b. Total funding received[6]:	US$ 912,000	▪ *NGO partners and Red Cross/Crescent:*	US$ 431,141
c. Amount received from CERF:	US$ 500,000	▪ *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)	34,070	34,577	68,647	34,070	34,577	68,647
Adults (≥ 18)				450	373	823
Total	**34,070**	**34,577**	**68,647**	**34,520**	**34,950**	**69,470**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs	50,455	51,198
Host population		
Other affected people	18,192	18,272
Total (same as in 8a)	**68,647**	**69,470**
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 increased reach of beneficiaries is due to the addition of the Child Protection Group members.	

[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.

CERF Result Framework			
9. Project objective	Addressing immediate protection needs of children In Rakhine State		
10. Outcome statement	Conflict-affected children in select areas of Rakhine State are protected from abuse, violence and exploitation, and survivors are identified and provided with life-saving case management services		
11. Outputs			
Output 1	Community-based child protection mechanisms for timely referral to services of children at risk or survivor of violence and/or separated children are strengthened		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	# of active community-based Child Protection Groups who identify children at risk of abuse and violence	36	40
Indicator 1.2	# of community members engaged in Child Protection Groups to identify children at risk of abuse and violence	645	823
Indicator 1.3	% of Child Protection Group members that are female	50%	45%
Indicator 1.4	# of active community-based Children and Adolescent Groups	40	20
Indicator 1.5	# of children and adolescents participating in Children and Adolescent Groups	750	2,252
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Continuous technical support to existing Child Protection Groups	Save the Children International and Danish Refugee Council, with technical support by UNICEF	SCI, DRC, RI and CFSI supported by UNICEF
Activity 1.2	Identifying of community members and capacity building to establish five Child Protection Groups in Maungdaw Township, Northern Rakhine State	CFSI, with technical support by UNICEF	CFSI with technical support by UNICEF
Activity 1.3	Continuous technical support to existing Children and Adolescent Groups	Save the Children International and Danish Refugee Council, with technical support by UNICEF	SCI and DRC with technical support by UNICEF
Activity 1.4	Identifying and capacity building of members for of five community-based Children and Adolescent Groups in Maungdaw Township, Northern Rakhine State	CFSI, with technical support by UNICEF	CFSI with technical support by UNICEF
Output 2	Child survivors of violence, exploitation and abuse or at risk thereof are being provided with life-saving psycho-social and case management support		
Output 2 Indicators	**Description**	**Target**	**Reached**

Indicator 2.1	# Children covered by child protection case management services	68,647	68,647
Indicator 2.2	# Children (M/F) provided with life-saving child protection case management support	1,400	401M / 322F
Indicator 2.3	# of identified separated and unaccompanied children whose interim care situation is being monitored and supported	750	72
Indicator 2.4	# Children (M/F) with physical or mental disabilities provided with life-saving child protection case management support	N/A 450	87M / 116F
Indicator 2.5	# Children (M/F) in early marriage provided with life-saving child protection case management support	N/A 200	45M /139F
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Building relations with local authorities in Maungdaw Township to establish child protection programming	UNICEF, CFSI	UNICEF, CFSI
Activity 2.2	Child Protection Service Mapping and Assessment in Maungdaw Township	UNICEF, CFSI	UNICEF, CFSI
Activity 2.3	Capacity-building of CFSI on case management	UNICEF, CFSI	UNICEF, CFSI
Activity 2.4	Continuous case management provided to existing caseload and newly-identified children in Sittwe, Pauktaw and Maungdaw Townships	Save the Children International, Danish Refugee Council and CFSI, with technical support by UNICEF	SCI, DRC, RI and CFSI with technical support from UNICEF.
Output 3	Safe spaces and essential life skills are being provided to adolescents to prevent negative coping-mechanisms including risky migration and GBV		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	# of adolescents (M/F) receiving essential life-skills	2,400	1,200M /1,052F
Indicator 3.2	# of surveyed adolescents judging the life-skills training to be relevant for their everyday protection issues	90%	91%
Indicator 3.3	# of surveyed adolescents reporting that they are more confident in making their own, informed decisions	85%	91%
Indicator 3.4	# of youth centers providing psycho-social support through offering an age-appropriate community space for socializing, play, learning	10	10
Indicator 3.5	# of adolescents provided psycho-social support through access to an age-appropriate safe community space for socializing, play, learning	1,500	2,252
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Youth facilitators in Maungdaw Township are identified and trained on delivering life-skills programming	CFSI, with technical support of UNICEF	CFSI with technical support of UNICEF

Activity 3.2	Existing youth facilitators receive ongoing technical support and facilitation quality is regularly monitored	Save the Children International and Danish Refugee Council, with technical support by UNICEF	SCI and DRC with technical support by UNICEF
Activity 3.3	Adolescents in Maungdaw Township are enrolled in life-skills course	CFSI, with technical support of UNICEF	CFSI with technical support of UNICEF
Activity 3.4	Youth Centers in Sittwe Township continue outreach to engage adolescents	Danish Refugee Council, with technical support by UNICEF	DRC with technical support by UNICEF
Activity 3.5	A survey with select adolescents is conducted to ensure relevance of materials, quality of facilitation and impact on coping mechanisms	UNICEF	UNICEF

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 total of 40 Child Protection Groups (CPGs) were established in the targeted townships. This number surpassed the target due to new CPGs having been established in Maungdaw district through CFSI's new project as well as the reformation of CPGs in Save the Children International (SCI) Sittwe and Pauktaw camps. The reformation was initiated to aim for greater gender parity amongst the groups. In many of the camps and communities, committee members are predominantly male due to cultural barriers and discrimination against women. In more conservative Muslim communities, it therefore took great advocacy efforts with community leaders to allow women to participate in groups. Gender parity amongst the groups stood at 45% by the project's end, which was deemed a great achievement. In addition, to ensure full participation of women, CPG's were split between males and females in some communities.

The case load of children provided with life-saving child protection case management support from January to June was nearly half the target of that of CFSI due to the project start date in January 2016 only. As CFSI was the first child protection actor in Maungdaw district and communities were new to child protection programming when the programme started, it focused on awareness raising and start-up of the community-based mechanisms (e.g. CPGs) to support referral to case workers. As communities enhanced their understanding of child protection and how to report cases, there was an increase in the number of reported cases.

In Sittwe and Pauktaw, SCI had an established case management system and supported the majority of cases in Sittwe and Pauktaw camps. DRC and RI were also new to Case Management and received the interagency training in May 2016.

The numbers relating to separated and unaccompanied children were lower than targeted. This was due to a change in baseline numbers where cases were mistakenly identified as family separation cases. This was corrected and many of the cases were registered under case management for further support. In the reporting timeframe seven unaccompanied and two separated children were reunified with their families.

Accessing equal numbers of male and female adolescents with the EXCEL life skills package proved challenging in all locations. This was mainly as a result of cultural barriers and perceptions of female adolescents in communities who are often confined to the home once they reach adolescence. Although in the above table the numbers do not vary greatly between boys and girls, at a camp level there were wider disparities in more conservative communities in Sittwe and Pauktaw and in particular in Maungdaw district. To overcome this in the future, a support network will be developed for youth facilitators to support different community engagement strategies and also to exchange methodology on how to present "taboo" subjects that are important for youth empowerment and protection. Some approaches in the past that have increased girls' engagement have been to provide the same session for parents to help guide how to discuss sensitive topics; providing home based sessions; and modifying youth facilities to provide greater privacy.

It is also clear from the evaluation that the overall programme (not limited to the CERF project) is well received by adolescents and that there are significant changes in behaviour from the life skills learnt. In comparison to boys' responses, girls responded feeling more confident in themselves, more confident in group work and better able to understand their own emotions and others, which are skills that help in negotiation, communication and critical thinking. For a population that has limited access to education, this programme is addressing a gap in services and vital lifesaving knowledge and practices.

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

The case management system developed is guided by standard operating procedures that measure the timeliness of the response and ensure the best interest of the child is accounted for at each stage of the case management cycle. Child participation in decision making is incorporated into this cycle based on the child's maturity and age. A satisfaction sheet was recently developed to enable beneficiaries to give feedback on the service they receive and feedback on the case worker who supported their case. Information sharing protocols are developed to maintain confidentiality of beneficiaries accessing case management services to ensure the principles of "safety, dignity, do no harm and confidentiality" and maintain the best interest of the child. Referral pathways are developed in line with community consultations to ensure that beneficiaries feel empowered to self-refer and have information on what services are available to support them. These posters were developed using a conflict-sensitive approach and contain pictures both tailored to the Muslim context as well as the Rakhine context. Posters were also made child friendly to ensure that children understand how to reach services, including children with disabilities. Children and communities were consulted throughout the process.

Within Sittwe and Pauktaw camps complaints mechanisms were developed for communities to be able to share any concerns they have with services. The mechanism aims to give feedback within two weeks of receiving a complaint.

Where setting up a project in Maungdaw district, time was taken to ensure positive community engagement and acceptance of the project, especially to explain the principles of child protection and referral processes. Also, the presentation of the adolescent programme to communities was conducted using different methodologies with varying success. The adolescent roundtable was used as a time to reflect on feedback from parents and communities relating to their culture and context. In Maungdaw, for reproductive health presentations, the community suggested that the children draw the development of the body, rather than use the pictures in the book. This was deemed more culturally appropriate. The opportunity to share the feedback from the communities has helped refine the adolescent programme and improve implementation.

An evaluation of the EXCEL package was conducted by Save the Children International gaining feedback from children who participated in the life skills package as well as parents of the children who participated. This evaluation has been shared with the sector and used to help develop the life skills programme.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
While no evaluation was planned for the project, a Save the Children International assessment was conducted on the EXCEL programme after the completion of phase one, and was shared with the sector as a data source for improving the EXCEL package. It is attached for further reference.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	**5. CERF grant period:**	02/10/2015 – 30/06/2016
2. CERF project code:	15-UF-CEF-104	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Water, Sanitation and Hygiene		☒ Concluded
4. Project title:	Emergency WASH services for IDPs in hard to reach areas of Kachin and northern Shan		

7. Funding

a. Total funding requirements:	US$ 9,500,000	d. CERF funds forwarded to implementing partners:	
b. Total funding received:	US$ 6,740,000	▪ *NGO partners and Red Cross/Crescent:*	US$ 327,195
c. Amount received from CERF:	US$ 400,000	▪ *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)	3,960	4,123	8,083	8,821	7,449	16,270
Adults (≥ 18)	6,799	7,565	14,364	8,829	6,645	15,474
Total	**10,759**	**11,688**	**22,447**	**17,650**	**14,094**	**31,744**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs	20,617	28,762
Host population	1,830	2,982
Other affected people		
Total (same as in 8a)	**22,447**	**31,744**
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 total number of beneficiaries reached was more than planned as a greater number of host community schools were covered. In addition, some activities were carried out in camps outside of those originally targeted, such as hygiene promotion sessions and IEC distribution.	

CERF Result Framework

9. Project objective	Provision of water supply, latrines, and hygiene materials to 22,447 IDPs and school children in hard to reach areas of Kachin and Northern Shan States, Myanmar

10. Outcome statement	22,447 emergency-affected people in Kachin and Northern Shan States have improved access to water and sanitation infrastructure, with accompanying improvements to hygienic behaviours and practices		
11. Outputs			
Output 1	People have equitable and sustainable access to sufficient quantity of safe drinking and domestic water		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	100 % of people who have improved access to safe drinking and domestic water	100%	124%
Indicator 1.2	30 water points rehabilitated / maintained and operated	100%	123% 23 rehabilitations 14 replacements On-going maintenance for all
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Water Quality Testing	SCI/Metta	Metta/SCI & WPN
Activity 1.2	Rehabilitation and maintenance of Water points	SCI/Metta	Metta/SCI & WPN
Output 2	People have equitable access to safe and sustainable sanitation and live in a non-contaminated environment		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	100 % of people with equitable access to safe and sustainable sanitation facilities	100%	137%
Indicator 2.2	175 of latrines constructed or rehabilitated, and maintained properly	175	**973** New -283 Repaired- 317 De-sludged-329 De-commissioned-44
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Rehabilitation and maintenance of sanitation facilities	SCI/Metta	Metta/SCI & WPN
Activity 2.2	Community Cleaning campaigns	SCI/Metta	Metta/SCI & WPN
Output 3	People adopt basic personal and community hygiene practices		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	Number of people sensitized to personal and environmental Hygiene	22,447	26,617
Indicator 3.2	8400 hygiene resupply kits distributed	8400	0
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Hygiene Promotion	SCI/Metta	Metta/SCI & WPN
Activity 3.2	Hygiene Kit resupply	SCI/Metta	Metta/SCI & WPN

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:

Indicator 2.3 Major costs were for latrine rehabilitation and maintenance activities. A breakdown of key actions is provided within the indicator section. Construction of new latrines was challenging in most camps due to lack of space. This increased maintenance costs and required the construction of additional temporary latrines where planning has not been granted for more permanent facilities. Desludging costs remain very high due to lack of operators and government service providers. A request from camp inhabitants for solid waste management bins was fulfilled along with training to address significant amounts of rubbish within the camp.

Indicator 3.1 Hygiene promotion sessions identified high needs for more bathing spaces which were provided through this project.

Indicator 3.2 Hygiene kit re-supply was covered under another donor. These funds were redirected to latrine maintenance related to points outlined above. Hygiene kit distribution is now discouraged under the WASH Cluster strategy unless specific acute needs are identified (such as lack of access to markets or freedom of movement).

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

Host communities participated in construction of water facilities and were consulted on planning and siting of infrastructures. Within camps volunteers from the community are primarily responsible for ensuring operation and maintenance of WASH facilities. Camp volunteers have been trained on water quality monitoring to give them a better understanding of how to ensure and monitor water quality within their communities and they have been provided with tools and equipment to ensure they can carry out minor repairs themselves. Feedback and awareness sessions were frequently held with camp communities to build awareness and actively involve them with improving their own water safety.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
This funding was used to fill critical gaps in program activities where partners continue to work. Given the length of time for implementation of these activities and the continued presence of the partners, no evaluation was planned/undertaken.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	**5. CERF grant period:**	28/09/2015 – 30/06/2016
2. CERF project code:	15-UF-CEF-105	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Sexual and/or Gender-Based Violence		☒ Concluded
4. Project title:	Addressing immediate protection needs of children and women, including survivors of GBV, in select hard-to-reach areas of Kachin State		

7.Funding

a. Total funding requirements[7]:	US$ 3,585,000	d. CERF funds forwarded to implementing partners:	
b. Total funding received[8]:	US$ 1,401,200	▪ *NGO partners and Red Cross/Crescent:*	US$ 166,139
c. Amount received from CERF:	US$ 196,240	▪ *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)	1,182	1,230	2,412	1,182	1,230	2,412
Adults (≥ 18)	2,023	2,265	4,288	2,023	2,265	4,288
Total	**3,205**	**3,495**	**6,700**	**3,205**	**3,495**	**6,700**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs	4,551	4,551
Host population	2,149	2,149
Other affected people		
Total (same as in 8a)	**6,700**	**6,700**
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 numbers are based on population access to the services provided.	

[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.

CERF Result Framework			
9. Project objective	Addressing immediate protection needs of women and children in hard-to-reach areas of Kachin State		
10. Outcome statement	Conflict-affected children and adults in hard-to-reach areas of Kachin State are protected from abuse, violence and exploitation, and survivors are identified and provided with life-saving case management services, with a focus on Gender-Based-Violence		
11. Outputs			
Output 1	Community-based protection mechanisms for timely referral to services of children and adults at risk or survivor of violence are strengthened		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	# of active community-based Child Protection Groups who identify children at risk of abuse and violence	5	16
Indicator 1.2	# of community members engaged in Child Protection Groups to identify children at risk of abuse and violence	44	123
Indicator 1.3	# of active community-based Children and Adolescent Groups	5	16
Indicator 1.4	# of children and adolescents participating in Children and Adolescent Groups	1,135	1,641
Indicator 1.5	# of adolescents (M/F) receiving essential life-skills	750	146M / 221F
Indicator 1.6	# men and boys are mobilised on gender-based violence prevention	600	93M / 762 B
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Continuous technical support to existing Child Protection Groups	KMSS, supported by PLAN International and UNICEF	KMSS supported by PLAN International and UNICEF
Activity 1.2	Continuous technical support to existing Children and Adolescent Groups	KMSS, supported by PLAN International and UNICEF	KMSS supported by PLAN International and UNICEF
Activity 1.3	Sessions with men and boys on caring for child development and awareness on gender-based violence	KMSS, supported by IMC and UNICEF	KMSS supported by IMC and UNICEF
Activity 1.4	GBV sensitization for camp, community and religious leaders	KMSS, supported by IMC and UNICEF	KMSS supported by IMC and UNICEF
Output 2	Adult and children in remote areas have access to age-appropriate and survivor-centred CPIE and GBV prevention and response services		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	# Children and adults covered by child protection and Gender-Based Violence case management services	6,700	6,700
Indicator 2.2	# Child survivors of violence (M/F), including GBV are provided with life-saving child protection case	60	23 (12M / 11F)

	management support		
Indicator 2.3	# Adult survivors of violence (M/F), including GBV are provided with life-saving case management support	40	8F
Indicator 2.4	# of safe community spaces for women and children	5	5
Indicator 2.5	# of children provided psycho-social support through access to an age-appropriate safe community space	1,200	1,641
Indicator 2.6	# of adults provided psycho-social support through access to an age-appropriate safe community space	1,000	544
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Provision of age-appropriate and survivor-centred counselling and case management, including home visits where requested	KMSS, supported by IMC and UNICEF	KMSS supported by IMC and UNICEF
Activity 2.2	Two GBV and CP case management refresher trainings in each of the five locations	IMC and PLAN, with technical support of UNICEF	IMC and PLAN with technical support of UNICEF
Activity 2.3	Out-reach to surrounding IDP camps and host community in Chipwi and Hpa Kant Townships	KMSS, supported by IMC and UNICEF	KMSS supported by IMC and UNICEF
Activity 2.4	Regular psycho-social support activities offered in the safe spaces, including debate clubs, cooking and responsive feeding, care for child development practice, parenting sessions, and additions to the core life-skills course for adolescents	KMSS, supported by IMC and UNICEF	KMSS supported by IMC and UNICEF

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:

Access to men and boys on GBV issues remained challenging. Within the centres, women responded well to the psychosocial support provided. Feedback from the community stated that women were very happy to participate in centre-based activities. They reported feelings of relief from their current stress and frustration by participating in activities which allow for more socialisation, cohesion and development of new skills that gave them a sense of empowerment. Development of content/curriculum for male engagement sessions was helpful for community facilitators in structuring sessions. The monitoring and technical supervision structure worked well due to the appointment of a dedicated International Medical Corps officer as focal point for the male engagement who directly supports child friendly spaces. However, development of the curriculum was challenging due to the limited feedback provided from male participants, particularly as provision of feedback is culturally challenging most especially in written form. In addition, to find the fixed participants for the male engagement curriculum was most difficult in and around Hpakant due to lack of time, as most men were engaging in livelihood activities.

In contrast to Rakhine State, accessing adolescent boys for the life skills programme in Kachin State was more challenging. Adolescent boys are often away from the camps to attend secondary school/private tuition, or in search of daily labour. Boys who participated showed a lack of confidence in comparison to girls. It was felt that having a male facilitator and more varied topics to discuss might increase interest.

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

The approach to project implementation was based on community participation regarding beneficiaries' rights, responsibilities and entitlements, feedback systems and evolving needs assessments. Transparency was crucial to the operational approach, and considerable time was planned for the requisite community consultations at the outset of the project. Before project implementation

began, UNICEF, Plan International and partners including local authorities and respective camp management committees, conducted project sensitization meetings and follow-up discussions with the IDPs and community leaders to ensure that they understood the objectives and modalities of the project, as well as their rights, roles and responsibilities. Beneficiaries were also consulted on the design of campaign activities, awareness-raising sessions, and referral mechanism to ensure appropriateness to local context and needs. An age, gender and culturally appropriate feedback and complaint mechanism in line with international humanitarian accountability standards was established in each targeted camp with a dedicated person assigned to collect the feedback on a regular basis and ensure the issues were dealt with appropriately. Appropriate procedures for handling feedback and complaints were established in cooperation with beneficiary communities.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
While no evaluation was planned for the project, a Save the Children International assessment was conducted on the EXCEL programme after the completion of phase one, and was shared with the sector as a data source for improving the EXCEL package. It is attached for further reference.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF WFP	**5. CERF grant period:**	29/09/2015 – 30/06/2016
2. CERF project code:	15-UF-CEF-106 15-UF-WFP-062	**6. Status of CERF grant:**	☐ Ongoing ☒ Concluded
3. Cluster/Sector:	Nutrition		
4. Project title:	Integrated Management of Acute Malnutrition (IMAM)		

7.Funding

a. Total funding requirements[9]:	US$ 1,933,000	d. CERF funds forwarded to implementing partners:	
b. Total funding received[10]:	US$ 496,477	▪ *NGO partners and Red Cross/Crescent:*	US$ 7,064
c. Amount received from CERF:	US$ 496,477	▪ *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)	2,704	2,496	5,200	6,230	5,224	11,454
Adults (≥ 18)						
Total	**2,704**	**2,496**	**5,200**	**6,230**	**5,224**	**11,454**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs		
Host population		
Other affected people	5,200	11,454
Total (same as in 8a)	**5,200**	**11,454**
In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or	Unit costs of the FBF distributed for the MAM treatment were lower than expected. As such, more WSB++ was procured than planned enabling treatment of a significantly higher number of children than originally planned.	

[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.

the age, sex or category distribution, *please describe reasons:*	Thus in all, 2,027 children were provided with MAM treatment, and an additional 9,427 children U5 benefitted from SAM treatment, TFP-FU and BSFP for prevention of acute malnutrition.

CERF Result Framework			
9. Project objective	To reduce malnutrition related morbidity and mortality among children aged 6-59 months through Integrated Management of Acute Malnutrition		
10. Outcome statement	Treatment of moderate acute malnutrition (MAM) is accessible and adequate for targeted children		
11. Outputs			
Output 1	Children with moderate acute malnutrition are identified and adequately treated		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	MAM treatment performance: cure, mortality, default, non-response rates	Mortality rate < 3%; Cure rate > 75%; Default rate < 15%; Non-response rate < 15%	Mortality rate: 0.2% Cure rate: 60% Default rate: 18% Non-respondent rate: 10%
Indicator 1.2	Proportion of eligible population who participate in programme	70%	26.1%
Indicator 1.3	Number of girls and boys receiving nutritious food, disaggregated sex, as % of planned	100% (960 boys; 1,040 girls)	101 % (1,212 boys; 815 girls)
Indicator 1.4	Quantity of nutritious food distributed, as % of planned	100% (107.6 MT)	143% (153.5 MT)
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Fortified blended food distribution for children 6 to 23 months under the treatment of moderate acute malnutrition programme	WFP and Malteser	WFP and Malteser
Activity 1.2	Fortified blended food distribution for children 24 to 59 months under the treatment of moderate acute malnutrition programme	WFP and Malteser	WFP and Malteser
Output 2	Treatment of severe acute malnutrition (SAM) is accessible and adequate for targeted children		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Number of children aged 6-59 months with severe acute malnutrition admitted to therapeutic care	3,200[11] (1,536 boys; 1,664 girls)	4,608 (1,705 boys; 2,903 girls)
Indicator 2.2	Percentage of exits from therapeutic care by children who have recovered	>75%	75.1%
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Procurement and transportation of nutrition supplies for Outpatient Therapeutic Programme (OTP)	In-kind donation of supplies to ACF	UNICEF and ACF

[11] CERF funding contributed to reaching SAM children in the project period (CERF target was 3,200). However, in order to treat all children in the area of implementation, other funding sources complemented CERF.

Activity 2.2	Procurement and transportation of nutrition supplies for Stabilization Centres (SC)	In-kind donation of supplies to ACF	UNICEF and ACF

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 outcomes achieved and discrepancies regarding beneficiaries were explained in the narrative section and in question 8.

Furthermore, against indicator 1.2, the target area covered for MAM treatment expanded throughout the year (covering more communities) which led to the proportion of the population reached being low and reaching only 26.1% of eligible population instead of the planned 70%. However, note that against indicator 1.3, the planned number of boys and girls reached (N=2,000 boys and girls), 101% were reached (N=2,027 boys and girls).

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

UNICEF has established accountability measures which promote community acceptance and engagement, including the use of an anonymous complaints and feedback mechanism. UNICEF and ACF applied the same accountability measures and ensured transparency of the project's actions through community sensitization meetings during which it shares criteria for beneficiary selection and staff recruitment, as well as information relating to the intervention.

UNICEF staff from Maungdaw and Yangon offices undertook monitoring of the project on a bi-monthly basis to ensure proper and effective use of supplies, proper registration of patients and stock taking records in the project areas. This was carried out as a complementary effort to ACF's accountability mechanisms already in place.

Project locations were selected based on the high burden of morbidity and mortality in children U5 due to SAM and where the least resources were available to address these cases. OTCs were staffed primarily by women, and nutrition education topics were especially designed for mothers to empower them to provide adequate care to their children and adequately use family resources through health education and breastfeeding counselling.

The ACF team worked closely with mothers, families and communities, contributing to women's empowerment in understanding the nutritional needs of their children, and provided support services to the most vulnerable children on a case-by-case basis.

WFP and its implementing partners used a complaints and feedback mechanism which was accessible to all beneficiaries. Malteser did not receive complaints for the MAM activities from the beneficiaries during the project duration. WFP's complaint and feedback mechanism (CFM) is easily accessible by all beneficiaries and can be used by calling the hotline, letter at the complaint box, email or talking to program staff. Each WFP sub-office has a CFM focal person who knows how to categorize and handle each (positive or negative) feedback.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
No evaluation was planned in the project proposal, therefore no evaluation budget was planned and no evaluation was carried out.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	FAO	**5. CERF grant period:**	02/10/2015 – 30/06/2016
2. CERF project code:	15-UF-FAO-027	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Food Security		☒ Concluded
4. Project title:	Livelihoods recovery support for conflict-affected communities in Northern Rakhine State, Myanmar		

7. Funding

a. Total funding requirements[12]:	US$ 4,000,000	d. CERF funds forwarded to implementing partners:	
b. Total funding received[13]:	US$ 3,283,000	▪ *NGO partners and Red Cross/Crescent:*	US$ 23,940
c. Amount received from CERF:	US$ 500,000	▪ *Government Partners:*	US$ 61,209

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)	4,551	3,676	8,227	5,018	4,644	9,662
Adults (≥ 18)	5,624	4,299	9,923	6,219	5,726	11,945
Total	**10,175**	**7,975**	**18,150**	**11,237**	**10,370**	**21,607**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs		
Host population	18,150	21,607
Other affected people		
Total (same as in 8a)	**18,150**	**21,607**

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 total number of beneficiaries reached (21,607) was higher than the planned number (18,150) due to household size of beneficiaries being larger than originally estimated. On average, actual household size was 6.5 members, instead of the original 5.5 members (average for Rakhine) estimated during planning.

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

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

CERF Result Framework			
9. Project objective	This project aims to increase production, access and availability of food, improved diet from relief to rehabilitation and development of vulnerable communities through the provision of livestock and agriculture related services in 2 Townships of Northern Rakhine State (Maungdaw, Buthidaung).		
10. Outcome statement	18,150 people affected by conflict sustainably improve their food security, resilience and nutritional status through increased food availability, especially for the protein component of their diet, and at the same time enhance their technical capacity to raise livestock, increase agriculture production and make optimum use of food stuffs available.		
11. Outputs			
Output 1	Increased crop and vegetable production for self-sustenance and better nutrition		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Number of households identified and selected	1,700	1,700
Indicator 1.2	Quantity of agricultural inputs procured (43,25 tons of seeds, 1,700 kits of vegetable seeds, 42.5 tons of fertilizers)	100%	100%
Indicator 1.3	Number of households receiving agricultural inputs	1,700	1,700
Indicator 1.4	Number of beneficiaries trained in improved agro-techniques	1,700	1,700
Indicator 1.5	Post-distribution report	1	1
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Development of selection criteria	FAO	FAO and Department of Agriculture
Activity 1.2	Identification and selection of beneficiaries	Department of Agriculture	Department of Agricultures
Activity 1.3	Procurement of seeds and other inputs	FAO	FAO
Activity 1.4	Distribution of agricultural inputs	Department of Agriculture	Department of Agriculture
Activity 1.5	Basic training on improved agro-techniques	Department of Agriculture	Department of Agriculture
Activity 1.6	Monitoring of activities and technical support	FAO	FAO and Department of Agriculture
Activity 1.7	Post-distribution monitoring and reporting	Department of Agriculture	Department of Agriculture
Output 2	Increased animal production to improve access to a balanced diet containing high quality animal proteins through small scale, low input livestock production making use of spare capacity in household manpower resources.		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Number of households identified and selected	1,600	1,600
Indicator 2.2	Quantity of livestock inputs procured	100%	100%

	(4 000 chicken, 800 goats, 400 piglets and 4 000 ducks + 3 month animal feeds)		(equivalent value reached with livestock type adjusted to meet beneficiary needs)
Indicator 2.3	Number of households receiving livestock inputs	1,600	1,600
Indicator 2.4	Number of beneficiaries trained on animal husbandry	1,600	1,600
Indicator 2.5	Post-distribution report	1	1
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Development of selection criteria	FAO	FAO and LBVD
Activity 2.2	Identification and selection of beneficiaries	LBVD	LBVD
Activity 2.3	Procurement of locally available livestock	FAO	FAO
Activity 2.4	Distribution of livestock related inputs and training	LBVD	LBVD
Activity 2.5	Training of beneficiaries on animal husbandry	LBVD	LBVD
Activity 2.6	Monitoring of activities and technical support	FAO	FAO and LBVD
Activity 2.7	Post-distribution monitoring and reporting	LBVD	LBVD

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:

There are no significant discrepancies between planned and actual outcomes, outputs and activities. It should be noted that the composition of the packages delivered to beneficiaries were modified slightly based on the results of the needs assessment and in response to community request.

Indicator 2.2: The original target was chicken, goats, piglets and ducks. Due to preference of beneficiaries, this target was adjusted to a proportional quantity of goats and pigs: 2,800 goats and 200 pigs. As reported in indicator 2.3, the same number of targeted households was reached.

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

In all phases of project implementation, FAO coordinated with targeted beneficiaries through its implementing partners, Department of Agriculture (DOA) and Livestock, Veterinary and Breeding Department (LBVD). Implementing Partners (IPs) conducted the selection of beneficiaries in accordance with selection criteria provided by FAO and after performing a needs assessment. An external evaluation was also conducted which revealed that in some cases, the village selection committees established to identify beneficiaries were not as participatory as intended. It is equally important to mention that the evaluation team acknowledged that the project was able to deliver assistance equally among Buddhist and Muslim communities. The evaluation report has also mentioned that the distribution sought to benefit households that were more vulnerable to economic disadvantages, such as being female-headed, headed by the elderly or containing a member who suffers from disabilities.

FAO staff frequently communicated with IPs staff (DOA and LBVD) in order to monitor the progress of work at state and township levels. FAO's Senior Emergency Coordinator, International Communication Consultants, Finance and Administration International Officer and National Consultants together with DOA and LBVD staff carried out visits in targeted villages in two townships. They monitored the project implementation and the administrative procedure, collected information and carried out the Focus Group Discussion (FGD) with respective beneficiaries to better understand their situation and how project activities were conducted as well as to receive their feedback.

After the distribution of livestock and harvest period, FAO conducted post-distribution assessment through a quantitative survey, qualitative interviews and FGD in order to get feedback from beneficiaries.

This project included a strong 'Do-No-Harm' component as support to Muslim communities (majority in Northern Rakhine State) is sensitive and could trigger new tensions between them and Rakhine Buddhist communities. As such, most vulnerable households of host/surrounding communities have been supported as well as Rakhine farmers.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☒
Evaluation conducted by the Center for Diversity and National Harmony has been completed (see attached). The following key findings were reported: 79% of respondent beneficiaries of the livestock component and 76% of respondent beneficiaries of the agricultural component reported that the distribution suited their needs. Furthermore, just 10% and 26% of participants from the agricultural and livestock components, respectively, reported that they would have preferred to receive food aid – indicating that overall, the inputs distributed were well-received and that livelihood recovery in the form of agricultural and livestock distribution was preferable to other forms of humanitarian assistance that do not offer sustainable prospects. For both the agricultural and livestock projects, over 75% of beneficiaries interviewed reported that they found the training useful or very useful. In humanitarian contexts, the value of training is often overlooked due to time constraints. Nonetheless, the positive response to the technical trainings undertaken in this project – particularly for the agricultural project – indicates that where possible, future emergency outreach programs should give scope for improving beneficiaries' knowledge. Some participants expressed doubt in the "training of trainers" model adopted by this project, believing that the opportunity for all beneficiaries to receive training directly from the implementing partners would have been more beneficial. Furthermore, it should be noted that the turnout for women at the training was low– especially in Muslim communities. The gender dynamics in Northern Rakhine State see women operate on a lower social level than men, which appears to have resulted in the exclusion of women from the technical trainings. This is exacerbated in the more conservative segments of the Muslim community in Northern Rakhine, where public interaction between men and women is discouraged, meaning that women were sometimes culturally forbidden from participating in training. In the context of an emergency program, the identification of beneficiaries normally rely on the village administrators and village leaders. While this method allowed for rapid and targeted distribution and that in this context, it is one of the more feasible options to allow rapid distribution of inputs, it should be noted that this approach contains some risks. In the case of the this project two main risks were identified: (1) in some cases the village administrator himself was sometimes found to be one of the beneficiaries and (2) the "village selection committees", established to mitigate potential bias in the beneficiary identification process, appeared to sometimes be close to, or be relatives of, the village administrator, and in some cases were also part of the beneficiary pool. These instances did not necessarily detract from the overall successes of the program as also the members of the "village selection committees" were affected by the floods, but it does present a case for more inclusive beneficiary identification processes that can better incorporate Accountability to Affected Populations principles. More generally, there also appeared to be a lack of communication with non-beneficiaries in villages, and more efforts should be dedicated to explain to villagers the reasons for the exclusion from the beneficiary lists. While this can be somewhat accounted for by the rapid nature of implementation in accordance to an emergency response and that the evaluators neither recorded any complaints nor appeared to cause any major problems, the issue should be considered in future programming.	EVALUATION PENDING ☐ NO EVALUATION PLANNED ☐

Deeper involvement of the targeted communities, as well as the inclusion of a transparent complaint mechanism, would ensure greater Accountability to Affected Populations. A majority of small-scale farmers from the agricultural program reported that they consumed their harvest, indicating the achievement of the objective to increase access to the availability of food. Beneficiaries with larger farmland typically sold their cowpeas/rice paddy, and thus earned a positive income. In general, the high-yield rice was very popular, as was the fertilizer. Meanwhile, respondents typically stated that they would have preferred to receive black cowpeas as opposed to white. The DOA recommended white cowpeas for distribution for their higher nutritional value and that they are frequently cooked in curries, which align with the nutrition-focused objectives of the project. It is suggested that respondents state they prefer black cow peas due to the higher price they fetch in the market. This indicates a need to raise greater awareness amongst communities of the value of nutrition. Furthermore, each agriculture beneficiary received a vegetable package – the produce of which also appeared to be consumed by most respondents. This demonstrates the achievement of a short-term improvement to the diets and nutritional intake of beneficiaries. Nonetheless, the vegetable kit were typically only recalled by respondents if they were prompted – which brings into question the relevance of the vegetable seeds in the eyes of the beneficiaries. The provision of training about nutritional intake would prove valuable in these environments, where the benefits of a diversified diet are not well understood. Livestock beneficiaries were, in general, pleased with the livestock they received, with a majority reporting that they had kept the animal with the intention to breed. Particularly amongst the Muslim community, 1 in 5 beneficiaries surveyed reported that they were currently selling animal products (i.e. goat milk), which indicates both a positive income boost as well as a nutritional outcome. A third of beneficiaries surveyed indicated that they had already sold their livestock. This demonstrates that some of the beneficiaries were indeed the poorest in the village and the on-sell, while not likely to provide a sustainable outcome, provides fast cash relief for the most desperate. FAO should build upon the relationship with the Department of Agriculture (DOA) and the Livestock, Veterinary and Breeding Department (LBVD). Stronger communication and guidance measures should be incorporated into future programming.	

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	UNFPA	**5. CERF grant period:**	02/10/2015 – 30/09/2016
2. CERF project code:	15-UF-FPA-033	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Sexual and/or Gender-Based Violence		☒ Concluded
4. Project title:	Gender based violence prevention and response through the provision of comprehensive multi-sectoral care and response in Northern Shan and hard to reach areas of Southern Kachin States		

7.Funding				
	a. Total funding requirements[14]:	US$ $729,200	d. CERF funds forwarded to implementing partners:	
	b. Total funding received[15]:	US$ 405,000	▪ *NGO partners and Red Cross/Crescent:*	US$ 289,214
	c. Amount received from CERF:	US$ 405,000	▪ *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)	365	312	677	1,127	601	1,728
Adults (≥ 18)	1,869	1,610	3,479	3,429	1,302	4,731
Total	**2,234**	**1,922**	**4,156**	**4,556**	**1,903**	**6,459**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs	2,333	5,959
Host population	1,823	500
Other affected people		
Total (same as in 8a)	**4,156**	**6,459**

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

[15] 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:	More IDPs were reached as UNFPA and their IPs conducted emergency response activities for newly arrived IDPs in Hsipaw, Kyaukme, Mine Yu Lay and Namt Pha Kar in addition to planned programming. Host community utilizing services in IDP camps were not differentiated from IDP camp community at this stage of the project. This is a point that UNFPA and their IPs will look at more closely in future implementations.

CERF Result Framework			
9. Project objective	Women and girls in Northern Shan and hard to reach areas of Southern Kachin States have access to expanded GBV services through integrated care in medical clinics, including information sessions, psychosocial activities, and GBV case management.		
10. Outcome statement	Women and girls feel safer because they receive improved access to targeted services, can safely access GBV psychosocial support, and live in communities with increased awareness on the consequences of GBV.		
11. Outputs			
Output 1	100% of reporting GBV survivors receive case management and GBV related health services in line with their needs and wishes by the end of the project cycle.		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	% of GBV survivors who state they received GBV related services in line with their wishes by the end of the project cycle.	100%	100%
Indicator 1.2	# of Post-Rape Kits distributed to clinics	3	3
Indicator 1.3	# of Dignity Kits distributed to vulnerable women and girls	1,000	1,000
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Assessment of women and girls' safety and needs in Northern Shan	UNFPA/IRC	UNFPA/IRC
Activity 1.2	Hiring of Response Officers and Case Workers	UNFPA/IRC	IRC
Activity 1.3.1	GBV Basics Training 3 days - Case Workers and ROs	UNFPA/IRC	UNFPA/IRC
Activity 1.3.2	GBV Referral Pathway training - IRC Health	UNFPA/IRC	IRC
Activity 1.3.3	GBV Referral Pathway training - KMSS Health	UNFPA/IRC	IRC
Activity 1.3.4	GBV Counselling Skills - Case Workers and ROs	UNFPA/IRC	IRC
Activity 1.3.5	GBV Case Management Skills - CWs and ROs	UNFPA/IRC	IRC
Activity 1.3.6	Safety Planning Training - CWs and ROs	UNFPA/IRC	IRC
Activity 1.3.7	Suicide Prevention Training - CWs and Ros	UNFPA/IRC	IRC
Activity 1.3.8	CMR Training - Key Health KMSS and IRC	UNFPA/IRC	UNFPA/IRC
Activity 1.3.9	Trafficking Prevention Training - Key staff, all departments	UNFPA/IRC	UNFPA/IRC
Activity 1.4	Rehabilitation of clinics to include private rooms for case management services	UNFPA/IRC	UNFPA/IRC
Activity 1.5	Implementation of case management services	UNFPA/IRC	UNFPA/IRC
Activity 1.6	Supervision of case management services	UNFPA/IRC	UNFPA/IRC
Activity 1.7	Distribute Commodities (Post Rape Kits and Dignity Kits)	UNFPA/IRC	UNFPA/IRC

Output 2	At least 4,156 community members participate in at least one GBV information session or awareness raising activity.		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Women receive increased awareness of GBV related services through targeted information sessions through the end of the project cycle.	1,066	2,929
Indicator 2.2	Girls receive increased awareness of GBV related services through targeted information sessions through the end of the project cycle.	166	1,127
Indicator 2.3	Community members, including men and boys, receive increased awareness of GBV through IEC material development and distribution through the end of the project cycle.	2,333	2,076
Indicator 2.4	Participation in International Days, including 16 Days of Activism by end of March 2016.	2,333	2,102
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Case workers receive training on conducting awareness raising and information sessions	UNFPA/IRC	IRC
Activity 2.2	Information and awareness raising sessions are held with women and girls	UNFPA/IRC	IRC
Activity 2.3	IEC materials are developed and distributed to community members	UNFPA/IRC	UNFPA/IRC
Activity 2.4	Information and awareness raising sessions are held with men and boys, including leaders	UNFPA/IRC	UNFPA/IRC
Output 3	Coordination mechanisms and service mapping are strengthened and improved among service providers and community based mechanisms to ensure sustainable services and referrals in line with GBV Guiding principles by the end of the project cycle.		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	Service mapping is conducted for areas of operation within first 3 months of project.	1	1
Indicator 3.2	Service mapping is disseminated to all relevant service providers within 6 months of project start.	1	1
Indicator 3.3	Referral pathway is reviewed, adjusted, and disseminated to relevant service providers and community before the end of the project cycle.	1	1
Indicator 3.4	Scoping Study for adaptation of SASA! is completed and informs target locations and communities	1	1
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Service mapping is conducted for areas of operation	UNFPA/IRC	UNFPA/IRC
Activity 3.2	Service mapping is disseminated to all relevant service providers	UNFPA/IRC	UNFPA/IRC
Activity 3.3	Referral pathways are reviewed with key stake holders	UNFPA/IRC	UNFPA/IRC

Activity 3.4	Referral pathways are reviewed and adjusted by GBV actors to improve relevance within local context	UNFPA/IRC	UNFPA/IRC
Activity 3.5	Referral pathway trainings are provided for key community members and groups	UNFPA/IRC	UNFPA/IRC
Activity 3.6	Scoping study for SASA! is conducted with key stakeholders	UNFPA/ Trócaire	Trócaire

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:

More than double the target for women reached with information sessions was achieved (target: 1,066; reached: 2,929). This was due in part to the large population of the camps which expanded during the project due to the arrival of newly displaced persons. UNFPA also strongly promoted women and girls' participation at information sessions due to the high risk of GBV among communities in IDP camps, particularly for those who had fled conflict, which resulted in high attendance rates.

Due to UNFPA's emergency response in addition to planned programming which included information sessions and the provision of Dignity Kits for newly displaced IDPs in Kyaukme and Hsipaw, many more girls under 18 were reached than planned (target: 166; reached: 1,127). This highlights the importance of reaching adolescent girls. The full target for Dignity Kit distribution was met (1000). Additional items drawn from Dignity Kits were also provided to women and girls as part of the flood response in northern Shan.

Female caseworkers reported difficulties with the attendance of men and boys in information sessions due to lack of interest and perception that GBV is a 'woman's issue', which is reflected in indicator figures (target: 2,333; reached: 2,076). More strategies for engaging men and boys are required for future programming including engaging male members of camp committees to promote GBV awareness and encourage male participation in activities as well as the recruitment of a male prevention officer.

Implementation delays at the beginning of the programme (due to challenges in recruitment for UNFPA and IPs) prevented UNFPA and their IPs from organizing events for 16 days of Activism in November 2015, while travel security restrictions imposed due to conflict reduced the number of persons reached by International Women's Day activities on March 8th. Accordingly, participation in these events fell below the set target (target: 2,333; reached: 2,102).

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

Community members were involved in the project evaluation assessment through focus group discussions and key informant interviews. Caseworkers were chosen directly from IDP communities and thus, as both beneficiaries as well as implementers of the project ensured culturally appropriate service provision. In addition, programming was directed through the project cycle through the continuous participation of leaders and community members.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☒
The project Evaluation Workshop was held on September 28th and 29th 2016 in Lashio with beneficiaries, camp committee members, IDP case workers, IRC, KMSS GBV and health teams and UNFPA. The results of the project evaluation assessment were discussed with participants who were asked to prioritize the results according to a scale of need, identifying the most critical (attached draft assessment). Programme objectives, successes and challenges and targeted communication materials were discussed. The programme strategy was also discussed, with community feedback on future programme strategy collected and reported in the process.	EVALUATION PENDING ☐ NO EVALUATION PLANNED ☐

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNFPA	**5. CERF grant period:**	04/09/2015 – 20/06/2016
2. CERF project code:	15-UF-FPA-034	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Provision of Access to Life Saving Reproductive Health Services to the Displaced and Local Population in Hard-to-Reach Areas in Kachin		

7. Funding

a. Total project budget:	US$ 529,200	d. CERF funds forwarded to implementing partners:	
b. Total funding received for the project:	US$ 482,178	▪ *NGO partners and Red Cross/Crescent:*	US$ 222,950
c. Amount received from CERF:	US$ 482,178	▪ *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 (below 18)	2,689	1,045	3,734	3,127	736	3,863
Adults (above 18)	3,286	1,278	4,546	5,175	855	6,030
Total	**5,975**	**2,323**	**8,298**	**8,302**	**1,591**	**9,893**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs	5,809	6,851
Host population	2,489	3,042
Other affected people		
Total (same as in 8a)	**8,298**	**9,893**

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	There was not a major discrepancy between planned and reached beneficiaries. This project exceeded its set target of 8,298 (F-5,975, M-2,323) people in need from Waingmaw and Mogaung Townships by 19%, with a total of 9,893 (F-8,302 and M-1,591) beneficiaries. Targets for males reached by RH services were not met due to the lack of male presence in targeted IDP camps and host communities.

CERF Result Framework			
9. Project objective	To ensure key life-saving reproductive health services are accessible and available to the displaced and local population in hard-to-reached areas in Kachin		
10. Outcome statement	Availability of access to life-saving reproductive health services in order to prevent excess maternal and neonatal mortality and morbidity amongst the affected population		
11. Outputs			
Output 1	**Access and referral to RH services provided;**		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Number of women received RH services	5,000[16]	4,152
Indicator 1.2	Number of men received RH services	2,000	918
Indicator 1.3	Number of pregnant women received RH related services including Ante-Natal Care [ANC] and Post Natal Care [PNC]	1,000	1,506
Indicator 1.4	Number of Emergency Obstetric Care [EmOC] and Sexual Violence clients referred	100	68
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Conduct outreach mobile clinic activity	MMA	MMA
Activity 1.2	Support provision of RH services in selected health facilities	MMA	MMA
Activity 1.3	Referral clients to higher health facilities	MMA	MMA
Output 2	**Essential RH Kits and commodities provided, RH facilities strengthened;**		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	# of RH Kits distributed	50	106
Indicator 2.2	# of Clean Delivery Kits distributed	3,000	5,431
Indicator 2.3	# of reproductive health unit of selected health facilities strengthened	1	44
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Procurement of RH Kits and commodities	MMA	MMA
Activity 2.2	Distribution of RH Kits and Clean Delivery Kits and commodities	MMA	MMA
Activity 2.3	Rehabilitation of RH unit of selected health facilities	MMA	MMA
Output 3	**Capacity of health staff on basic RH services developed, Reproductive health education sessions provided;**		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	# of female staff trained on MISP and RH related issues	30	32

[16] In indicator 1.1, 'services' is the total of activities listed in indicator 1.3, 1.4, and 3.3. The initial target of 5,000 does not reflect this formula. Accordingly, while UNFPA exceeded set targets for 1.3 & 3.3, this success is not reflected in indicator 1.1 reached.

Indicator 3.2	# of male staff trained on MISP and RH related issues	15	15
Indicator 3.3	# of women attended reproductive health education sessions	2,500	2,578
Indicator 3.4	# of men attended reproductive health education sessions	1,000	658
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Conduct training on MISP and RH related issues	MMA	MMA
Activity 3.2	Conduct reproductive health education sessions to the affected communities	MMA	MMA

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 number of females reached by RH education sessions was 2,578 which exceeded the set target of 2,500. Similarly, a total of 1,506 females received RH related services including ante-natal and post-natal care, above the set target of 1,000. These higher numbers can be explained by the high RH needs of women and girls in these communities. However, UNFPA only received 68 cases which required referrals of the total target of 100, with all cases presented having received referrals as needed. Only 918 males received RH related services, representing under half of the targeted 2,000 males. The number of males reached by RH education sessions was also under the target, reaching 658 males with the total target of 1,000. In Waingmaw and Mogaung Townships, it is common for the majority of the male population of communities to seek work in locations beyond the Township, returning only sporadically to their village of origin. For this reason, the project did not achieve its set male targets.

The project also had a broad reach through Sexual and Reproductive Health related information broadcast through local radio station (Padamyar FM) in hard to reach communities, however this cannot be quantified.

The number of Clean Delivery Kits and RH kits distributed was more than the initial targeted numbers by 2,431 and 56 respectively as the procurement cost of kits was less than estimated and so allowed the procurement and distribution of additional kits.

Reproductive Health Units of 44 health facilities (of 2 Township Hospitals, 6 Station Health Units, 1 Maternal and Child Health Clinic, 8 Rural Health Centres and 27 sub centres from Waingmaw and Mogaung Townships) were strengthened with refurbishment of the labour room, providing labour beds, septic tanks and cold chain for RH medicines like Oxytocin. All 68 emergency Obstetric cases were referred to referral level health facilities.

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

Beneficiaries were involved in the design phase of the project through the Implementing Partner, the Myanmar Medical Association. Through their close relationship with communities, feedback was used to inform the design of the project. Regular feedback was collected from beneficiaries as part of community health sessions, which was regularly reviewed to determine whether the project was addressing community needs and project objectives throughout implementation. This feedback was overwhelmingly positive, and thus few changes were needed to be made to activities during implementation. Beneficiaries were also interviewed as part of monitoring visits, conducted during and after implementation to assess the project. Through these discussions, beneficiaries identified a need for more family planning services and more specifically increased choice in regards to family planning commodities. While UNFPA could not provide these within the scope of the project, in response to these comments UNFPA discussed the feedback with the State Health Department and developed a referral mechanisms in order for the Government to provide additional services and commodities through Government Health facilities.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
There is no plan to evaluate this specific CERF funded project. An evaluation exercise of UNFPA's overall humanitarian programme will be conducted in latter part of the second quarter of 2016. UNFPA will share the evaluation report after the completion of the exercise.	EVALUATION PENDING ☒
	NO EVALUATION PLANNED ☐

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNHCR	**5. CERF grant period:**	28/09/2015 – 30/06/2016
2. CERF project code:	15-UF-HCR-051	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Shelter		☒ Concluded
4. Project title:	Shelter support to IDPs in Kachin and northern Shan states		

7. Funding

a. Total funding requirements[17]:	US$ 3,578,000	d. CERF funds forwarded to implementing partners:	
b. Total funding received[18]:	US$ 897,561	▪ *NGO partners and Red Cross/Crescent:*	US$ 465,010
c. Amount received from CERF:	US$ 497,561	▪ *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)	531	473	1,004	490	469	959
Adults (≥ 18)	434	387	821	473	393	866
Total	**965**	**860**	**1,825**	**963**	**862**	**1,825**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs	1,825	1,825
Host population		
Other affected people		
Total (same as in 8a)	**1,825**	**1,825**

[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:	One partner (KMSS-Lashio) having recently entered into a partnership with UNHCR and hence not familiar with the procurement procedures, caused delay in the take-off of the implementation of shelters. Therefore, KMSS-Lashio finally conducted shelter repair activities only, instead of shelter construction as initially planned at the proposal stage. However, the other partners exceeded their initial targets, which explains that in total, if we add to the CERF funding the additional grants received by UNHCR to build new shelters during the implementation period, 682 shelters and attached kitchens were constructed; benefiting approximately 3,410 individuals.

CERF Result Framework			
9. Project objective	To reduce existing shelter gap in Kachin and northern Shan states (which stands at over 2,000 households) through provision of 365 temporary shelters units or major shelter repair.		
10. Outcome statement	IDPs will be more secure in temporary shelters and be encouraged to uptake the responsibility for care and maintenance emphasising their self-reliance; Quality standards related to shelter in Kachin and northern Shan states will increase through engagement with local partners and authorities on new constructions.		
11. Outputs			
Output 1	1,825 IDPs supported with new temporary shelter construction		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	365 new temporary shelters and kitchen units created	365	365
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Assessments undertaken	UNHCR	UNHCR and partners
Activity 1.2	Identification of implementing partners and contractual procedures	UNHCR	UNHCR
Activity 1.3	Identification of vulnerable families	UNHCR	UNHCR and partners
Activity 1.4	Implementing of shelter and kitchen construction	Partners	Partners
Activity 1.5	Monitoring	UNHCR	UNHCR and partners

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:

During the implementation period, shelter provision to IDPs remained one of the core activities of UNHCR aimed at improving the protection and living condition of the persons of concern. As previously mentioned, as one of our partners finally focused on shelter repair instead of construction of new units, changes were operated regarding the location of the new shelters. Thanks to CERF funding, 365 new shelters and attached kitchens have been built.

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

In collaboration with or through its partners (especially in areas where UNHCR does not have access), UNHCR undertook assessments involving beneficiaries, in discussion on how to improve the services which are provided to them and on the best way to fill the shelter

gaps. The agency further fostered the involvement of affected population through camp committees and protection groups, actively promoting awareness and mitigation within the communities. CCCM remains indeed essential as a structure for ensuring community participation. Dedicated focal agencies help consolidate not only data in camps but ensure that common standards and types of support are applied across camps to the extent possible. Being part of the camp committees, the affected population takes actively part in the coordination and planning. Moreover, when and where feasible, the implementation of shelter repair activities directly involved beneficiaries as some of them were recruited for daily labour.	
14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
No evaluation has been carried out neither pending. However, UNHCR is currently assessing the possibility of using cash modality in its future shelter programming.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	IOM	**5. CERF grant period:**	07/10/2015 – 30/09/2016
2. CERF project code:	15-UF-IOM-032	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Support to Emergency Health Referrals in Northern Rakhine State		

7.Funding			
	a. Total funding requirements[19]:	US$600,000	d. CERF funds forwarded to implementing partners:
	b. Total funding received[20]:	US$517,489	▪ *NGO partners and Red Cross/Crescent:*
	c. Amount received from CERF:	US$ 517,489	▪ *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)	1,599	1,476	3,075	480	626	1106
Adults (≥ 18)	187	151	338	2240	348	2588
Total	**1,786**	**1,627**	**3,413**	**2720**	**974**	**3694**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs	1,669	226
Host population	1,744	554
Other affected people (Muslim population)		2,914
Total (same as in 8a)	**3,413**	**3,694**
In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution,	There were less IDPs supported on emergency referrals due to the fact that several health partners (INGOs) established temporary clinics in the IDP camps and provided consultations and treatment to IDPs.	

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

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

please describe reasons:	IOM coordinated and collaborated with INGOs working in the IDP camps on emergency referrals from the camp or hospital to a tertiary hospital through supporting transportation, cost of treatment, meals, etc.

CERF Result Framework			
9. Project objective	To support access to emergency health care for 3,000 population and reduce barriers in accessing lifesaving health care services in 3 Townships Northern Rakhine State		
10. Outcome statement	Vulnerable populations of Northern Rakhine State, including IDPs and host communities, have improved access to lifesaving emergency referrals,		
11. Outputs			
Output 1	Vulnerable populations of Northern Rakhine State, including IDPs and host communities, have improved access to lifesaving emergency referrals,		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Number of persons referred in the township health hospital	3,025	1,924
Indicator 1.2	Number of persons supported with transportation cost , meals, and other cost during referral	3,025	3,694
Indicator 1.3	Number of persons provided with orientation on referral mechanism	300	263
Indicator 1.4	Number of townships with referral mechanism established	3	3
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Support to emergency referrals in Pauktaw, Myebon and Buthidaung population with a focus on maternal and child health, and major life threatening emergencies as well SGBV referrals.	IOM/BHS/THD	IOM/BHS/THD
Activity 1.2	Established mechanism for supporting transport and treatment cost associated with referrals in collaboration with township hospitals and health facilities	IOM/BHS/THD	IOM/BHS/THD
Activity 1.3	Working with Township Health Department, Basic Health Staff, Volunteer Health Workers and Village Tract Health Committees on early detection and identification of medical conditions needing access to emergency health care support and referrals, and establishing mechanisms protocols and process for emergency referrals.	IOM/BHS/THD	IOM/BHS/THD
Output 2	Increased availability of emergency health care provision		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Number of health care facilities assessed (hospitals and rural health centres)	32	54
Indicator 2.2	Number of health care facilities supported with supplies, medicines, repaired	14	16
Indicator 2.3	Number of BHS staff trained and distributed with clean delivery kits	75	100

Output 2 Activities	Description	Implemented by (Planned)	Implemented by (Actual)
Activity 2.1	Support capacity for providing life-saving treatment in existing health facilities depending on local needs (e.g. augmentation of staff, provision of life-saving drugs and equipment, training on emergency obstetric care, helping baby breath, and Emergency Child care and trauma care etc.)	IOM	IOM
Activity 2.2	Support to critical reproductive health interventions including promoting adequate clinical care for SBGV and provision of critical reproductive health commodities (e.g. clean delivery kits, post-rape kits).	IOM/	IOM/UNFPA
Output 3	80% of health care facilities has a functioning EWARS and improved data collection , analysis and dissemination of critical health information		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	% of health care facilities has a functioning EWARS	80%	50%
Indicator 3.2	Number of coordination meetings, planning amongst BHS staff and THD	6	19
Indicator 3.3	Number of monthly report shared to partners and other stakeholders	8	21
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Coordinate with State Health Department, local authorities and community in rolling out the proposed early warning and response system (EWARS) for communicable diseases, as well as critical health incident report monitoring throughout these 3 townships.	IOM/SHD/ BHS/WHO	IOM/SHD/ BHS/WHO
Activity 3.2	Support the collection, processing, analysis and dissemination of critical health information of displaced and vulnerable populations including maintaining a database of access to, availability of, and outcomes of life saving health services.	IOM	IOM

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. The implementation of early warning and response system (EWARS) took several months to be implemented as this is led by the Ministry of Health in collaboration with the State Health Department and WHO. The delay was due to development of EWARS forms and roll out of training at the State Health level and then to Township level. In July 2016, the first initial training was conducted by MOH/WHO at the State Health Department for all Township Health Medical Officers. The EWARS training on the township level wherein Basic Health Staff (BHS) will be trained for collection and reporting is yet to be planned by the State Health level. It was only initiated as a pilot EWARS to NGOs/health partners working on IDP camps wherein EWARS system is implemented and reported back to the Health Cluster in collaboration with the State Health Department. The township-wide EWARS has yet to be systematized and train the BHS. However, even though the training was not yet implemented at the township level, IOM supported Pauktaw and Buthidaung in monitoring and surveillance system in the community and supported Buthidaung, Pauktaw and Sittwe on several special EPI response on the outbreaks of Polio, Measles and Japanese Encephalitis in Rakhine State especially in Northern Rakhine State. Thus the actual outcome has only covered 50% given that it was not fully operational at the RHC level.

2. The cost of referral (transportation, cost of treatment, etc.) differs from each patient medical condition and IOM was able to reach more beneficiaries than the planned target numbers.

3. Additional activities were added with no cost in the approved No Cost Extension: (a) IOM was appointed as the Interim Health Cluster Coordinator on the national level from May to September 2016 (b) Support was provided to SHD on the development of the Rakhine Emergency Health Response Plan, wherein all Township Medical Officers were gathered in a workshop to develop / plan a document for emergency health response plan for the State and their townships in collaboration with RRD and IOM DRR team. Through this support, a document was developed for Rakhine.
13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:
Consultations and discussions were made with the State Health Department, Township Health Departments, BHS staff and local leaders before and during the project design and implementation. Assessment of health care facilities through interview with BHS staff were also conducted to ensure that needs of the population and health care facility is targeted. A feedback mechanism was also established for the patients supported with emergency referrals.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
Evaluation was not planned for this project due to the short duration of the project and context. However, during the implementation of all activities, several visits from State Health Department, Township Health Department, Health Cluster Coordinator in Rakhine and key IOM Technical persons were made and provided recommendations to enhance the support to the target beneficiaries.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	WFP	**5. CERF grant period:**	02/10/2015 – 30/06/2016
2. CERF project code:	15-UF-WFP-061	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Food Security		☒ Concluded
4. Project title:	Lifesaving Assistance for Most Vulnerable Populations in Rakhine State under WFP Protracted Relief and Recovery Operation Supporting Transition by Reducing Food Insecurity and Undernutrition among the Most Vulnerable.		

7.Funding				
	a. Total funding requirements[21]:	US$ 1,172,706	d. CERF funds forwarded to implementing partners:	
	b. Total funding received[22]:	US$ 1,172,706	▪ *NGO partners and Red Cross/Crescent:*	US$ 30,232
	c. Amount received from CERF:	US$ 1,172,706	▪ *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)	21,760	21,760	43,520	21,643	21,643	43,286
Adults (≥ 18)	44,800	39,680	84,480	44,559	39,467	84,026
Total	**66,560**	**61,440**	**128,000**	**66,202**	**61,110**	**127,312**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs	128,000	113,257
Host population		
Other affected people		14,055
Total (same as in 8a)		**127,312**
In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	In October 2015, as a result of cyclone Komen an increased number of malnourished children was identified in the northern region of Rakhine. Therefore, WFP increased its delivery of FBF in the region of northern Rakhine.	

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

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

CERF Result Framework			
9. Project objective	Ensure people in need of food assistance have equitable and safe access to adequate food assistance.		
10. Outcome statement	Improved food consumption over assistance period for targeted individuals		
11. Outputs			
Output 1	1,060 MT of food commodities distributed to 128,000 targeted people (oil 60 days, rice 10 days, fortified blended food 180 days) in sufficient quantity and quality		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	# of people receiving food assistance disaggregated by women, men, girls and boys	100% of 128,000 targeted people	127,312
Indicator 1.2	# Quantity of food commodities distributed, disaggregated by type as % of planned (530 MT rice, 240 MT of oil, 290 MT of fortified blended food)	100% of targeted 1,060 MT	1,199
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	General food distribution targeting 128,000 people	WFP and partners	WFP, CDN, MHAA, MHDO, Plan, Save
Activity 1.2	Fortified blended food distribution targeting 12,800 children aged 6 – 59 months	WFP and partners	ACF, AGE, Malteser, MHDO
Activity 1.3	Procurement of 1,060 MT of mixed commodities	WFP	WFP

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:

There was an increase in the number of children aged 6 – 59 months reached against the plan; therefore a significant quantity of FBF was distributed in Sittwe and northern Rakhine. In northern Rakhine the increase was a result of cyclone Komen wherefore the distribution plan for FBF had to be revised. From January till June 2016, a total of 253 MT of FBF supported by CERF funding was delivered to Maungdaw and Buthidaung. Considering that children aged 6 – 59 months are provided with 3kg of FBF per month, the CERF funds enabled assistance to 14,055 children on a monthly basis. In Sittwe, the initially proposed targeted number of 12,800 children under 5 increased to 18,537 after the Consortium of Dutch NGOs (CDN) conducted a beneficiary verification. Furthrmore, in Sittwe mixed food commodity distribution was provided to a maximum of 124,996 IDPs living in nine IDP camps, receiving a total of 942 MT mixed commodities. This corresponds to 98% of the monthly targeted 128,000 IDPs.

Despite the increased procurement of FBF, WFP could address the needs of all the 128,000 proposed beneficiaries by complementing the CERF funds with funds from other donors which were explicitly restricted to provide rice, pulses, oil and salt but not having a nutrition component. In this multi-donor action, commodities purchased with CERF funding were complemented by other donors in the manner allowing the most effective and efficient response to all targeted beneficiaries.

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

Monitoring of relief interventions is conducted through three mechanisms: Monthly food distribution monitoring, Complaints and Feedback Mechanism (CFM) and Post Distribution Monitoring (PDM):

Monthly distribution monitoring includes collection of operational data on the number of beneficiaries assisted, amount of food or cash distributed and assistance coverage to monitor the progress and to make operational adjustments. It is also through those monitoring mechanisms that WFP ensures that different needs of women, men, girls and boys are met.

The Complaint and Feedback Mechanism (CFM), which enables the recipients of food assistance to directly communicate with WFP, was launched in April 2016. The main objective of the CFM is to provide a two-way communication between WFP and beneficiaries in relation to WFP's food assistance programme.

Beneficiaries are able to express their concerns and provide both positive and negative feedback through this mechanism. This also gives WFP the opportunity to respond to comments and also to incorporate useful feedback to help improve the assistance programme. Feedback is reviewed by the SOs and consolidated in the CO on a monthly basis.

From 2016, WFP has started conducting Post Distribution Monitoring exercises twice a year, and the first one was conducted in June 2016. Post Distribution Monitoring monitors the outcomes of the food and/or cash assistance with regards to the well-being of the affected population under relief assistance, including the level of food consumption, dietary diversity, access to distribution sites and experience of the distribution process, and gender and protection considerations. Data collection was made through the use of mobile technology, which has now been introduced as a standard practice in WFP Myanmar.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☒
In June 2016, WFP has conducted a post-distribution monitoring (serving as an evaluation) for life-saving food assistance for IDPs, including in Rakhine State. The collected data is currently being analysed and the report is expected to be published in November.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☐

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	WHO	**5. CERF grant period:**	01/10/2015 – 30/06/2016
2. CERF project code:	15-UF-WHO-039	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Bridging The Gap For Saving Mother's And Newborn Lives Around The Time Of Birth		

7.Funding				
	a. Total funding requirements[23]:	US$ 400,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received[24]:	US$ 200,000	▪ *NGO partners and Red Cross/Crescent:*	US$ 186,916
	c. Amount received from CERF:	US$ 200,000	▪ *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)	490	486	976	614	637	1,251
Adults (≥ 18)	3,296	460	3,756	2,380		2,380
Total	**3,786**	**946**	**4,732**	**2,994**	**637**	**3,631**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs	1,305	934
Host population	3,427	2,697
Other affected people		
Total (same as in 8a)	**4,732**	**3,631**

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

[24] 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 project could not be implemented in all targeted locations because of unstable security situations, particularly due to increased number of clashes between armed actors.

CERF Result Framework			
9. Project objective	To support the Maternal, New born and Child Health (MNCH) and Nutrition services in targeted areas.		
10. Outcome statement	3,296 women of reproductive age and 976 girls and boys under five have increased chance of survival in targeted areas		
11. Outputs			
Output 1	Number of IDP population with access to basic health care services. 550 PLWs and mothers of 976 girls and boys under five are empowered through women's circles with life-saving knowledge and practices		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Number of PLWs who attend 4x antenatal care	195 PLW	252 PLW (29% more than the initial target)
Indicator 1.2	Number of PLW who practice initiation of breastfeeding within 1 hour of delivery	166 PLW	113 PLW (68% of the initial target)
Indicator 1.3	Number of timely and appropriate referrals of pregnant women (disaggregated by age) and children under five (disaggregated by sex) with complications	43 women and 51 children	49 pregnant women received timely referrals (14% more than the initial target) and 58 children under five with complications received timely referrals (14% more than the initial target)
Indicator 1.4	Number of male family members (fathers, etc.) engaged in awareness raising activities	460	363 male family members (79% of the initial target) engaged in health awareness raising activities.
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Project start-up	Plan-CHAD	Plan-CHAD
Activity 1.2	Perform 24 FGD's and 48 in-depth interviews with reproductive aged women, PLW, fathers, grandmothers/fathers to assess the barriers (traditional, geographic, social and seasonal) to institutional deliveries	Plan-CHAD	Plan-CHAD
Activity 1.3	1 referral fund management training for community volunteers	Plan-CHAD	Plan-CHAD
Activity 1.4	Establish 1 emergency referral fund managed by CHAD as a mechanism for women, newborns and children with complications	Plan-CHAD	Plan-CHAD
Activity 1.5	1 TOT IYCF and responsive care trainings for 11 CHAD staff members	Plan-CHAD	Plan-CHAD-State Nutrition Team. The training was

			conducted in collaboration with the State Nutrition Team.
Activity 1.6	1 training for 24 female host-community/camp volunteers, including the promotion of ANC, safe and clean delivery, PNC, identifying and responding to MNCH danger signs, breastfeeding, IYCF gender equality and male engagement	Plan-CHAD	Plan-CHAD
Activity 1.7	1 TOT Lactation training 3 days CHAD	Plan-CHAD	Plan-CHAD
Activity 1.8	1 Lactation training 24 host-community/camp volunteers	Plan-CHAD	Plan-CHAD
Activity 1.9	Establish 24 weekly mother circles attended by PLW, fathers and children under five in 24 host-community/camps [promote antenatal care attendance, safe and clean delivery, postnatal care, identifying and responding to MNCH danger signs, breastfeeding, IYCF and responsive care]	Plan-CHAD	Plan-CHAD
Activity 1.10	1 monthly nutritional surveillance in host communities and camps in May and June	Plan-CHAD	Plan-CHAD-Community volunteers-State Nutrition Team-Township Health Department. The nutritional surveillance was conducted by Plan, CHAD and community volunteers in collaboration with the State Nutrition Team and Township Health Department.
Activity 1.11	Set up and maintain 24 host-community / camp based reporting and recording mechanisms (accountability) of health access services.	Plan-CHAD	Plan-CHAD
Output 2	Number of IDP population with access to reproductive, maternal and child health care including emergency obstetric care		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Number of PLW, newborns and children U-5 with increased access to MNCH services	195 PLW and 780 children under five (80% of 244 PLW and 976 children)	252 PLW and 927 children under five (29% and 19% more, respectively, than the initial target)
Indicator 2.2	Number of TBA's and AMW's trained	24 TBAs/AMWs	47 TBAs/AMWs (96% more than the initial target)
Indicator 2.3	Number of Postnatal visits attended by a midwife within 48 hours	212 expected deliveries	100 deliveries (47% of the initial target)
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	1 Practical Training of existing AMW's and TBA's [in the 'Do's and Don'ts' including hand washing and Essential Newborn Care and timely and safe referral]	Plan	Plan- State Nutrition Team-Township Health Department. Plan International provided financial and logistics support for the training and State Nutrition Team and

			Township Health Department facilitated the trainings.
Activity 2.2	1 Practical Training of AMW's and TBA's in IYCF and responsive care, growth monitoring	Plan	Plan-Township Health Department-District Health Department. Plan International provided financial and logistics support for the training and the District and Township Health Department facilitated the trainings.
Activity 2.3	Plan and Township Health Department THD perform 4 Integrated monitoring and support visits (phased 2x monthly then 2 bi- monthly) to 4 Health Centres [to follow up with Midwives referrals, outreach activities, supplies and recording and reporting systems etc.]	Plan	Plan-Township Health Department. Plan and Township Health Department collaborated in joint monitoring visit.
Activity 2.4	To support travel allowance of midwives performing postnatal care through 212 expected home visits integrated with providing support and follow up to AMW's and TBA's	Plan	N/A. The travel allowance was not possible to support midwives because Plan had no MoU with the Ministry of Health.
Output 3	The Township Health Office 1 TMO, 1 HA1, 1 Township Health Nurse 33 midwives have the capacity to provide consistent and responsive MNCH services (including schedulable outreach activities) for the selected IDP camps and host communities		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	Number of births assisted by skilled birth attendant disaggregated by age	191 deliveries	104 (55% of the target)
Indicator 3.2	Township level coordination workshop with Township Health Department	4	0
Indicator 3.3	TOT for key THD staff	1	0
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	1 MNCH coordination workshop 15 participants (disaggregated by sex) (2 days) per township participants to include key THD staff, responsible midwives, Plan and CHAD staff	Plan	The MNCH coordination workshop did not take place as planned. SEE BELOW
Activity 3.2	1 TOT technical skill using mammanatalie, neonatalie and low birth weight babies for 2 Township Medical Officers, 2 Health Assistants and 2 Township Health Nurses to be cascaded to midwives in Continued Medical Education-with an added component of staff attitudes and behaviours and respectful and inclusive care.	Plan	The TOT did not take place as planned.
Activity 3.3	Project Manager provides technical support for existing practical sessions provided by HA and Township Health Nurse for 33 midwives during 6 monthly Continued Medical Education workshops to update skilled birth attendants to maintain skills. The Plan project midwife would participate in relevant sessions.-with an added component of staff attitudes and behaviours and respectful and inclusive care.	Plan	The technical support did not take place as planned.

Activity 3.4	4 times documentation of gaps and bottlenecks within the township supply chain process (demand and supply) of life saving essential maternal, new born and child commodities, following activity 2.3. Presented to TMO. According to the findings, Plan International Myanmar provided 2 mammanatiles and 5 neonatalie (MNCH commodities).	Plan	Plan – Please see Annex 4 for detailed description of activity
Activity 3.5	Evaluation	Plan	Evaluation did not take place as planned.

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 following discrepancies between planned and actual activities occurred:

Activity 3.1 The MNCH coordination workshop was not conducted because Plan International Myanmar regularly coordinated with the State Health Department through the Health Cluster Coordination Meetings. It was understood by both sides that this was sufficient time to address coordinating issues. The budget was reallocated to activity 2.2.

Activity 3.2 It was decided late to not conduct the ToT technical training of skills for township staff members as planned. All target participants (2 Township Medical Officers, 2 Health Assistants and 2 Township Health Nurses) had completed a ToT with the same agenda by the Ministry of Health. MOH did not inform the project team of its decision that a TOT would be conducted during crucial phase of project planning. The budget was reallocated to provision of materials to beneficiaries for clean delivery.

Activity 3.3 The technical support to government staff did not happen due to the lack of a MoU between Plan and the MoH. The budget was reallocated to activity 2.1.

Activity 3.5 The project evaluation was not carried out because of the delay in the no cost extension request which led to insufficient time to perform a project evaluation. The unspent budget is still in Plan International and it is not reaching to WHO.

The following discrepancies between planned and actual outputs occurred:

The overachievement of the project's overall target for girls and boys under five (1,251 girls and boys under five; 28% more than the initial target of 976 girls and boys under five) who have increased chance of survival in targeted areas is due to the change in the number of targeted communities.

The overachievement of the target for pregnant and lactating women - PLW (1,362 PLW - 148% more than the initial target of 550 PLW) empowered through women's circles with life-saving knowledge and practices is due to the change in number of target communities. The underachievement of the target for girls and boys, 765 girls and boys under five - 28% less than the initial target of 976 girls and boys under five) empowered through women's circles with life-saving knowledge and practices is due to the change in the number of targeted communities.

The overachievement in antenatal care services (252 PLW, 29% more than the initial target) is due to the fact that during the project period, 57 new pregnant women emerged and were added to our original targeted 195 pregnant women and they all received the antenatal care services.

The underachievement (113 PLW - 32% less than the initial target of 166 PLW) in initiated breastfeeding within 1 hour of delivery is partly due to the change in the number of targeted communities from 24 to 20 communities in line with the CERF funds received. Another reason of the underachievement is due to the fact that some women didn't receive MNCH training or service on time to become aware of the importance of breastfeeding initiation within 1 hour.

The overachievement in patient referral in a timely manner to the nearest government hospitals (49 pregnant women and 58 children under five with complications; 14% more than the initial target of 43 pregnant women and 51 children under five with complications) is due to the higher actual number of patients who needed referral support.

The overachievement in the access to maternal and child health care service (252 PLW and 927 children under five; 29% and 19% more, respectively, than the initial target)) is the result of the effort and commitment of individual staff members. Furthermore due an increase in need and actual number of beneficiaries it was easy to increase accessibility.

The reason for the overachievement in number of TBAs and AMWs trained on basic emergency obstetric and neonatal care 47 TBAs/AMWs (96% more than the initial target of 24) is due to the fact that 23 TBAs and AMWs from Waing Maw township joined the training though it was intended only for the 24 TBAs and AMWs from existing project area. The underachievement in postnatal visit by a midwife within 48 hours (100 postnatal visit -47% of targeted of the initial target) is due to low number of actual deliveries. The underachievement in births assisted by skilled birth attendants (104 births -55% of the initial target) is due to low actual deliveries.

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

AAP has been ensured during project design, implementation and monitoring through transparency, sincerity and commitment. The target population were informed well about this project, including awareness raising sessions and initial community group discussions. Plan International Myanmar showed sincere concern for welfare of the beneficiaries by demonstrating concrete action, training and empowering them with knowledge on maternal, neonatal and child health and nutrition.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
Project evaluation was not able to be carried out because of the delay in the no cost extension request which led to insufficient time to perform a project evaluation.	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-WHO-039	Health	WHO	INGO	$186,916
15-UF-CEF-104	Water, Sanitation and Hygiene	UNICEF	INGO	$152,269
15-UF-CEF-104	Water, Sanitation and Hygiene	UNICEF	NNGO	$174,926
15-UF-CEF-103	Child Protection	UNICEF	INGO	$92,829
15-UF-CEF-103	Child Protection	UNICEF	INGO	$21,852
15-UF-CEF-103	Child Protection	UNICEF	INGO	$216,300
15-UF-CEF-103	Child Protection	UNICEF	NNGO	$100,160
15-UF-CEF-105	Child Protection	UNICEF	INGO	$166,139
15-UF-WFP-062	Nutrition	WFP	INGO	$7,064
15-UF-CEF-106	Nutrition	UNICEF	INGO	$0
15-UF-HCR-051	Shelter & NFI	UNHCR	NNGO	$58,604
15-UF-HCR-051	Shelter & NFI	UNHCR	NNGO	$197,470
15-UF-HCR-051	Shelter & NFI	UNHCR	NNGO	$208,936
15-UF-FPA-034	Health	UNFPA	NNGO	$222,950
15-UF-FAO-027	Food Assistance	FAO	GOV	$31,620
15-UF-FAO-027	Food Assistance	FAO	GOV	$29,589
15-UF-FAO-027	Food Assistance	FAO	INGO	$23,940
15-UF-WFP-061	Food Assistance	WFP	NNGO	$3,978
15-UF-WFP-061	Food Assistance	WFP	INGO	$3,897
15-UF-WFP-061	Food Assistance	WFP	NNGO	$6,978
15-UF-WFP-061	Food Assistance	WFP	INGO	$1,663
15-UF-WFP-061	Food Assistance	WFP	NNGO	$4,497
15-UF-WFP-061	Food Assistance	WFP	NNGO	$6,978
15-UF-WFP-061	Food Assistance	WFP	INGO	$910
15-UF-WFP-061	Food Assistance	WFP	INGO	$1,332
15-UF-FPA-033	Protection	UNFPA	INGO	$277,614
15-UF-FPA-033	Protection	UNFPA	INGO	$11,600

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

AAR	After Action Review
ACF	Action Contre la Faim, Action for Green Earth
AGE	Action for Green Earth
AMW	Auxiliary Midwife
B-EmOC	Basic Emergency Obstetrics Care
BHS	Basic Health Staff
BSFP	Blanket Supplementary Feeding Programme
CCCM	Camp Coordination and Camp Management
CDK	Clean Delivery Kit
CDN	Consortium of Danish NGOs
C-EmOC	Comprehensive Emergency Obstetrics Care
CFS	Child Friendly Spaces
CFSI	Community Family Services International
CHW	Community Health Worker
CO	WFP Country Office
CPG	Child Protection Groups
CRM	Clinical Management of Rape
DoA	Department of Agriculture
DRC	Danish Refugee Council
ECC	Emergency Child Care
EmOC	Emergency Obstetrics Care
EPI	Extended Programme of Immunization
EXCEL	Extended and Continuous Education and Learning
FAO	Food and Agriculture Organization of the United Nations
FBF	Fortified Blended Food
FBF	Fortified Blended Food
FGD	Focus Group Discussion
FSS	Food Security Sector
GBV	Gender Based Violence
GCA	Government Controlled Areas
HA	Health Assistant
HC	Health Center
HRP	Humanitarian Response Plan
IDP	Internally Displaced Person
IEC	Information, Education and Communication
IMC	International Medical Corps
IOM	International Organization for Migration
IPs	Implementing Partners
IRC	International Rescue Committee
IYCF	Infant and Young Child Feeding

KAP	Knowledge Attitudes and Practices
KBC	Kachin Baptist Convention
KMSS	Karuna Mission Social Solidarity
LBVD	Livestock Breeding and Veterinary Department
MAM	Moderate acute malnutrition
Metta	Metta Development Foundation
MHAA	Myanmar Health Assistant Association
MHDO	Myanmar Heart Development Organization
MMA	Myanmar Medical Association
MNCH	Maternal and Child Health
MoHS	Ministry of Health and Sports
MT	Metric Tons
MW	Midwife
NFI	Non Food Items
NGCA	Non-Government Controlled Areas
NGO	Non-Governmental Organisations
NRS	Northern Rakhine State
NSS	Northern Shan State
O&M	Operation and Maintenance
OPD	Out Patient Department
OTP	Outpatient Therapeutic Programme
PHC	Primary Health Care
PLAN	Plan International
PLW	Pregnant and Lactating Women
PSS	Particular psychosocial support
RC/HC	Resident Coordinator and Humanitarian Coordinator
RH	Reproductive Health
RHC	Rural Health Center
RI	Relief International
RUTF	Ready to Use Therapeutic Food
SAM	Severe acute malnutrition
SCCT	Super Community Caretakers
SCI	Save the Children International
SFP	Supplementary Feeding Programme
SO	WFP Sub-Office
SRH Kit	Sexual Reproductive Health Kit
Sub-RHC	Sub Rural Health Center
TBA	Traditional Birth Attendants
TFP-FU	Therapeutic Feeding Programme – Follow up
TH	Traditional Healers
THD	Township Health Department

TMO	Township Medical Officer
TOT	Training of Trainers
VHW	Volunteer Health Worker
WASH	Water, Sanitation and Hygiene
WPN	Wun Pawng Ninghtoi
WSB	Wheat Soya Blend