

**RESIDENT/HUMANITARIAN COORDINATOR  
REPORT ON THE USE OF CERF FUNDS  
MALAWI  
RAPID RESPONSE  
DROUGHT  
2019**

**19-RR-MWI-33930**

<b>RESIDENT/HUMANITARIAN COORDINATOR</b>	<b>MARIA JOSE TORRES MACHO</b>
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REPORTING PROCESS AND CONSULTATION SUMMARY	
a. Please indicate when the After-Action Review (AAR) was conducted and who participated.	4 October 2019
On the 4 <sup>th</sup> October, the UNRCO coordinated the After-Action Review reflecting on the utilization of funding received, identifying challenges encountered and areas for improvement for the wider UNCT Malawi. The four UN agencies who received CERF funding for the Drought Response, namely WFP, UNICEF, UNFPA and WHO, participated in the AAR. Prior to the AAR, all UN agencies participated in an AAR planning meeting and completed individual agencies reports through consultation with partners at the cluster level. The UN Resident Coordinator (UNRC) opened and chaired the meeting while OCHA ROSEA Humanitarian Affairs Officer facilitated the discussions.	
b. Please confirm that the Resident Coordinator and/or Humanitarian Coordinator (RC/HC) Report on the use of CERF funds was discussed in the Humanitarian and/or UN Country Team.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
The final draft of the RC/HC Report was sent to the UN Country Team for their review. Their comments were implemented in the Report.	
c. Was the final version of the RC/HC Report shared for review with in-country stakeholders (i.e. the CERF recipient agencies and their implementing partners, cluster/sector coordinators and members and relevant government counterparts)?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
The final version of the RC/HC Report was sent to the CERF recipient agencies. They were asked to share it with their implementing partners and government partners.	

## PART I

### **Strategic Statement by the Resident/Humanitarian Coordinator**

During the Lean Season 2018/2019, the Government of Malawi faced a humanitarian crisis with over 3.3 million classified as IPC3 and IPC4 in accordance with the Multi Vulnerability Assessment Committee (MVAC) report. Of the 27 districts, 15 were prioritised where 20 per cent of the population faced emergency food crisis. The rapid allocation of CERF funding enabled the Humanitarian Country Team, the Government of Malawi and its partners to respond to an escalating crisis in a timely, efficient manner providing people with life-saving assistance and preventing a worsening humanitarian crisis. We are proud to confirm that CERF funding supported life-saving interventions in food security, nutrition, health and WASH, protection assistance to 1,656,744 affected by the lean season.

Specifically, time-critical access to life-saving, while food and nutrition services was provided to 1,049,937 children, access to safe water and hygiene was delivered to 670,180 people, drugs were distributed to support children with severe acute malnutrition (SAM), enhanced disease surveillance through community health workers outreach in communities and distributed and equipped health centres with reproductive health kits. Throughout the response, messaging on prevention of sexual exploitation and abuse and GBV was disseminated widely in communities and through various social mediums.

## **1. OVERVIEW**

**TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US\$)**

<b>a. TOTAL AMOUNT REQUIRED FOR THE HUMANITARIAN RESPONSE</b>	<b>114,339,469</b>
<b>FUNDING RECEIVED BY SOURCE</b>	
CERF	10,000,426
COUNTRY-BASED POOLED FUND (if applicable)	0
OTHER (bilateral/multilateral)	41,879,748
<b>b. TOTAL FUNDING RECEIVED FOR THE HUMANITARIAN RESPONSE</b>	<b>51,880,174</b>

**TABLE 2: CERF EMERGENCY FUNDING BY PROJECT AND SECTOR (US\$)**

<b>Date of official submission: 17/01/2019</b>			
<b>Agency</b>	<b>Project code</b>	<b>Cluster/Sector</b>	<b>Amount</b>
UNFPA	19-RR-FPA-002	Protection - Sexual and/or Gender-Based Violence	397,294
UNICEF	19-RR-CEF-006	Nutrition - Nutrition	1,009,202
UNICEF	19-RR-CEF-007	Water Sanitation Hygiene - Water, Sanitation and Hygiene	599,995
WFP	19-RR-WFP-004	Nutrition - Nutrition	1,490,546
WFP	19-RR-WFP-006	Food Security - Food Assistance	5,996,866
WHO	19-RR-WHO-005	Health - Health	506,523
<b>TOTAL</b>			<b>10,000,426</b>

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US\$)	
Total funds implemented directly by UN agencies including procurement of relief goods	8,700,143
Funds transferred to Government partners*	738,533
Funds transferred to International NGOs partners*	484,211
Funds transferred to National NGOs partners*	77,539
Funds transferred to Red Cross/Red Crescent partners*	0
Total funds transferred to implementing partners (IP)*	1,300,283
<b>TOTAL</b>	<b>10,000,426</b>

\* These figures should match with totals in Annex 1.

## 2. HUMANITARIAN CONTEXT AND NEEDS

Food insecurity had risen sharply in southern and central Malawi in early 2019 due to rainfall deficits that resulted in below-average 2018 main and winter (irrigated maize) harvests as well as an outbreak of Fall Armyworm (FAW), respectively. Production capacity had reduced due to consecutive dry spells, an outbreak of Fall Armyworm, low agriculture prices for cash crops and reduced production capacity of maize (a staple food crop) by 28 percent, down 20.3% compared to the 5-year average. Major cereal crops typically contribute about 75 percent of rural households' annual food requirement. As a result, very poor and poor households were increasingly reliant on market purchases, due to household production deficits. According to FEWS NET, the start of 2019 has been characterized by below-average with erratic rainfall patterns, resulting in limited agricultural activities, significantly lowering labour opportunities for poor households in the South. As a result of significantly below-average income from staple and cash crop sales and reduced agricultural income during the winter harvest period, poor households were expanding beyond typical coping strategies by selling more livestock, seeking casual labour opportunities much earlier than normal, and increasing the intensity and frequency of other income generating activities such as firewood and charcoal sales.

**The Malawi 2018/2019 lean season impacted 22 percent of the population - 3.3 million people -who faced crisis or emergency food insecurity (IPC Phase 3 and 4) across 27 districts.** This represents an increase of 1.1 million people from the previous IPC figures (July to September 2018) and a tripling of the number of severely food insecure people at the same time the year before (1 million). Fifteen priority districts were identified, where 20 percent of more of the population faced crisis and emergency food insecurity, of which thirteen were in the Southern Region. The fifteen prioritized districts represented 2.3 million people in IPC 3 and 4 phases during this period.

**The peak of the lean season between January to March 2019 critically affected household food insecurity, prior to the winter harvest season which was expected to begin in April 2019.** What little stocks of food households had at the start of the lean season had been exhausted and reliance on markets to supplement food needs had increased during the lean season. Meanwhile, there were less opportunities for agricultural livelihoods activities and some districts in Southern Malawi were reporting increasing prices in the cost of maize as the national demand increased.

**At the same time, a majority of those who faced crisis and emergency food insecurity had received only minimal food assistance at the peak of the lean season in January.** The Government of Malawi had responded through drawing on their in-country grain reserve, distributing 138,488 MT tons of maize across 27 districts of Malawi. Through this distribution, the Government provided 50 kg of maize, per household, per month to support lean season nutritional needs. However, the Government's response was delayed and, following a one-off distribution in October, the response only just began in December 2018 and in some places not until January 2019.

**Malnutrition rates were rising, particularly amongst the most vulnerable. Community Management of Acute Malnutrition (CMAM) admissions from June to October 2018 increased by over 25 percent in comparison to the same period in 2017.** An estimated 21,134 children were at risk of SAM and 64,515 of MAM from January to December 2019; of

which 7,925 children were at risk of SAM (or 37.5 percent of the annual caseload for 2019) occurred within and immediately after the peak of the lean season from February to July 2019. In Malawi 23 percent of child mortality cases were associated with under-nutrition and children with MAM were four times and SAM nine times more likely to die than well-nourished children. Vulnerable children, pregnant and lactating women and people living with HIV remained the most at risk during this critical period, with national HIV prevalence estimated at 8.8 percent, one of the highest in the world. Around 2 percent of people living with HIV and 7 percent of people that were on antiretroviral and tuberculosis treatment suffered from severe and moderate acute malnutrition in an average year, according to Ministry of Health reports, these vulnerable individuals needed critical nutrition support to prevent further deterioration in their health, as access to food sources reduced.

**Limited outreach of community based nutritional screening for children had impacted the ability to detect MAM and SAM cases early, when treatment and programmes were able to respond.** Due to limited active case finding, children were admitted into health centres with deteriorated SAM conditions, often with further health complications. Undernourished people, especially vulnerable groups and children, were more susceptible to infections, including respiratory infections, malaria and diarrhoea due to their low immunity. A scaled-up health response to quickly identify and treat SAM children admitted to Nutrition Rehabilitation Units (NRU's) was urgently needed during the lean season to fully support recovery efforts.

**Decreasing ability to access safe water sources and limited water available for household hygiene use, increased the risk for widespread diseases outbreaks during this critical period.** In Malawi, approximately 19 of 28 districts were prone to Cholera Outbreaks, and four districts were already reporting increasing numbers of diarrheal incidence and two confirmed Cholera cases. In drought-prone districts, the functionality of water points had further reduced below 67 percent, as the water table was significantly dropping. The WASH sector estimated that conditions during the peak of the lean season were likely to decrease functionality of water sources to about 30 percent, causing an over 495,000 people to suffer from critical WASH situations. Some shallow wells and surface water sources were already drying up; forcing women to wake up very early and travel longer distances to fetch water. Increasing household access to safe water and awareness of hygiene practices, prioritizing WASH insecure populations in districts targeted for food and nutrition response was essential to prevent further deterioration. In addition, there was a need to ensure an active surveillance system is in place in critical food insecure districts to early detect and respond to outbreaks in order to prevent loss of life and mitigate against large-scale outbreaks.

**Rising food insecurity caused women and girls to have to travel longer distances to seek food and water, increasing protection risks, especially for sexual violence.** GBV and other forms of violence targeting women and children were already prevalent in Malawi, with an estimated 14.5 percent of women physically abused and 25.3 percent of those sexually abused (MDHS 2016). Given rising levels of food insecurity, GBV and intimate partner violence were expected to increase as a consequence of heightened strain on households, as evidenced by past experience. A 2017 study found in three districts targeted with a food response that 31 percent of women and girls reported experiencing sexual abuse or GBV during the drought response. Additionally, anecdotal reports in the food insecure districts in 2018/2019 include men luring young girls to marry them in exchange for food, as well as transactional sex and rape. Without appropriate services to support, investigate and resolve these issues, women and girls were unlikely to come forward and seek assistance.

**Following the MVAC and IPC assessment, the Government of Malawi, with the support of the international community, launched a Lean Season Response Plan from October 2018 – March 2019.** The Government of Malawi provided in-kind maize distribution across all 27 districts and requested support from the international community to provide the supplementation for the food basket (through CASH transfers) and life-saving Nutrition, Health, WASH and Protection assistance. However, the in-kind maize distribution was delayed, and distributions began only in the last week of December 2018 and early January 2019. The ability of the Government to respond was also expected to be challenged during the peak of the lean season as this coincided with the run-up to the elections in April 2019. There was urgent need to scale-up multi-sectoral life-saving assistance at the peak of the lean season. CERF funding supported multi-sectoral time-critical response in 9 of the 15 prioritized districts (which had 20 percent or more of the population in IPC 3 and 4) with Food assistance (through CASH transfer top-up of food basket in five districts), Nutrition, Health, WASH and protection services.

**In March 2019, Malawi was hit by heavy rains accompanied by strong winds as a consequence of Cyclone Idai, which led to severe flooding across several districts in the southern region.** Consequently, the Government of Malawi and the

Humanitarian Country Team (HCT) had to respond to two disasters concurrently as a large portion of the population affected by the lean season was also affected by the floods. With loss of shelter to over 86,000 people, many people were displaced into temporary IDP camps in 15 districts. UN agencies and implementing partners reprogrammed activities to respond to the humanitarian needs of those residing in the camps. Under its CERF-funded project, UNICEF upscaled its hygiene message, chlorination and installation of temporary latrines as a means of preventing disease outbreak such as cholera. It successfully reached 760,524 people as compared to 200,000 planned. Mass nutrition screening took place in the camps to prevent deterioration in malnutrition increased the number of children by 200%. As beneficiaries reported loss of livelihoods and food supplies due to flooding, WFP – as part of its CERF-funded project - extended the cash distribution in four districts to meet the food assistance needs.

### 3. PRIORITIZATION PROCESS

**The first priority of the CERF funding was to ensure that a full nutritional basket is provided to the most vulnerable people facing crisis and emergency food insecurity in five prioritized districts.** Under the Government-led Lean Season Response Plan (October 2018 to March 2019), the Government's response only met the maize requirements, leaving out the non-cereal commodities to ensure a full nutritional food basket. Given the availability of non-cereal commodities in the market and the functioning of markets across the country, a decision with the Government was made that the non-cereal commodities would be provided through Cash-Based Transfer top-up for the pulses, oils and Corn Soya Blend (CSB). Of the fifteen priority districts identified as having 20 percent or more of the population in IPC 3 or higher, WFP initially provided cash-based response in nine districts; six districts with support of USAID (Phalombe, Chikwawa, Machinga, Balaka, Blantyre and Nsanje), three districts with support of CERF (Mangochi, Salima and Mulanje). In addition, Save the Children and Malawi Red Cross both covered one district. CERF's funding was initially meant to enable WFP to scale up its operation to the aforementioned three additional highly food insecure districts. However, due to similar cash-based programs provided by OXFAM in Mulanje and due to a late funding approval, WFP decided to deliver assistance to other districts with equally high percentage of IPC affected population. Consequently, Chiradzulu, Neno and Zomba districts were selected to absorb the funding of Mulanje district. This increased the total caseload from 683,101 beneficiaries in three districts to 820,067 beneficiaries in five districts, assisted with support of CERF. Eventually, a total of fourteen out of fifteen priority districts have therefore been targeted with cash-based assistance for the peak of the lean season period, January to March 2019.

**The second priority of the CERF funding was to implement a multi-sectoral life-saving response in the peak of the lean season with Nutrition, Health, and WASH assistance in eight of the nine districts in which WFP provided cash-based assistance and the Government providing in-kind maize distribution, and Protection targeting all nine prioritized districts where WFP initially provided Cash top-up assistance.** The clusters focused on the following priorities:

- **Nutrition scaled-up MAM and SAM services, through WFP and UNICEF, in eight districts, ensuring access to comprehensive package of CMAM services.** WFP expanded lifesaving therapeutic treatment of acute malnutrition to 36,614 people with moderate acute malnutrition (MAM) across the eight districts. MAM children from 59 months to 15 years and pregnant and lactating women have been assisted with Corn Soya Blend with sugar (4.5kgs) plus vegetable oil (0.5 litres) whilst MAM children 6 to 59 months have been treated with CSB++ (3.0Kgs) on a fortnightly basis. Moderately and severe acute malnourished adults and adolescents received super cereal (9kgs) and vegetable oil (1 litre) provided on a monthly basis to MAM clients with SAM clients provided with Super Cereal with sugar (4.5kgs) and RUTF (42 sachets) every fortnight. The UNICEF CERF funding targeted to reach and save lives of 7,925 identified with SAM. Eventually UNICEF reached 7,459 children under-five and 977 children between 5 and 15 years old, totalling 8,436 children with SAM. CERF funding also supported the scale-up of active community case finding activities in IDPs camps by screening 1,049,937 children under five for acute malnutrition, identifying MAM and SAM cases and ensuring earliest possible access to treatment programmes. WFP and UNICEF worked with the Ministry of Health in implementation of the CMAM package.
- **Health and WASH CERF funded programmes targeted the same population as Nutrition, providing a fully integrated approach.** The WHO CERF project supported with drug provision to six district health centres, especially centres that treat children admitted with SAM with complication through Nutrition Rehabilitation Units. WHO also provided scale-up to disease

surveillance, promoting early detection and treatment for potential disease outbreaks in at risk high food insecure districts. UNICEF WASH project, initially targeting the same eight districts as Nutrition, ensured that those targeted with food assistance, nutrition and health support would have increased access to safe water and hygiene promotion messaging. However, the CERF response was later adjusted to provide emergency life-saving WASH services to displaced populations in all districts affected by the floods of March. Consequently, a significant larger number of beneficiaries were reached than initially planned (670,524 instead of 200,000).

- **Protection ensured access to treatment and service provision for GBV survivors, as a critical component of the lean season response.** UNFPA's CERF funded project targeted nine priority districts where WFP was initially providing Cash assistance, increasing access to clinical management for survivors of GBV, including post-rape treatment, HIV/STI testing/treatment, delivery and post-abortion care as well as emergency psychological care. Further, UNFPA targeted the same nine districts receiving the WFP Cash-based assistance with cost-effective emergency communications with the affected communities to allow for the targeted population's access to protection and referral services. UNFPA worked with WFP's already established Community Based Complaints Mechanisms to ensure that referrals mechanisms and communication on services available is accessible to populations targeted as a part of the lean season response. Following the floods of March, UNFPA expanded the scope of its project and targeted more beneficiaries in the same nine districts.

### **HCT CERF Strategy Development and Prioritization Process:**

In Malawi the Humanitarian Emergency Response is coordinated through a Humanitarian Country Team (HCT), made up of Government representatives, Heads of UN Agencies, NGOs and donors; under the leadership of the Resident Coordinator and the Government of Malawi Principal Secretary for the Department of Disaster Management Affairs (DoDMA). The HCT meets monthly and regularly discussed the lean season response and strategic direction. On 18 December 2018, following delays in the Government's planned maize distributions and information indicating a further deteriorating situation, the HCT decided to urgently scale-up the lean season response. While UN Agencies and NGO partners continued to mobilize with donors and internal resources to respond to the increasing needs, an appeal for CERF funding was prioritized to support immediate critical life-saving response.

Following the decision by the HCT, the relevant clusters (Food Security, Agriculture, Health, Nutrition, Protection and WASH) met to discuss priorities for the CERF allocation. Given that fifteen districts were already prioritized as part of the response effort, clusters geographically prioritized their efforts to complement the WFP cash-based assistance and the Government's food response. WFP, with the support of USAID and CERF funding, prioritized nine districts with the highest levels of food insecure population in IPC phase 3 and 4. Nutrition, WASH and Health provided a fully integrated assistance package targeted eight of the nine districts where WFP is working. WFP supported a community-based complaints and feedback mechanism (CBCM) in all nine districts where they operated and where other agencies were providing service delivery in the eight districts targeted by CERF, utilized the CBCM to ensure that feedback and complaints were incorporated and addressed during the CERF response.

The Nutrition Cluster met to discuss how to ensure fully coordinated CMAM package across the eight districts including the agencies support to the Ministry of Health and the scale-up of active case finding within the communities. WASH and Health sectors discussed priority activities within the inter-cluster meeting to ensure that most critical life-saving priority activities would be undertaken with CERF funding. This included support for the full CMAM package and active community case finding activities, increasing safe water supply access and drug provision to support NRU's and increasing disease surveillance activities in targeted districts. GBV response was prioritized by the inter-cluster working group as a key protection component in the response. Following the meeting the protection cluster, UNICEF and UNFPA, met to discuss the GBV component of the project in detail and harmonize how UNFPA's CERF funded project could link to UNICEF's on-going programmes including communication on case management and access to services for children.

CERF recipient agencies undertook consultation within their respective clusters and with implementing partners. While food security and Nutrition were activated as a part of the government lean season appeal, they were able to implement CERF in line with agreed cluster priorities and further consultations with implementing partners. Health, Protection and WASH partners had undertaken consultations within the cluster to agree on time-critical priorities for the allocation of funding and additional

meeting where held bilaterally with implementing partners. Agencies expressed that the application process was rapidly facilitated due to the urgent need to address life-saving priorities that clusters that were already activated as a part of the lean season had an easier time in coordination and consultation as cluster priorities were already established. More coordination and consultation was needed for clusters that were activated as a part of the scale-up (Health, WASH and Protection) and all clusters highlighted the importance of establishing clear priorities within the cluster at the onset of the planning process.

#### 4. CERF RESULTS

CERF allocated \$10,000,426 to Malawi from its Rapid Response window to provide life-saving assistance to Malawians affected during the lean season. This funding enabled UN agencies and partners to assist 882,378 people of which, 86,231 people were assisted with primary health care services; 670,524 people with hygiene messages, 35,967 pregnant women delivered with clean delivery kits; 29 rape survivors with post rape treatment with drugs; 3,117 cases of sexually transmitted infections with treatment; 70 women with miscarriage and abortion complications with treatment; 36,614 people with life-saving nutritional commodities; 809,067 beneficiaries received cash transfers to top-up their nutritional basket; 8,300 children under five years of age were saved after successfully recovering from Severe Acute Malnutrition (SAM).

**WFP (Food Security)** reached 809,067 beneficiaries with cash transfers in five districts. Monthly transfers of US\$12 per households were done for the last two months (February and March) of the response to complement the Government's cereal distributions. Cash transfer top-up enabled beneficiaries to access non-cereal components of the food basket to complement the Government's cereals distribution. Dietary diversification of the beneficiary households increased by 12 percent from the baseline as beneficiary households consumed five or more food groups. Beneficiary households that received a combination of food and cash had better dietary diversity as compared to beneficiaries that only received food.

**WFP (Nutrition)** provided 36,614 people with 851 MT of life-saving nutritional commodities in eight districts. The commodities aided in the management of SAM and MAM for children, pregnant and lactating women, adults and adolescents living with HIV and TB (PLHIV). WFP conducted Quality Improvement Learning Sessions in 90 health facilities implementing Nutrition Care Support and Treatment (NCST). One session was conducted in each facility with 10 people trained at each health facility totalling 900 people. Individual Nutrition counselling was provided to 12,004 admitted within NCST programme, while all caregivers for children received group nutrition counselling.

**UNICEF (Nutrition)** reached a total of a total of 8,436 children (3,990 Male, 4,446 Female) with severe acute malnutrition (SAM) were admitted and treated through the community-based management of acute malnutrition (CMAM) program. The lives of 8,300 children under five years of age (representing 93.3 percent) were saved after successfully recovering from SAM. UNICEF procured 190 cartons of F75 and 9,510 cartons of Ready-to-Use Therapeutic Food (RUTF) which ensured timely access of the lifesaving supplies for referred children with SAM. In addition, 1,049,937 under five children were screened for acute malnutrition of which 12,095 children (9,530 MAM; 2,565 SAM) were referred to the CMAM program for further assessments.

**WHO (Health)** procured lifesaving medicines and medical supplies for six out of 15 of the most affected districts ensuring access to health services; trained 600 health care workers (100 per district) on early disease outbreak detection, investigation and response and supported the six districts to conduct 480 mobile outreach clinics sessions providing equitable access to health services. The project reached 86,231 people with different primary health care services through integrated outreach clinics.

**UNICEF (WASH)** provided emergency water treatment and conducted mass household chlorination to ensure safe drinking water to over 338,289 (172,527 children and 165,762 adults) chlorinated 53 water sources; and rehabilitated 50 non-functional boreholes. Over 56,041 people who were displaced or affected by the floods (in districts also affected by the lean season) were provided with access to temporary sanitation. A total of 11,949 school children also benefitted from the provision of latrines provided. Over 670,000 people were reached with hygiene messages through multiple channels such as community radios, hygiene promotion community meetings, drama performances etc.



**UNFPA (Protection)** procured and distributed Reproductive Health (RH) kits of which 35,967 pregnant women were assisted to deliver with clean delivery kits; a total of 29 rape survivors received post rape treatment with drugs; a total of 3,117 cases of sexually transmitted infections were treated; and 70 women with miscarriage and abortion complications were treated. A total of 165 service providers including health workers, social welfare officers and police officers were trained on Minimum Initial Services Package (MISP) including on clinical management of rape. Furthermore, a total of 1,040 displaced adolescents and women were provided with dignity kits.

## 5. PEOPLE REACHED

Overall, the UN agencies and their implementing partners reached more people than initially planned. During the course of the response, fifteen districts were affected by flooding due to Cyclone Idai which changed the scope of the emergency in terms of needs and size of the affected population. UN agencies and implementing partners revised programmes, increased number of districts and responded according to the humanitarian needs.

To effectively target beneficiaries and ensure accurate reporting on beneficiaries reached, Agencies used community committees to verify that beneficiaries receiving assistance were the intended beneficiaries by using national identity cards (a unique identifier) for verification during distribution and ensuring that beneficiaries were not duplicated. The reported beneficiaries are those reached and consistently reported on monthly basis, which avoided multiple counting as this was based on unique identifier. Other Agencies such as WFP also used distribution reports at end of every distribution cycle that were reviewed, checked against the planned distribution lists and tracked for consistency by WFP. Furthermore, UNICEF used end user monitoring to estimate number of people reached with the different life-saving supplies, safe water, hygiene promotion and sanitation services. The total number of beneficiaries was calculating using the highest number of “other affected persons” (Food security/Food assistance figures), plus the number of “IDPs” (from the WASH sector figures) and the number of “Host Communities” number (from the Protection sector figures).

**WFP’s Food Security** initially targeted 683,101 for the lean season response. As CERF funding was approved in January 2019, a month later than the planned start date of the proposed emergency response, resources meant for January transfers as well as funds earmarked for Mulanje district were reprogrammed to deliver assistance to other districts with equally high percentage of IPC affected population. In addition, districts who were on their last month of transfers for lean season response were hit by floods and reported loss of food, livelihoods and crops resulting in further intervention. Overall, an additional 126,000 people were reached increasing the total number to 809,067 reached with cash transfers. WFP avoided duplication by checking distribution reports against the plan distribution lists. Also, community committees were used to verify beneficiaries. While WFP Nutrition reached the targeted 36,614 people.

**UNICEF (Nutrition)** was able to support a total a total of 8,436 children (3,990 Male, 4,446 Female) with severe acute malnutrition (SAM) were admitted and treated through the community-based management of acute malnutrition (CMAM) program. UNICEF also screened 1,049,937 children which is about three times more children than initially planned, because they supported mass nutrition screening for children who were displaced in camp settings due to the flooding. UNICEF avoided duplication of beneficiaries by ensuring monthly screening and by calculating the total reached as an average for the duration of the intervention, not as cumulative. While UNICEF’s WASH scaled up its dissemination of hygiene messages to mitigate against disease outbreak and increased sensitization of hygiene practices especially in the camp settings reaching 476,330 instead of 200,000 planned.

**WHO (Health)** reached 79.5% of its planned beneficiaries (108,525 planned, 86,231 reached). Meanwhile, all 600 health workers targeted for training were trained and all mobile outreach clinics were delivered as planned. WHO used a standard

reporting form in order to avoid duplication of efforts and double counting of beneficiaries. Also, the 4W matrix helped in avoiding duplication.

**UNFPA (Protection)** had initially targeted 16,498. With savings made in key budget lines, UNFPA procured additional 30 RH kits and over 1,040 dignity kits which allowed them to reach an additional 35,967 other affected persons.

<b>TABLE 4: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY CATEGORY<sup>1</sup></b>		
<b>Category</b>	<b>Number of people (Planned)</b>	<b>Number of people (Reached)</b>
<b>Host communities</b>	683,101	809,067
<b>Refugees</b>	0	0
<b>Returnees</b>	0	0
<b>Internally displaced persons</b>	0	37,344
<b>Other affected persons</b>	0	35,967
<b>Total</b>	<b>683,101</b>	<b>882,378</b>

<sup>1</sup> Best estimates of the number of people directly supported through CERF funding by category.

<b>TABLE 5: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY SEX AND AGE<sup>2</sup></b>					
	<b>Men (≥18)</b>	<b>Women (≥18)</b>	<b>Boys (&lt;18)</b>	<b>Girls (&lt;18)</b>	<b>Total</b>
<b>Planned</b>	160,833	167,397	173,887	180,984	<b>683,101</b>
<b>Reached</b>	202,044	246,424	212,697	221,213	<b>882,378</b>

<sup>2</sup> Best estimates of the number of people directly supported through CERF funding by sex and age (totals in tables 4 and 5 should be the same).

<b>TABLE 6: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (PERSONS WITH DISABILITIES)<sup>3</sup></b>					
	<b>Men (≥18)</b>	<b>Women (≥18)</b>	<b>Boys (&lt;18)</b>	<b>Girls (&lt;18)</b>	<b>Total</b>
<b>Planned (Out of the total targeted)</b>	N/A	N/A	N/A	N/A	<b>N/A</b>
<b>Reached (Out of the total reached)</b>	N/A	N/A	N/A	N/A	<b>N/A</b>

<sup>3</sup> Best estimates of the number of people with disabilities directly supported through CERF funding.

<b>TABLE 7a: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY SECTOR (PLANNED)</b>					
<b>By Cluster/Sector (Planned)</b>	<b>Men (≥18)</b>	<b>Women (≥18)</b>	<b>Boys (&lt;18)</b>	<b>Girls (&lt;18)</b>	<b>Total</b>
Health - Health	9,376	10,158	43,410	45,581	<b>108,525</b>
Nutrition - Nutrition	4,320	7,680	11,808	12,797	<b>36,605</b>
Water Sanitation Hygiene - Water, Sanitation and Hygiene	42,140	43,860	55,860	58,140	<b>200,000</b>
Protection - Sexual and/or Gender-Based Violence	3,167	3,431	4,752	5,148	<b>16,498</b>
Food Security - Food Assistance	160,833	167,397	173,887	180,984	<b>683,101</b>

**TABLE 7b: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY SECTOR (REACHED)**

By Cluster/Sector (Reached)	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Health - Health	7,450	8,071	34,493	36,217	<b>86,231</b>
Nutrition - Nutrition	4,322	7,682	15,800	17,246	<b>45,050</b>
Water Sanitation Hygiene - Water, Sanitation and Hygiene	100,362	104,459	133,040	138,469	<b>476,330</b>
Protection - Sexual and/or Gender-Based Violence	3,117	40,880	4,200	6,120	<b>54,317</b>
Food Security - Food Assistance	194,176	202,267	202,267	210,357	<b>809,067</b>

## 6. CERF'S ADDED VALUE

### a) Did CERF funds lead to a fast delivery of assistance to people in need?

YES ☒

PARTIALLY ☐

NO ☐

During the AAR, all UN agencies agreed that the CERF approval process was very responsive and released funding within 10 days of approval to respective agencies. UN agencies and implementing partners were then able to start implementation of their activities to rapidly reach drought-affected households. Through the timely release of CERF funding, WFP was able to initiate cash transfers reaching over 809,067 beneficiaries to purchase additional pulses and cereals to complement the Government's in-kind distribution. With the onset of floods, CERF approved the timely extension of the cash transfers program to beneficiaries in four districts who had lost their foods and livelihoods.

UN agencies noted that a lot of resources had to be used for procurement, which took a long time and their own internal systems were not responsive enough to emergency demands. Other agencies, such as UNICEF and WFP have pre-established MOUs with suppliers which enables a quicker procurement process, a model of good practice which will be replicated. Additionally, UN agencies reflected that their application to CERF funds was very late, namely at the peak of the lean season (January 2019), which, if applied sooner, could have seen a more timely and effective delivery of response activities.

### b) Did CERF funds help respond to time-critical needs?

YES ☒

PARTIALLY ☐

NO ☐

CERF funding helped to respond to time-critical needs as it has enabled the UN agencies to provide humanitarian responses to drought-affected populations. It enabled agencies to target the right people at the right time through the provision of life-saving food assistance and nutrition.

CERF funding supported UNICEF to expand its WASH prevention interventions such as chlorination and hygiene messaging to prevent disease outbreak. While WHO stated that it scaled up its mobile outreach clinics in communities and camps, further contributing to mitigating against disease outbreaks by treatment of malaria. While UNFPA (Protection) gave the example that they could not have procured drugs to treat Sexual Transmitted Infections (STIs) in local clinics without the CERF funding.

### c) Did CERF improve coordination amongst the humanitarian community?

YES ☒

PARTIALLY ☐

NO ☐

During the lean season response, the Government of Malawi only activated two clusters; Food Security and Nutrition. There was general agreement amongst the humanitarian community that food security and nutrition should be prioritized for funding. Initially, the Inter-Cluster Coordination seemed to be absent but as the situation worsened and the humanitarian needs increased, and a decision to apply for CERF funding was agreed discussions widened and broadened the response with the activation of the WASH, Health and Protection clusters. Hence, it was deemed that coordination did improve with the injection of CERF funding. Additionally, UN teams did joint field visits, which was deemed very positive and improved collaboration in interventions in targeted districts.

UN agencies with partners on the ground enhanced their coordination and implementation as discussions were ongoing on how best to respond while other agencies such as UNFPA were challenged as their partner is primarily the Ministry of Health and less with direct NGO implementers. With CERF funding, coordination at district level increased, as partners were directly implementing activities reporting

to clusters and monitoring progress.

**d) Did CERF funds help improve resource mobilization from other sources?**

YES ☒

PARTIALLY ☐

NO ☐

With the injection of CERF funding, UN agencies reported that they were relatively successful in mobilising additional resources into the response, as they were able to highlight where the needs were. For example, WFP nutrition secured additional funding from the Swiss Government to respond to nutrition needs in health facilities. While USAID Food For Peace topped up cash transfers into the most affected districts challenging the funding through WFP. Other agencies such as WHO were able to secure funding to replenish stock used during the response.

Overall, it was more challenging to obtain adequate funding for the drought response and this highlights the importance of enhancing the linkages between humanitarian and resilience programmes thereby building the resilience of communities affected by regular shocks.

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

The lean season 2019/2020 response was Government led and mostly focused on cereal distribution. With the humanitarian partners it was broadened to a mixed response. Through CERF funding, WFP (Food Security) was able to provide cash top ups to households to purchase additional cereals and pulses complementary to the government donation. The cash top up enabled households to improve the dietary diversity.

During the response, the national ID was used to track beneficiaries in distribution points for the first time ever. It has huge potential to increase the timeliness and efficiency of emergency response, avoid duplication of efforts and enhance coordination efforts through potential standardised distribution lists.

## 7. LESSONS LEARNED

**TABLE 8: OBSERVATIONS FOR THE CERF SECRETARIAT**

Lessons learned	Suggestion for follow-up/improvement
<b>Flexibility in programming</b> was deemed very positive by recipient agencies as circumstances such as geographically targeted areas changed due to other partners covering areas.	N/A
<b>CERF supported an integrated multi-sectoral approach</b> to the food security emergency. At the height of the lean season and faced with a deteriorating situation there was a need to scale-up the emergency response across key life-saving sectors in support of the already activated food security and nutrition response. CERF supported in a kick-start of critical funding for WASH, Health and Protection.	N/A
<b>CERF supported in increasing the coordination</b> around the lean season response. The lean season plan activated by the Government only activated food security and nutrition, through CERF's implementation it supported activation and enhanced coordination of other sectors.	N/A
<b>CERF supported timely response</b> through quick approval process, and timely disbursement of funds. Agencies that were able to support rapid scale-up at the height of the lean season. The process was very quick turnaround from the CERF Secretariat to ensure life-saving assistance reached people quickly.	N/A

**TABLE 9: OBSERVATIONS FOR COUNTRY TEAMS**

Lessons learned	Suggestion for follow-up/improvement	Responsible entity
1.1 Consultation process: Mandates were not very clear of what each agency is bringing to the table.	1.1 Need for better coordination of consultation process.	HCT and Clusters
1.2 Consultation process: Criticism of NGO partners because of limited consultation or involvement. Engagement with CSOs seems quite unclear.	1.2 Need for a platform to include all partners and more effective engagement of CSOs in consultation process.	DoDMA, UNCT
1.3 Consultation process: Engagement with Government is difficult, due not full activation of all clusters at the start of the response	1.3 Need for DoDMA to lead and engage Government line ministries in the planning process to ensure activation and engagement of supportive clusters.	DoDMA
2.1 Application submission: Reactive and late CERF application submission (at peak of lean season).	2.1 Need for more proactive and timely CERF application submission. Need for earlier discussion within HCT to apply for CERF grant.	HCT, UNCT
3.1 Protection mainstreaming: Difficulty to recognize and monitor protection issues. They tend to be silent.	3.1 Need for quantifying protection issues and regularly monitoring.	UNCT
4.1 Transparency funding: Districts did not have information of what funding was coming into their	4.1 Need for active line ministries in all districts to keep oversight.	Line Ministries

districts. National level needs to have overview of what funding is going where on local lower level.		
4.2 District-based coordination: NGOs raise concerns about district-based coordination and look for partnerships to support. This will help UN to be more efficient. Links back to long term work at district level.	4.2 Need for reflection on whether district is able to respond. Need for a district support approach, stronger districts that can roll out Nexus.	UNCT
5.1 Umbrella agreements with partners: UNICEF and WFP were able to facilitate fast delivery thanks to umbrella standby agreements with a couple of partners, from whom they chose the partners they could prefinance. They acknowledged that it would have been challenging if they would have had to start from scratch. This links back to preparedness and prepositioning. Implementing partners are very important to start response before getting CERF funds.	5.1 Umbrella agreements can be used by all UN agencies. UN agencies to deliberate and share experiences about partners and how it worked.	UNCT
6.1 Needs assessment: Not all sectors were involved in MVAC process in order to capture needs beyond food security.	6.1 Integrate all relevant sectors in the MVAC process to capture needs beyond food security.	MVAC, DoDMA
6.2 Needs assessment: There was a late release of IPC results.	6.2 Undertake training of all relevant stakeholders on the IPC methodology to ensure buy in and speedy release of results	DoDMA

## PART II

### 8. PROJECT REPORTS

#### 8.1. Project Report 19-RR-FPA-002 - UNFPA

1. Project Information			
<b>1. Agency:</b>	UNFPA	<b>2. Country:</b>	Malawi
<b>3. Cluster/Sector:</b>	Protection - Sexual and/or Gender-Based Violence	<b>4. Project Code (CERF):</b>	19-RR-FPA-002
<b>5. Project Title:</b>	Prevention of and response to Gender Based Violence (GBV) and addressing other protection needs of women and children		
<b>6.a Original Start Date:</b>	05/02/2019	<b>6.b Original End Date:</b>	04/08/2019
<b>6.c No-cost Extension:</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	If yes, specify revised end date:	N/A
<b>6.d Were all activities concluded by the end date?</b> (including NCE date)		<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (if not, please explain in section 3)	
<b>7. Funding</b>	<b>a. Total requirement for agency's sector response to current emergency:</b>		<b>US\$ 615,729</b>
	<b>b. Total funding received for agency's sector response to current emergency:</b>		<b>US\$ 397,294</b>
	<b>c. Amount received from CERF:</b>		<b>US\$ 397,294</b>
	<b>d. Total CERF funds forwarded to implementing partners</b>		<b>US\$ 0</b>
	of which to:		
	Government Partners		US\$ 0
International NGOs		US\$ 0	
National NGOs		US\$ 0	
Red Cross/Crescent		US\$ 0	

2. Project Results Summary/Overall Performance
<p>Through the CERF RR grant, UNFPA procured and distributed Reproductive Health (RH) kits of which 35,967 pregnant women were assisted to deliver with clean delivery kits (RH kits 2A; Kit 6B and midwifery kits); a total of 29 rape survivors received post rape treatment with drugs from RH Kit 3; a total of 3,117 cases of sexually transmitted infections were treated with RH kit 5; and 70 women with miscarriage and abortion complications were treated with RH Kit 8. A total of 165 service providers including health workers, social welfare officers and police officers were trained on Minimum Initial Services Package (MISP) including on clinical management of rape. Furthermore, a total of 1,040 displaced adolescents and women were provided with dignity kits.</p> <p>An estimated population of 2,890,000 including displaced people were reached with messages on Gender-based Violence (GBV) and Sexual Exploitation through 4,333 adverts on radio stations and other Information, Education and Communication (IEC) materials. The project assisted a total of 18,350 people in 9 districts that were hard hit by drought and floods (Phalombe, Chikwawa, Machinga, Balaka, Blantyre, Nsanje, Mangochi, Mulanje and Salima) from February to July 2019 to meet their Sexual and Reproductive Health (SRH) needs and prevent/address GBV including sexual exploitation and abuse.</p>

3. Changes and Amendments
<p>During the course of implementation, all the 9 target districts under the project were also affected by floods; a development that changed the scope of the emergency response in terms of needs and size of the affected population. In response, UNFPA submitted a reprogramming request to CERF which was approved in order to align the response to the expanded scope and emerging needs of the</p>

affected population. Specifically, UNFPA mobilized its internal capacity for sub-cluster coordination through the deployment of an international GBV Sub-cluster coordinator and 2 full time field coordinators (RH Coordinator and GBV Coordinator) to coordinate day to day activities of the humanitarian response. Furthermore, additional kits in form of midwifery kits and RH Kit 6B (clinical delivery assistance kit) were identified to support the needs of the affected population. As such, adjustments to the original plan were made on:

1. The budget for staff and other personnel costs meant for 25% contribution of salaries of the UNFPA Humanitarian Officer and Gender Officer was revised downwards from US\$30,356 to US\$24,700 to cater for personnel costs of full time Consultants (RH Coordinator and GBV Coordinator) for a period of 3 months to coordinate day to day activities in the field.
2. The budget for supplies, commodities and materials was increased from US\$112,047 to US\$207,817 to procure additional kits (RH Kit 6B, midwifery kits and dignity kits) that were identified as a result of the floods that affected the 9 target districts during the course of implementation.
3. The budget for contractual services allocated for contractual services including hiring of vans for distribution of Reproductive Health kits and engagement of radio stations to disseminate messages on GBV was reduced from US\$91,450 to US\$58,627 as there were savings due to the engagement of various community radio stations under a single contract with YONECO FM which significantly reduced the cost.
4. Travel costs allocated for UNFPA staff and Government partners on monitoring of field activities was reduced from US\$119,350 to US\$79,075 as the recruitment of 2 full time consultants (RH Coordinator and GBV Coordinator) that were based in Blantyre led to a reduction in travel requirements for UNFPA staff based in Lilongwe to travel to the field to monitor activities. Additionally, training of 90 health workers on clinical management of rape was not undertaken as some of its components were partly integrated into Minimum Initial Services Package (MISP) training where a total of 165 service providers including health workers were targeted.
5. General operating and other indirect costs allocated for production of IEC materials on key messages related to GBV and SRH were reduced from US\$18,000 to US\$1,084 as the IEC materials were produced at a significantly lower cost.

#### 4.a NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (PLANNED)

Cluster/Sector	Protection - Sexual and/or Gender-Based Violence				
Planned	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Host communities	3,167	3,431	5,148	4,752	16,498
Refugees	0	0	0	0	0
Returnees	0	0	0	0	0
Internally displaced persons	0	0	0	0	0
Other affected persons	0	0	0	0	0
Planned	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people planned")	N/A	N/A	N/A	N/A	N/A

#### 4.b NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (REACHED)

Cluster/Sector	Protection - Sexual and/or Gender-Based Violence				
Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Host communities	3,117	4,913	4,200	6,120	18,350
Refugees	0	0	0	0	0
Returnees	0	0	0	0	0



Internally displaced persons	0	0	0	0	0
Other affected persons	0	35,967	0	0	35,967
<b>Reached</b>	<b>Men (≥18)</b>	<b>Women (≥18)</b>	<b>Boys (&lt;18)</b>	<b>Girls (&lt;18)</b>	<b>Total</b>
Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	0
In case of significant discrepancy between figures under planned and reached people, either in the total numbers or the age, sex or category distribution, please describe reasons:	<p>The project reached more people because of the expanded scope of the response which came about due to the floods after Cyclone Idai, which also affected the 9 districts that were targeted under the initial drought response. The savings that were made in some budget lines allowed for more commodities and services to be extended to more beneficiaries. Specifically, the procurement of 30 packs of RH Kit 6B (Clinical Delivery Assistance Kit) made it possible for the project to benefit over 30,000 other affected persons beyond the host communities. Additionally, other affected persons beyond the host communities benefited from pregnancy test kits from RH kit 3 which were enough for approximately 17,000 women. The 30 packs of RH Kit 5 (HIV/STI treatment kit) benefited about 7,500 people through mobile clinics and health facilities where both host communities and other affected persons were reached. The procurement of 1,040 dignity kits, which were not part of the original budget, made it possible for the project to reach more people in the host communities than initially anticipated.</p>				

## 5. CERF Result Framework

<b>Project Objective</b>	Preventing and responding to Gender Based Violence and Sexual Exploitation and Abuse of boys, girls, men and women in 15 food insecure districts in Malawi.
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<b>Output 1</b>	RH Kits are procured delivered and distributed			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 1.1	Number of and type of Reproductive Health Kits distributed	Kit 2 (Clean delivery): 4 Kits 3 (Pregnancy Test and Post Rape Treatment): 17 Kit 5 (PEP/ HIV/STI Treatment): 30 Kit 8 (Management of Miscarriage Complications of Abortion): 70	Kit 2A=4 Kit 3= 17 Kit 5=30 Kit 6B = 30 Kit 8 = 70 Midwifery Kit = 50 Dignity kits = 1,040	MOH district monthly reports
Indicator 1.2	Number of Monitoring reports from MOH to UNFPA	6	6	UNFPA field-based humanitarian team
<b>Explanation of output and indicators variance:</b>		<p>RH Kit 6B and midwifery kits were added to complement RH Kit 2A which is individual clean delivery kit. RH kit 6B and Midwifery Kits are facility-based kits and include drugs and specialized equipment which are extremely useful to assist with safe deliveries. The dignity kits were very important as they assisted adolescents, pregnant women and lactating mothers to maintain their dignity in camps and temporary communities. Since UNFPA had deployed 2 full time consultants to coordinate day to day activities of the humanitarian response, monitoring reports were prepared by the consultants on weekly and monthly basis in collaboration with the district health team.</p>		
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		
Activity 1.1	Procurement, delivery and distribution of the RH Kits	MOH/UNFPA		

Activity 1.2	Monitor distribution of RH Kits	UNFPA/MOH
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<b>Output 2</b>	Women, girls, boys, and men exposed to GBV and SEA are clinically managed and treated			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 2.1	Number of health workers oriented/reoriented on post rape management	90	0	UNFPA field-based humanitarian team
Indicator 2.2	The number of boys, girls, men and women who have been sexually abused who are clinically managed and treated	9,900	29	Health facility records
<b>Explanation of output and indicators variance:</b>		The low reported figure of 29 is attributed to under reporting of abused cases at the health facility level due to sensitivity of the matter. This is also due to the high target of 9,900 as it was based on the MISP guidelines which meant that the 17 packs of RH Kit 3 which were procured were enough to cover the minimum needs of PEP (prevention of pregnancy and HIV/STI infection) for 5,000 persons (i.e. rape survivors), plus those who need pregnancy tests and other clinical management associated with rape. The discrepancy between the target of 90 against the achievement of 0 on the number of health workers oriented on post rape management is due to the fact that funds were instead used for Training of Trainers (ToT) sessions on MISP targeting a total of 165 service providers consisting of health workers, social welfare officers and police where components of clinical management of rape were integrated into the MISP training. Funds were further reprogrammed to strengthen MISP in the 9 target districts where 107 service providers were oriented on MISP.		
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		
Activity 2.1	Clinical orientation of health workers on clinical management of rape protocols.	MOH, Ministry of Gender, UNFPA		
Activity 2.2	Clinical management of rape/defilement/GBV cases	UNFPA/MOH-Kit 3		

<b>Output 3</b>	GBV and SEA monitoring, reporting, referral and coordination mechanisms are strengthened.			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 3.1	Number of people who received key messages	1,584,000	2,890,000+	Broadcasting logs and estimated listenership for Malawi Broadcasting Corporation, Zodiak Broadcasting Corporation, Goal Malawi YONECO community radios
Indicator 3.2	Number of orientation sessions targeting the Malawi Police Services and Civil Protection Committee	9	3	District orientation/training reports
Indicator 3.3	Number of reported cases of GBV and SEA that are identified, managed and referred.	TBD	133	YONECO records
<b>Explanation of output and indicators variance:</b>		Number of people that were reached with key messages exceeded the target by close to 100% due to the engagement of more community radio stations through a single contract with YONECO. Due to the increased number of radio		

		<p>stations (5 community and 3 national radio stations); the messages did not reach only communities in the camps but also included all communities in the entire districts because of the use of radio broadcasting. To measure this number, UNFPA used the average number of who had access to radios/mobile phones, which was the major source of getting the information out. This also included the rest of the affected population and not just the displaced people in all the nine affected districts. An average of about 4 to 6 people had access to radio per household. UNFPA also used an estimated number of people who had access to posters and other IEC materials which were distributed during food distribution in the camps.</p> <p>Although the orientation sessions on MISP were reduced from 9 to 3, the number of participants did not change as the districts were clustered into 3 clusters.</p>
Activities	Description	Implemented by
Activity 3.1	Dissemination of common key messages regarding GBV and other forms of violence and available protection services through community radios as well as at food distribution points.	Malawi Broadcasting Corporation, Zodiak Broadcasting Corporation, Goal Malawi YONECO community radio – UNICEF- messages agreed at national level
Activity 3.2	Incorporate GBV response and reporting on SEA into the community-based complaints and feedback mechanisms used by WFP and its partners including use of telephone hotlines	Ministry of Gender, YONECO
Activity 3.3	Orientation and engagement with Community Policing Department of the Malawi Police Service and Civil Protection Committees at the District level	MPS, Judiciary, Health Education Social Welfare, CSOs Traditional leaders.
Activity 3.4	Reorientation of the Ministry of Gender staff on systematic GBV monitoring and reporting as well as feedback mechanism on the Prevention of Sexual Exploitation and Abuse during emergency response.	UNFPA, UN Women UNICEF, Action AID, Care Malawi, Red Cross, YONECO, CAVOC
Activity 3.5	Monitoring and Evaluation of the CERF project including monthly progress reports and field visits	UNFPA, District Social Welfare/ Health

## 6. Accountability to Affected People

### 6.a IASC AAP Commitment 2 – Participation and Partnership

**How were crisis-affected people (including vulnerable and marginalized groups) involved in the design, implementation and monitoring of the project?**

The affected people were involved in community coordination meetings, camp planning meetings, feedback and reporting mechanisms. The camp-based committees, comprising of affected communities, were actively involved in the identification of beneficiaries including the identification of women and girls in camps that received dignity kits. The camp-based committees were also actively engaged with the organization of awareness campaigns as well as monitoring and follow up of GBV cases. In fact, one camp committee was able to identify and take appropriate action with the district social welfare office where chiefs were asking sexual favours from women in order to be registered for various relief items.

**Were existing local and/or national mechanisms used to engage all parts of a community in the response? If the national/local mechanisms did not adequately capture the needs, voices and leadership of women, girls and marginalised groups, what alternative mechanisms have you used to reach these?**

Yes. The civil protection committees were established and trained on prevention and management of GBV in some of the target districts and were also actively involved in raising awareness of GBV in camps and affected communities.

**6.b IASC AAP Commitment 3 – Information, Feedback and Action**

**How were affected people provided with relevant information about the organisation, the principles it adheres to, how it expects its staff to behave, and what programme it intends to deliver?**

Community leaders were trained as Trainers of Trainers (TOT) on GBV and PSEA at district level. Participants were also engaged in one-on-one sessions and focus group discussions (FGDs). The communities also got information from IEC materials as well as radio messages.

**Did you implement a complaint mechanism (e.g. complaint box, hotline, other)? Briefly describe some of the key measures you have taken to address the complaints.** Yes ☒ No ☐

Suggestion boxes were put in all the camps to enable victims of any abuse including sexual assault to report anonymously. The affected communities had also access to the YONECO hotline though it was mostly used for reporting of cases related to the abuse of power by chiefs and other duty bearers such as diverting relief items. Referral pathways were also created to raise awareness among affected people on identifying issues and how to report the issues to relevant authorities for assistance.

**Did you establish a mechanism specifically for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints? Briefly describe some of the key measures you have taken to address the SEA-related complaints.** Yes ☒ No ☐

The District Social Welfare Offices/gender offices established GBV reporting mechanisms in the camps and affected communities and worked in partnership with NGOs including YONECO to conduct regular awareness campaigns on GBV. Additionally, drop in boxes were established in the camps for reporting of abuse cases anonymously. For the few cases that were reported on SEA, The District Social Welfare Offices in collaboration with the camp committees were capacitated to follow up and investigate. These include a case in one of the camps where chiefs were asking women for sexual favours in order to be registered for various relief items. The other case was reported from another camp where a mentally disturbed girl was defiled.

**Any other comments (optional):**

Only a few cases of sexual abuse were recorded from the camps and communities in the districts that were affected by the disaster. This was besides the districts establishing drop in boxes in the camps for reporting of abuse as well as conducting regular awareness campaigns on GBV. However, this does not mean that sexual abuse cases were not happening but rather people are still trapped with the "culture of silence". Only cases related to abuse of power by Chiefs and camp management committees such as diverting of food aid were some of the cases that people were comfortable to report. Moving forward, it would be worthwhile conducting a sample based personal interview study to quantify the magnitude of various forms of GBV in the camps and affected communities. It was clear during the monitoring visits that people were not comfortable to talk about issues of GBV in a group setting. Alternatively, as districts should be supported to undertake post-mortem meetings with partners to assess and document incidences of GBV including possible threats of sexual abuse cases during the disaster period.

**7. Cash Transfer Programming**

**Did the project include one or more Cash Transfer Programmings (CTP)?**

Planned	Achieved
No	No

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

No evaluation has been carried out since it was not included in the original plan. However, the protection cluster conducted a lessons-learned exercise which analysed GBV sub cluster response including UNFPA's CERF funded activities.

EVALUATION CARRIED OUT ☐

EVALUATION PENDING ☐

NO EVALUATION PLANNED ☒

## 8.2. Project Report 19-RR-CEF-006 - UNICEF

1. Project Information			
1. Agency:	UNICEF	2. Country:	Malawi
3. Cluster/Sector:	Nutrition - Nutrition	4. Project Code (CERF):	19-RR-CEF-006
5. Project Title:	Strengthening management of severe acute malnutrition in 8 food insecure districts		
6.a Original Start Date:	01/02/2019	6.b Original End Date:	31/07/2019
6.c No-cost Extension:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	If yes, specify revised end date:	N/A
6.d Were all activities concluded by the end date? (including NCE date)		<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (if not, please explain in section 3)	
7. Funding	a. Total requirement for agency's sector response to current emergency:		US\$ 5,482,579
	b. Total funding received for agency's sector response to current emergency:		US\$ 3,854,312
	c. Amount received from CERF:		US\$ 1,009,202
	d. Total CERF funds forwarded to implementing partners		US\$ 355,826
	of which to:		
	Government Partners		US\$ 278,287
	International NGOs	US\$ 0	
	National NGOs	US\$ 77,539	
	Red Cross/Crescent	US\$ 0	

## 2. Project Results Summary/Overall Performance

Through CERF's RR grant, UNICEF and its partners reached a total of 1,049,937 (491,371 Males, 558,566 Females) under 5 children through nutrition screening in the eight targeted districts. From the nutrition screening, 12, 095 children (9,530 MAM; 2,565 SAM) were referred for treatment in the Community-based Management of Acute Malnutrition (CMAM) program for further assessment. Overall, a total of 7,459 children under-five (3,506 Males, 3,953 Females) and 977 children 5-15 years with SAM were admitted in the CMAM program in the eight targeted districts from February to July 2019.

The lives of 8,300 children under five years of age (representing 93.3 percent) were saved after successfully recovering from SAM, 222 (2.5 percent) died, 184 (2.1 percent) defaulted while 194 (2.2 percent) did not respond to treatment and were referred for further investigations. These program performance indicators were within the internationally agreed minimum SPHERE standards (recovery rates greater than 75 percent, defaulter rate less than 15 percent and death rate below 10 percent). Through this CERF grant, UNICEF procured 190 cartons of F75 and 9, 510 cartons of Ready-to-Use Therapeutic Food (RUTF) which ensured timely access of the lifesaving supplies by the children hence contributed to good program performance.

## 3. Changes and Amendments

Malawi was hit by heavy rains accompanied by strong winds which led to severe flooding across several districts in southern region in the country in March 2019. This affected access to implementation sites as people were displaced into camps. UNICEF, in collaboration with the Ministry of Health and District Councils, prioritised mass nutrition screening for children who were displaced in camps in the targeted districts. In addition, UNICEF could not provide money for active case finding directly to two districts councils namely Machinga and Mulanje because these councils delayed reporting on a previous grant. This resulted in delays in the kick-off of the implementation of activities in these districts. UNICEF therefore collaborated with two local NGOs, the Parent and Child Health Initiative Trust (PACHI) and Female Empowerment and Education Centre (FEEC) to facilitate community mobilization, behaviour change communication and

active case finding in Machinga and Mulanje respectively. With the support from the NGOs, the districts were able to adjust their plans accordingly and managed to achieve the desired results within the projects timeframe.

#### 4.a NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (PLANNED)

Cluster/Sector	Nutrition - Nutrition				
Planned	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Host communities	0	0	182, 000	168,000	350,000
Refugees	0	0	0	0	0
Returnees	0	0	0	0	0
Internally displaced persons	0	0	0	0	0
Other affected persons	0	0	0	0	0
Planned	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people planned")	N/A	N/A	N/A	N/A	N/A

#### 4.b NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (REACHED)

Cluster/Sector	Nutrition - Nutrition				
Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Host communities	0	0	3,990	4,446	8,436
Refugees	0	0	0	0	0
Returnees	0	0	0	0	0
Internally displaced persons	0	0	0	0	0
Other affected persons	0	0	0	0	0
Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	0
In case of significant discrepancy between figures under planned and reached people, either in the total numbers or the age, sex or category distribution, please describe reasons:	<p>Note that it was agreed with the CERF secretariat to include only those children admitted to the CMAM program and those supported with supplementary food as direct beneficiaries, while the target figures included also children screened.</p> <p>UNICEF supported mass nutrition screening during the flood response, screening 11,049,937 children including 491,371 boys and 558,566 girls. The integration of active case finding into existing platforms and systems like Child Health Days (CHDs), integrated Community Case Management (iCCM), care groups etc. enabled UNICEF to reach more children than was initially planned.</p>				

## 5. CERF Result Framework

<b>Project Objective</b>	The objective of the project is to ensure equitable access to life saving nutritional services in 8 districts for vulnerable children (boys and girls) at the community and facility level that meet national and internationally recommended minimum standard of care for a population affected at the peak of the lean season
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<b>Output 1</b>	Quality treatment provided to children with SAM in 8 food insecure districts improved			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 1.1	% children who are discharged as recovered from SAM	>75%	93.3%	DHIS-2
Indicator 1.2	% children who are discharged as defaulted	<15%	2.1%	DHIS-2
Indicator 1.3	% children who are died from SAM	<10%	2.5%	DHIS-2
Indicator 1.4	# of Nutrition Rehabilitation Units (NRUs) and Outpatient therapeutic program (OTP) sites in affected districts stocked with RUTF, and F75	100%	100%	DHIS-2
Indicator 1.5	# of NRUs and OTP sites in affected districts reported stock outs	<2%	0%	DHIS-2
<b>Explanation of output and indicators variance:</b>		The timely identification of cases through active case finding and mass nutrition screening coupled with availability of lifesaving commodities in health facilities contributed highly to saving the lives of children.		
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		
Activity 3.1	Conduct supportive supervision and mentorship in all the targeted facilities	UNICEF/MOH		
Activity 3.2	Procure F-75 and RUTF	UNICEF/MOH		
Activity 3.3	Distribute RUTF and F75 to OTPs and NRUs sites	UNICEF/MOH		

<b>Output 2</b>	Children with acute malnutrition are timely identified and referred for treatment			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 2.1	# of children reached through nutrition screening	350,000	1,049,937	Activity reports by implementing partners
Indicator 2.2	# of new admissions to CMAM program (NRU, OTP)	7,925	8, 436	DHIS-2
<b>Explanation of output and indicators variance:</b>		UNICEF supported mass nutrition screening during the flood emergency response in the host community as well as in the camps. This therefore enabled UNICEF to reach more children than initially planned. Because of mass nutrition screening, more children with SAM were identified and admitted into the CMAM program than initially planned.		
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		
Activity 2.1	Conduct active case finding of children with acute malnutrition at community level in the 8 affected districts	District Councils and IPs		

<b>6. Accountability to Affected People</b>
<b>6.a IASC AAP Commitment 2 – Participation and Partnership</b>
<b>How were crisis-affected people (including vulnerable and marginalized groups) involved in the design, implementation and monitoring of the project?</b>
<p>The project design and planning were done based on the needs assessments and consultations with districts structures including the District Nutrition Coordination Committees (DNCC), the District Health Management Teams (DHMT), Area Nutrition Coordination Committee (ANCC) as well as learning and recommendations from community and nutrition cluster members on the nutrition emergency response 2015-17. The affected people were directly involved in defining their priority needs. This was done using focused group discussions and key informant interviews, during the various inter-sectoral rapid assessments, including the government led Post Disaster Needs Assessment (PDNA) in April 2019. The affected population in key community/camps were clearly asked what their immediate needs were and based on this the feedback UNICEF and other humanitarian actors were able to tailor the response accordingly. In addition, with this support UNICEF conducted review meetings and joint monitoring visits with DNCCs, ANCCs, DHMTs, focus group discussions and key informant interviews with the affected community members to ascertain the successes, challenges and map way forward in program implementation. The findings from these review meetings helped UNICEF and its partners to provide effective delivery of appropriate life-saving interventions to both children affected by acute malnutrition including people with disabilities. This included strengthening of behaviour change communication messages on maternal infant and young child nutrition (MIYCN) practices to prevent malnutrition.</p>
<b>Were existing local and/or national mechanisms used to engage all parts of a community in the response? If the national/local mechanisms did not adequately capture the needs, voices and leadership of women, girls and marginalised groups, what alternative mechanisms have you used to reach these?</b>
<p>UNICEF provided technical support to the Department of Nutrition, HIV and AIDS (DNHA) in coordinating the Malawi nutrition cluster which resulted in timely contingency and response planning, adequate resources mobilization and effective implementation of quality treatment of children with SAM during the 2019 emergency response. UNICEF also worked with District Councils through the District Nutrition Coordination Committees and other lower level structures to strengthen coordination and ensure integration of active case finding. UNICEF trained 62 district team members from emergency prone districts in Nutrition in Emergency to allow the districts to respond to the situation. This strengthened the capacity of the DNCCs and ANCCs to engage with affected communities through focus group discussion and key informant interviews to identify the needs of children, girls and women including those displaced into camps. In addition, the DNCCs were better able to coordinate the nutrition response, collect data, report on the activities as well as implement relevant activities to the flood affected areas. UNICEF provided leadership in ensuring up to date data in relation to nutrition situation during the 2019 emergency response through the monthly nutrition bulletin.</p>
<b>6.b IASC AAP Commitment 3 – Information, Feedback and Action</b>
<b>How were affected people provided with relevant information about the organisation, the principles it adheres to, how it expects its staff to behave, and what programme it intends to deliver?</b>
<p>During the inter-sectoral rapid assessments affected people were orientated on key humanitarian principles and the need to ensure everyone affected by the crisis is supported. During focus group discussions camp leaders and other traditional leaders were sensitized to be impartial and ensure that those who needed care most including children under five and pregnant and lactating women were prioritised. The service providers, camp leaders and the people in camps were also sensitized on protection including prevention of sexual abuse and exploitation (PSEA) and gender-based violence (GBV), the need to voice their concerns where they see things not working well and hold the service providers accountable.</p>
<b>Did you implement a complaint mechanism (e.g. complaint box, hotline, other)? Briefly describe some of the key measures you have taken to address the complaints.</b>
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<p>Even though UNICEF did not specifically implement complaints handling strategies, government structures through the civil protection committees at village, area and district level were used to receive and address complaints. UNICEF received complaints such as inadequate screening in camps which was addressed through the DNCC and ensuring weekly screening for acute malnutrition of under five children in camps. There were also issues on the lack of a prevention ration for children under-two and pregnant and lactating women in both the lean season and flood emergency response food baskets which were brought to the attention of the Department of Disaster Management Affairs (DoDMA) and the food security cluster for their action. The Food Security cluster was however not able to immediately take action due to resource constraints.</p>



**Did you establish a mechanism specifically for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints? Briefly describe some of the key measures you have taken to address the SEA-related complaints.** Yes ☐ No ☒

At the start of the crisis issues relating to SEA was not well coordinated, in terms of identification and reporting. During the response, both humanitarian actors and the affected population were sensitized on SEA. All UN staff were required to complete the PSEA course, and further encouraged and supported to report any cases of SEA.

**Any other comments (optional):**

N/A

## 7. Cash Transfer Programming

**Did the project include one or more Cash Transfer Programmings (CTP)?**

Planned	Achieved
No	No

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

Since UNICEF declared the flooding effects an L2 emergency, a Real-Time Evaluation (RTE) was conducted covering the whole response action in the three affected countries. The evaluation report is still under review and not yet released. However, the overall emergency Nutrition performance in Malawi was rated as very good.

EVALUATION CARRIED OUT ☒

EVALUATION PENDING ☐

NO EVALUATION PLANNED ☐

### 8.3. Project Report 19-RR-CEF-007 - UNICEF

1. Project Information			
1. Agency:	UNICEF	2. Country:	Malawi
3. Cluster/Sector:	Water Sanitation Hygiene - Water, Sanitation and Hygiene	4. Project Code (CERF):	19-RR-CEF-007
5. Project Title:	Emergency WASH Response to 8 Food Insecure districts in Malawi		
6.a Original Start Date:	12/02/2019	6.b Original End Date:	11/08/2019
6.c No-cost Extension:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	If yes, specify revised end date:	N/A
6.d Were all activities concluded by the end date? (including NCE date)		<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (if not, please explain in section 3)	
7. Funding	a. Total requirement for agency's sector response to current emergency:		US\$ 1,800,000
	b. Total funding received for agency's sector response to current emergency:		US\$ 3,051,905
	c. Amount received from CERF:		US\$ 599,995
	d. Total CERF funds forwarded to implementing partners of which to:		US\$ 371,664
	Government Partners		US\$ 0
	International NGOs		US\$ 371,664
National NGOs		US\$ 0	
Red Cross/Crescent		US\$ 0	

### 2. Project Results Summary/Overall Performance

Through this CERF RR grant, UNICEF and its partners provided emergency water treatment and conducted mass household chlorination to ensure safe drinking water to 338,289 people of whom 172,527 children – (87,989 girls and 84,539 boys); and 165,762 adults – (84,539 women and 81,223 men); chlorinated 53 water sources; and repaired / rehabilitated a total of 50 existing non-functional boreholes. Over 56,041 (28,581 women and 27,461 men) who were displaced or affected by the floods were provided with access to temporary sanitation. Furthermore, a total of 11,949 school children also benefitted from the provision of latrines during the project period. A total of over 670,000 people were reached with hygiene messages through multiple channels. The WASH interventions ensured delivery of WASH services following SPHERE standards. The water supply response ensured supply within acceptable walking distance, and safety of water for drinking. The hygiene messaging had a massive reach, contributing to control of cholera outbreaks with no cases reported in all camps. The emergency sanitation facilities did not meet the requirement due to the large camp populations and short implementation period. However, measures were built in for regular cleaning and disinfection to ensure proper use and reduce the risk of disease outbreak.

### 3. Changes and Amendments

The project initially targeted to reach 200,000 people affected by the drought arising from the lean season, within their original areas of settlement. However, with the massive flooding that damaged infrastructure and livelihoods, a significant population was displaced to temporary IDP settlements. As a result, the CERF response was adjusted to prioritize providing the displaced populations with emergency life-saving WASH services, particularly water treatment and hygiene promotion. Also, the hygiene promotion component was intensified to cover bigger populations in all districts affected by the floods, to help control the spread of cholera.

A reprogramming request was submitted to the CERF secretariat to use the uncommitted balance of US\$ 40,000 (initially allocated to support monitoring activities by districts and for which other funding sources have been used) to increase the hygiene promotion activities, targeting all lean season communities and villages. But since the proposed budget variations were within the acceptable variance and

within the same budget line (Transfers and Grants to Counterparts), UNICEF was able to go ahead with the proposed changes without having to finalize the formal request.

#### 4.a NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (PLANNED)

Cluster/Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene				
Planned	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Host communities	42,140	43,860	55,860	58,140	200,000
Refugees	0	0	0	0	0
Returnees	0	0	0	0	0
Internally displaced persons	0	0	0	0	0
Other affected persons	0	0	0	0	0
Planned	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people planned")	N/A	N/A	N/A	N/A	N/A

#### 4.b NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (REACHED)

Cluster/Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene				
Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Host communities	100,362	104,459	133,040	138,469	476,330
Refugees	0	0	0	0	0
Returnees	0	0	0	0	0
Internally displaced persons	7,868	8,190	10,430	10,856	37,344
Other affected persons	0	0	0	0	0
Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	N/A

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

The overall achievement for WASH interventions regarding the population reached were significantly bigger than the planned 200,000 people; having achieved results of up to 476,330 people reached. This was mainly due to distribution and use of water treatment chemicals at households. In addition, the massive dissemination of hygiene messages through multiple methods including through community radios in three districts of Nsanje, Chikwawa and Salima resulted in 670,524 people reached as indirect beneficiaries. The achievements in each of the three main components of WASH were higher than planned. For provision of safe drinking water supply a total of 338,289 people were reached as compared to the planned 120,000. This was also achieved through multiple methods that included house to house water chlorination which had greatest outreach, rehabilitation of water points, construction of new solar powered reticulated water schemes, and some water trucking. The total number of latrines constructed was 208 as compared to 50 planned. This was so because the target for the lean season was for cholera treatment centres only; however, with the displacement of the same target population as result of the floods more temporary latrines were required especially in the IDP camps. As a result, the response action included use of additional existing prefabricated latrines from other resources. For

	hygiene promotion alone, over 670,524 people were reached, with expansion of the targeted population within the affected districts, and the increase in radio and other messaging, to reduce the spread of cholera.
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## 5. CERF Result Framework

<b>Project Objective</b>	Provision of emergency WASH response to vulnerable population in Malawi (including localized flash floods affected communities)
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<b>Output 1</b>	Increased access to safe water supply to affected people (drinking, cooking and personal hygiene)			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 1.1	No. of water points treated (source)	30	53	UNICEF and partner implementation reports
Indicator 1.2	No. of households provided with water treatment chemicals	40,000	95,266	UNICEF and partner implementation reports
Indicator 1.3	% of tests with 0 faecal coliforms/100ml of water (at non-chlorinated water collection location)	80% (1,600)	83% (3,381)	UNICEF and partner implementation reports
Indicator 1.4	% of tests showing free residual chlorine at least 0.1mg/L and turbidity NTU5 or below in chlorinated water storage container	80% (1,600)	54% (51,191)	UNICEF and partner implementation reports
Indicator 1.5	No. of households provided with water collection and storage containers	2,000	6,157	UNICEF and partner implementation reports
Indicator 1.6	No. of households collecting a minimum of 7.5l/p/d up to 15 l/p/d of safe water (range as per Sphere standards for total basic needs)	2,000	6,157	UNICEF and partner implementation reports
Indicator 1.7	No. of households with sufficient daily water storage capacity (50L for 5 family members average)	2,000	6,705	UNICEF and partner implementation reports
Indicator 1.8	No. of existing waterpoints rehabilitated	30	50	UNICEF and partner implementation reports
Indicator 1.9	% of households collecting drinking water from protected water source only	80% (1,600)	90% (6,157)	UNICEF and partner implementation reports
<b>Explanation of output and indicators variance:</b>		<p>Due to the flooding, more people were found in need of support than planned and the risk of cholera outbreak increased. Hence the coverage with water testing and treatment, and rehabilitation was substantially expanded to ensure that more people within the target districts were reached, to ensure people did not get contaminated water.</p> <p>Many households reached did not quickly adopt the use of chlorine for treating drinking water or applied lower doses, due to the taste and misconceptions about the substance. While only 54% of the households served were found to have sufficient chlorine residual, overall many more households than initially targeted actually used chlorine correctly and hence were assured of safe water.</p>		
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		
Activity 1.1	Procurement of WASH supplies	UNICEF		
Activity 1.2	Selection of NGO partner(s)	UNICEF		

Activity 1.3	Water quality testing at sources and households	United Purpose / UNICEF
Activity 1.4	Water treatment at source	United Purpose / UNICEF
Activity 1.5	Provision of household water treatment chemicals and mass household chlorination households, institutions, temporary collection centres (see details in the budget)	United Purpose / UNICEF
Activity 1.6	Provision of water collection and storage containers (see details in the budget)	United Purpose / UNICEF
Activity 1.7	Rehabilitation of non-functional water points	United Purpose / UNICEF

<b>Output 2</b>	Increased access to secure dignified sanitary facilities (latrines, bathroom shelters, handwashing facilities) in CTCs			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 2.1	No. of emergency latrines installed in Child-to-Child clubs (CTCs)	50	162	UNICEF and partner implementation reports
Indicator 2.2	No. of emergency bath centres installed in CTCs	50	162	UNICEF and partner implementation reports
<b>Explanation of output and indicators variance:</b>		Due to the flooding, several people were displaced into temporary IDP camps. These camps critically needed sanitation facilities, so construction of latrines and bathing shelters was prioritised and installed there. During the project period, no major cholera outbreak occurred with the good mobilisation and hygiene promotion, and as a result no sanitation facilities were installed at CTCs.		
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		
Activity 2.1	Identification of sites	United Purpose / UNICEF		
Activity 2.2	Dispatch of pre-fabricated emergency latrines to target areas	United Purpose / UNICEF		
Activity 2.3	Pit excavation and installation of emergency latrines and bath shelters in CTCs (the NGO that will support the installation is the same contracted for output 1)	United Purpose / UNICEF		
Activity 2.4	Decommissioning of latrines and site clearance	United Purpose / UNICEF		

<b>Output 3</b>	Appropriate hygienic practices in place			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 3.1	No. of people reached with hygiene messages	120,000	670,524	United Purpose / UNICEF
Indicator 3.2	% of people with knowledge of at least 3 critical times for handwashing	80% (480)	70% (190,775)	United Purpose / UNICEF
Indicator 3.3	% of households with hand washing facilities that have water and soap present	30% (9,000)	41% (15,828)	United Purpose / UNICEF
<b>Explanation of output and indicators variance:</b>		Community radios were used to disseminate hygiene messages including on cholera prevention, with wide reach beyond district borders hence the high numbers achieved. Soap was provided in all emergency camps for hand washing and bathing. And hand washing at 3 critical times was emphasized in camps and in surrounding communities to prevent cholera. While 70% of the population reached could correctly recall critical times for handwashing, the actual numbers were much higher than the target. And adoption of handwashing practice was higher than targeted, both in number of households and proportion of all those reached with hygiene promotion.		
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		

Activity 2.1	Identification of target groups (the NGO that will support the installation is the same contracted for output 1)	UNICEF
Activity 2.2	Household handwashing promotion	United Purpose, Story Workshop, Centre for Development Communication/ UNICEF
Activity 2.3	Hygiene campaigns/dramas/demonstrations	United Purpose, Story Workshop, Centre for Development Communication/ UNICEF
Activity 2.4	Distribution of soap to population in most critical need	United Purpose / UNICEF

## 6. Accountability to Affected People

### 6.a IASC AAP Commitment 2 – Participation and Partnership

#### **How were crisis-affected people (including vulnerable and marginalized groups) involved in the design, implementation and monitoring of the project?**

This being an emergency response project, the affected populations were involved through their community leaders, especially in the IDP camps both in the assessment of needs, determination of requirements and in the distribution of NFI's as well as involvement in some service provision such as digging of pits for sanitation. They were also made aware of supplies delivered to camps, through transparent deliveries and disclosure of the types and quantities to the leaders. The distribution principles and approaches were also discussed with the camp committees and other leaders, and they or other representatives were actively engaged in the distribution processes.

Among communities that were not displaced and in areas of return, the main response actions were household water treatment and hygiene promotion. These of necessity required active community engagement for successful implementation. The project implementation actively engaged government extension workers, Health Surveillance Assistants (HSA) in reaching out to discuss the needs and implementation roles.

#### **Were existing local and/or national mechanisms used to engage all parts of a community in the response? If the national/local mechanisms did not adequately capture the needs, voices and leadership of women, girls and marginalised groups, what alternative mechanisms have you used to reach these?**

In preparing and delivering the emergency response, UNICEF worked closely with the local traditional and elected leaders and existing community structures. Working with these leaders, camp committees were formed to manage the camps and coordinate with government and support agencies. UNICEF and partners actively engaged these camp committees and leaders in the needs' assessment and actual delivery stages. Through appropriate engagement with them and involving the HSAs, useful information was obtained to guide in project implementation.

For some situations, special groups were targeted. For instance, women and girls were engaged for their special needs such as menstrual hygiene requirements and distribution of related menstrual hygiene management (MHM) kits; both in camps and schools. Originally the provision of bath shelters were not in the plan but were later incorporated after the women expressed the urgent need of the same.

### 6.b IASC AAP Commitment 3 – Information, Feedback and Action

#### **How were affected people provided with relevant information about the organisation, the principles it adheres to, how it expects its staff to behave, and what programme it intends to deliver?**

Following the needs assessment, UNICEF primarily worked with NGO partners in the delivery of the response. As part of the partnership agreements, the NGOs signed a commitment to follow core principles and values, including commitment to transparency and accountability, and against fraud, corruption, sexual exploitation and abuse, and child abuse. While working to follow these principles and values, the NGO partners provided some information to the leaders and communities on their commitments during delivery. The UNICEF team during support supervision ensured that the implementation adhered to the principles of emergency response. However, in the circumstances, no separate measures were taken to explain to the affected population the humanitarian principles.

#### **Did you implement a complaint mechanism (e.g. complaint box, hotline, other)? Briefly describe some of the key measures you have taken to address the complaints.**

Yes ☐ No ☒

UNICEF did not specifically implement a complaint mechanism for the project. But the camp management and government structures through the civil protection committees were used to receive and address any complaints that arose. No specific complaints were received regarding the WASH project.

<p><b>Did you establish a mechanism specifically for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints? Briefly describe some of the key measures you have taken to address the SEA-related complaints.</b></p> <p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>A mechanism for reporting and handling SEA was not established at the start of the project. However, in the course of the response, humanitarian actors and the affected population were sensitized on SEA. And under a sister project, community-based complaints mechanisms were strengthened and linked to the hotline, for ease of reporting cases of SEA.</p> <p><b>Any other comments (optional):</b> N/A</p>
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7. Cash Transfer Programming	
Did the project include one or more Cash Transfer Programmings (CTP)?	
Planned	Achieved
No	No

8. Evaluation: Has this project been evaluated or is an evaluation pending?	
Since UNICEF declared the flooding effects a L2 emergency, a Real-Time Evaluation (RTE) was conducted covering the whole response action in the three affected countries. The evaluation report is still under review and not yet released. However, the overall emergency WASH performance in Malawi was rated as very good.	EVALUATION CARRIED OUT <input checked="" type="checkbox"/>
	EVALUATION PENDING <input type="checkbox"/>
	NO EVALUATION PLANNED <input type="checkbox"/>

#### 8.4. Project Report 19-RR-WFP-004 - WFP

1. Project Information			
1. Agency:	WFP	2. Country:	Malawi
3. Cluster/Sector:	Nutrition - Nutrition	4. Project Code (CERF):	19-RR-WFP-004
5. Project Title:	Management of moderate acute malnutrition in the most affected food insecure districts		
6.a Original Start Date:	05/02/2019	6.b Original End Date:	04/08/2019
6.c No-cost Extension:	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	If yes, specify revised end date:	30/10/2019
6.d Were all activities concluded by the end date? (including NCE date)		<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (if not, please explain in section 3)	
7. Funding	a. Total requirement for agency's sector response to current emergency:		US\$ 4,200,000
	b. Total funding received for agency's sector response to current emergency:		US\$ 2,151,210
	c. Amount received from CERF:		US\$ 1,490,546
	d. Total CERF funds forwarded to implementing partners of which to:		US\$ 0
	Government Partners		US\$ 0
	International NGOs		US\$ 0
National NGOs		US\$ 0	
Red Cross/Crescent		US\$ 0	

#### 2. Project Results Summary/Overall Performance

With the CERF RR grant, WFP provided 36,614 people (7,682 women, 4,322 men and 24,610 children) with 851 mt of life-saving commodities in eight districts (Balaka, Blantyre Chikwawa, Machinga, Mangochi, Mulanje, Phalombe and Salima) from February to October 2019. The nutritional commodities aided in the management of severe and moderate acute malnutrition for children, pregnant and lactating women, adults and adolescents living with HIV and TB (PLHIV) during the Lean Season. WFP also aimed to ensure quality of nutrition service delivery by conducting Quality Improvement Learning Sessions in all the 90 facilities implementing Nutrition Care Support and Treatment (NCST). One session was conducted in each facility with 10 people trained at each health facility totalling 900 people.

Individual Nutrition counselling was provided to 12,004 (7,682 women and 4,322 men) admitted within the Nutrition Care and Treatment Support (NCST) programme. While all caregivers for children received group nutrition counselling. Key topics discussed included dietary diversification, Water and sanitation, disease prevention, Family planning etc.

Corresponding to the SPHERE standards for Treatment of Acute Malnutrition Programmes, the Supplementary Feeding Programme reached an average recovery rate of 90.4%, death rate of 0.3%, default of 5.0% and non-response of 4.3%.

#### 3. Changes and Amendments

The approval of CERF funds (end January 2019) took place while the lean season response had already started (December 2019). This is coupled with the lengthy lead time for commodity procurements-which was seriously impeded by the low local capacity for the production of Ready-to-Use Therapeutic Food (RUTF) for treatment of SAM as well quality challenges in the local production of Corn Soya Blend (CSB). These challenges delayed the timeliness in dispatches of the nutrition lifesaving commodities for management of Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) for children, Pregnant and Lactating women and PLHIV. During that period,



beneficiaries were still reached using commodities from existing commodities from other funding sources (internal loan) and were reimbursed upon arrival of the CERF supported commodities.  
As such, WFP requested a no-cost extension from CERF under the Nutrition project which was approved and extended to 30 October 2019 to allow for effective delivery of assistance.

#### 4.a NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (PLANNED)

Cluster/Sector	Nutrition – Nutrition				
Planned	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Host communities	4,320	7,680	11,808	12,797	36,605
Refugees	0	0	0	0	0
Returnees	0	0	0	0	0
Internally displaced persons	0	0	0	0	0
Other affected persons	0	0	0	0	0
Planned	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people planned")	N/A	N/A	N/A	N/A	N/A

#### 4.b NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (REACHED)

Cluster/Sector	Nutrition – Nutrition				
Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Host communities	4,322	7,682	11,810	12,800	36,614
Refugees	0	0	0	0	0
Returnees	0	0	0	0	0
Internally displaced persons	0	0	0	0	0
Other affected persons	0	0	0	0	0
Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	0
In case of significant discrepancy between figures under planned and reached people, either in the total numbers or the age, sex or category distribution, please describe reasons:	N/A				

## 5. CERF Result Framework

<b>Project Objective</b>	Contribute towards reducing morbidity and mortality due to acute malnutrition for under-five children, pregnant and lactating women (PLW) and People Living with HIV and AIDS (PLHIV) in the 8 targeted districts, through treatment of moderate acute malnutrition.
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<b>Output 1</b>	Food and nutritional products distributed in sufficient quantity and quality and in a timely manner to targeted beneficiary households			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 1.1	Quantity of food assistance distributed, disaggregated by type of commodities, as % of planned	100% (851.4 mt)	99.97% (851.197mt)	WFP commodity procurement report
Indicator 1.2	Number of women, boys and girls receiving food assistance, disaggregated by beneficiary category and sex, as % of planned	100% (12,797 girls, 11,808 boys, 7,680 women, 4,320 men)	100% (12,800 girls, 11,810 boys, 7,682 women, 4,322 men)	MoH CMAM & NCST Programme data base
Indicator 1.3	Number of health facilities assisted, as % of planned	100% (194)	100% (194)	Field monitoring reports
Indicator 1.4	% children who are discharged as recovered (MAM)	>75% or 17,700	90.3% or 22,243	MoH CMAM Programme data base
Indicator 1.5	% children who are discharged as defaulted (MAM)	<15% or 3,540	5% or 1,236	MoH CMAM Programme data base
Indicator 1.6	% children who died (MAM)	<3% or 708	0.3% or 70	MoH CMAM Programme data base
<b>Explanation of output and indicators variance:</b>		These indicators are well within the SPHERE standards as shown in project summary section above		
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		
Activity 1.1	Procurement of specialized nutritious products	WFP		
Activity 1.2	Distribution of specialized nutritious products	WFP		
Activity 1.3	Timely community mobilization and active case findings for early identification, referral and follow up	Ministry of Health (MoH)		
Activity 1.4	Monitoring and reporting on the programme implementation	Ministry of Health through existing Health management information systems; District Health Information System (DHIS), and MoH Excel based CMAM programme data base		

<b>Output 2</b>	Messaging and counselling on specialized nutritious foods and infant and young child feeding (IYCF) practices implemented effectively			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 2.1	Number of women/men beneficiaries receiving nutrition messaging supported by WFP, as % of planned	100% (12,000)	100% (12,004)	NCST Programme data Ministry of Health
<b>Explanation of output and indicators variance:</b>				
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		
Activity 2.1	Conduct nutrition education and cooking demonstrations at every SFP clinic	Ministry of Health		

<b>Output 3</b>	Technical support provided to enhance management of Moderate Acute Malnutrition			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 3.1	Frequency of support supervision, mentoring and coaching visits conducted by WFP and MOH to facilities	Monthly	Monthly (Field Monitoring Health assistants conducted monthly visits for the period while joint supervision at National level was done once)	Monitoring Field Reports
<b>Explanation of output and indicators variance:</b>				
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		
Activity 3.1	Conduct monthly supervisory visits on the implementation of the programme.	WFP and Ministry of Health		

## 6. Accountability to Affected People

### 6.a IASC AAP Commitment 2 – Participation and Partnership

#### How were crisis-affected people (including vulnerable and marginalized groups) involved in the design, implementation and monitoring of the project?

As the programme is embedded within the Government system, there was no need for design for the project. Participation of crisis-affected people was only considered in the implementation and monitoring of the project.

Community engagement for Community Management of Acute Malnutrition (CMAM) was conducted through existing care groups to engage the care group promoters and cluster leaders to support active case finding including referral and follow up of children with acute malnutrition with health facilities within the catchment area. Community engagement promoted better response to community needs and concerns as communities were empowered and capable of addressing their own needs. It also led to cost effectiveness, accountability, sustainability and equity. The actors involved in the community engagement included religious and traditional leaders, health care providers, community outreach workers and volunteers, donors and agriculture extension workers. Community members forming the village health committee was a reliable communication platform which allowed continuous dialogue with communities and inspired their participation in health and nutrition practices. The communities also used the village health committee to voice their insights and identify new barriers as well as timely and jointly develop local solutions. Community engagement also led to integration of CMAM with other community activities for example promotion of positive infant and young child feeding practices, WASH, nutrition screening etc. Through community engagement, WFP and its partners, community health workers and volunteers were able to monitor the quality of the programme.

#### Were existing local and/or national mechanisms used to engage all parts of a community in the response? If the national/local mechanisms did not adequately capture the needs, voices and leadership of women, girls and marginalised groups, what alternative mechanisms have you used to reach these?

The response was fully coordinated by the Nutrition Cluster at national level with membership of all stakeholders in nutrition. At national level, WFP collaborated with other partners in the development of 4Ws for nutrition cluster response where the earmarked CERF activities were included. At the local level, District Executive Committees (DEC) worked very closely with NGO partners through the District Nutrition Coordination Committees for updates on implementation of nutrition programmes within the districts and identify key issues to assist the district managers in their support to the implementing facilities. At local level, the project utilised care-groups and the village nutrition coordination committees for discussions with all community members (including women, girls and other marginalized groups) on Nutrition programming within the community.

### 6.b IASC AAP Commitment 3 – Information, Feedback and Action

#### How were affected people provided with relevant information about the organisation, the principles it adheres to, how it expects its staff to behave, and what programme it intends to deliver?

As the programme is embedded in the Ministry of Health's systems, clients received messaging on the intervention upon admission into the Malnutrition intervention in Health facilities within their communities.

**Did you implement a complaint mechanism (e.g. complaint box, hotline, other)? Briefly describe some of the key measures you have taken to address the complaints.**

Yes ☒ No ☐

WFP has a Complaint and Feedback Mechanism (CFM) that utilizes a hotline managed by Youth Net and Counselling (YONECO), a third-party to guarantee independence and accountability). In addition, suggestion boxes, helpdesks and face to face meetings managed by Cooperating Partners were also included as channels for handling complaints with these three generally ranked as the most commonly used channels during distributions. Cases are escalated to and resolved in collaboration with partners, district councils and WFP. All cooperating partners in the Districts are required to orient all their project staff on CFMs, Accountability to Affected Populations (AAP), gender and protection, including sexual exploitation and abuse and also appoint a designated focal person for gender and protection who leads on CFMs for WFP supported programmes and finally provide a platform for receiving complaints from the affected communities at the distribution point e.g. helpdesk, suggestion box, pre-distribution talks etc. Data from all partners on WFP related concerns are collated in the WFP data base in the SUGAR CRM.

Furthermore, at district level, an ombudsperson is placed to handle all gender and protection issues at the district council. Additionally, protection committees have been set up at community and area levels to ensure that community members have a platform for complaints management.

**Did you establish a mechanism specifically for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints? Briefly describe some of the key measures you have taken to address the SEA-related complaints.**

Yes ☐ No ☒

Internally, WFP has a Protection on Sexual Exploitation and Abuse (PSEA) focal point both at country office and field office levels who provide sensitization and guidance on handling PSEA. All Cooperating partners were also sensitized on PSEA and were all obligated to appoint a PSEA focal point who was trained to handle all issues of protection and sexual exploitation and abuse.

**Any other comments (optional):**

WFP is in the process of revising the Standard Operating Procedures for its partner in handling complaints and feedback mechanisms Youth Net and Counselling (YONECO) on case follow-up and harmonizing of the CFMs of all UN agencies for easy referrals, following up of cases and better coverage.

## 7. Cash Transfer Programming

**Did the project include one or more Cash Transfer Programmings (CTP)?**

Planned	Achieved
No	No

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

As the treatment of severe and moderate acute malnutrition is ongoing with new cases registered every month, the project is still being implemented and as such, an evaluation will not be carried out presently. However, there is an overall After-Action Review of the support led by Government that aims to assess the impact of the whole response. As such, the nutrition component which was a part of the response will be assessed. The After-Action Review is ongoing and should be concluded in the coming months.

EVALUATION DONE ☐

EVALUATION PENDING ☐

NO EVALUATION PLANNED ☒

## 8.5. Project Report 19-RR-WFP-006 - WFP

1. Project Information			
1. Agency:	WFP	2. Country:	Malawi
3. Cluster/Sector:	Food Security - Food Assistance	4. Project Code (CERF):	19-RR-WFP-006
5. Project Title:	Support to the Government Lean Season Response with Cash-Based Transfer top-up		
6.a Original Start Date:	21/01/2019	6.b Original End Date:	20/04/2019
6.c No-cost Extension:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	If yes, specify revised end date:	
6.d Were all activities concluded by the end date? (including NCE date)		<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (if not, please explain in section 3)	
7. Funding	a. Total requirement for agency's sector response to current emergency:		US\$ 68,990,585
	b. Total funding received for agency's sector response to current emergency:		US\$ 17,686,866
	c. Amount received from CERF:		US\$ 5,996,866
	d. Total CERF funds forwarded to implementing partners		US\$ 112,547
	of which to:		
	Government Partners		US\$ 0
	International NGOs		US\$ 112,547
	National NGOs		US\$ 0
	Red Cross/Crescent		US\$ 0

## 2. Project Results Summary/Overall Performance

With this CERF RR grant, WFP reached 809,067 beneficiaries (396,443 men and 412,624 women) with cash transfers in five districts of Chiradzulu, Mangochi, Neno, Salima and Zomba during the Lean Season in 2019 with approximately, US\$ 4, 879,122. Monthly transfers of US\$ 12 per households were done for the last two months (February and March) of the response period to complement the Government's cereal distributions. The cash transfer top up provided the beneficiaries ability to access non-cereal components of the food basket to complement the cereals distributed by Government.

According to Outcome monitoring reports, dietary diversification of the beneficiary households increased by 12 percent from the baseline as beneficiary households consumed five or more food groups. Specifically, it was noted that beneficiary households that received a combination of food and cash had better dietary diversity as compared to beneficiaries that only received food. Furthermore, it was noted that the percentage of households that had a borderline/acceptable food consumption score went from 79% to 95% from baseline to end line. This showed an indication of food security in such households.

## 3. Changes and Amendments

CERF funding was approved on 31 January 2019 and in line with WFP policy of not aiding retroactively, resources meant for January transfers (the planned start date) had to be proposed for reprogramming to aid other districts with equally highly affected populations. In addition, Mulanje district initially earmarked for CERF funding was already being supported by other partners at the time WFP secured CERF funding. As a result, Chiradzulu (28% in IPC 3), Neno (31% in IPC 3) and Zomba (28% in IPC 3) districts were selected to receive food assistance through cash transfers to affected households for February and March 2019. The change increased the number of beneficiaries from 683,101 to 809,067 covering 5 targeted districts. A communication on these changes was made to CERF Team in February followed by a formal request for a no-cost extension in March 2019.

In March 2019 towards the end of lean season response, 15 districts in southern region of Malawi were hit by Cyclone Idai induced floods, which resulted in increase in number of people in need of food assistance. Some of the districts affected were already receiving the last

month of transfers for the lean season support from CERF funds. These districts were Neno, Chiradzulu, Zomba and Mangochi. Floods Assessments reports indicated loss of food, livelihoods, shelter and crops. Based on these reports the Food Security Cluster recommended further intervention in these districts to ensure the affected households are food secure.

#### 4.a NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (PLANNED)

Cluster/Sector	Food Security - Food Assistance				
Planned	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Host communities	160,833	167,397	173,887	180,984	683,101
Refugees	0	0	0	0	0
Returnees	0	0	0	0	0
Internally displaced persons	0	0	0	0	0
Other affected persons	0	0	0	0	0
Planned	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people planned")	N/A	N/A	N/A	N/A	N/A

#### 4.b NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (REACHED)

Cluster/Sector	Food Security - Food Assistance				
Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Host communities	194,176	202,267	202,267	210,357	809,067
Refugees	0	0	0	0	0
Returnees	0	0	0	0	0
Internally displaced persons	0	0	0	0	0
Other affected persons	0	0	0	0	0
Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	0
In case of significant discrepancy between figures under planned and reached people, either in the total numbers or the age, sex or category distribution, please describe reasons:	<p>The increase in number reached against planned was due to increase in targeted districts as result of WFP-internal reprogramming. The funding was approved on 31 January 2019 and in line with WFP policy of not aiding retroactively, resources meant for January transfers (the planned start date), had to be proposed for reprogramming to deliver assistance to other districts with equally high percentage of IPC affected population. As a result, Chiradzulu (28% in IPC 3), Neno (31% in IPC 3) and Zomba (28% in IPC 3) districts were selected to receive food assistance through cash transfers to affected households for February and March 2019. This reprogramming resulted in increase in total caseload to be reached with cash transfers from the initial 683,101 beneficiaries in three districts to 809,067 beneficiaries in five districts over period of two months of February and March, which are critical months where vulnerable households have increased food insecurity at household level.</p>				

## 5. CERF Result Framework figures

<b>Project Objective</b>	The overall objective of the project is to save lives, reduce the impact of the shocks on the well-being of affected population in the three districts that are IPC 3 and above, and ensure that vulnerable populations, including women, children, the elderly and people with disabilities have access to adequate resources and prevent households from sliding further into severe vulnerabilities and reverting to negative coping mechanisms.
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<b>Output 1</b>	Cash transfers are distributed in sufficient quantity and quality and in a timely manner to targeted beneficiary households			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 1.1	Percentage of targeted households with borderline to acceptable Food Consumption Score	90% (Same for Male and Female headed households)	95%	End line evaluation
Indicator 1.2	Percentage of female-headed households with reduced/stabilized Coping Strategy Index	100%	48%	End line Evaluation
Indicator 1.3	Percentage of households with less than 50% household expenditure allocated to food	>80%	52%	End line Evaluation
Indicator 1.4	Percentage of households consuming 4 or more food groups (Household dietary diversity)	4 or more (100%)	88%	End line Evaluation
Indicator 1.5	Number of people receiving cash assistance disaggregated by age and sex and as a percentage of plan	100% (693,101)	118% (809,067)	Invoices from Financial Service Providers
Indicator 1.6	Total amount of cash transferred to beneficiary households as a percentage of planned	100% (\$4,878,243)	(100%) \$4,879,122	CERF grant consumption report
Indicator 1.7	Number of joint monitoring visits conducted	3	3	Outcome monitoring
Indicator 1.8	Number of people trained as a percentage of planned	100% (12)	100% (12)	End line Evaluation
<b>Explanation of output and indicators variance:</b>		<p>Due to high levels of sharing food entitlements amongst beneficiaries, most households did not have enough food for the intended period. Due to high levels of poverty and vulnerability, resources are usually not adequate for everyone. Therefore, vulnerable targeted households that are receiving assistance feel have a social obligation and they willingly share their entitlements to non-beneficiaries that are equally food-insecure.</p> <p>As such, some beneficiary households still reverted to negative coping strategies despite receiving food assistance. Similarly, the percentage of households allocating less than 50% to food expenditure was not as planned due to the high rate of sharing among beneficiaries. Hence, the low rate of achievement in indicator 1.2 and 1.3.</p>		
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		
Activity 1.1	Baseline survey	WFP and Department of Disaster Management Affairs (DoDMA) in the Ministry of Homeland Security.		
Activity 1.2	Endline survey	WFP and DoDMA		
Activity 1.3	Cash distributions	WFP, DoDMA, Cooperazione Internazionale, Emmanuel International, Plan International, Save the Children, World		

		Vision International (NGO Partners) and Financial Service Providers
Activity 1.4	Market Assessment	WFP, DoDMA, NGO partners
Activity 1.5	Complaints and Feedback Mechanism put in place	WFP, NGOs and DoDMA
Activity 1.6	Field monitoring visits	WFP and DoDMA
Activity 1.7	Training enumerators and M&E focal points in monitoring and evaluation	WFP and DoDMA

## 6. Accountability to Affected People

### 6.a IASC AAP Commitment 2 – Participation and Partnership

**How were crisis-affected people (including vulnerable and marginalized groups) involved in the design, implementation and monitoring of the project?**

The Joint Emergency Food Assistance Programme (JEFAP) targeting guidelines were used in the targeting of beneficiaries. The JEFAP targeting emphasizes on increasing community participation in beneficiary selection and verification of eligibility of beneficiaries. Thus, using JEFAP guidelines, community-based beneficiary targeting, and verification was conducted to increase participation of the crisis affected people. The targeting criteria also gives priority to the most vulnerable groups including food insecure elderly, disabled and chronically ill.

The process was guided by WFP contracted NGO partners in collaboration with Government through District Councils. At community level the process made use of local civil protection committees, community leaders and community members who were sensitised on the guidelines and targeting criteria which they used to select households that were registered for assistance. As much as possible, membership of civil protection committees are area and village levels included representation from marginalised groups to ensure their participation and that their concerns are also heard during the design, implementation and monitoring of the response

Village civil protection committees and community members were highly engaged during cash distributions for onsite support to beneficiaries and ensuring that all issues or concerns from the beneficiaries are dealt with at the cash distribution centre. Furthermore, community feedback mechanisms were put in place during the response to ensure the views of the affected population are captured and taken into consideration.

**Were existing local and/or national mechanisms used to engage all parts of a community in the response? If the national/local mechanisms did not adequately capture the needs, voices and leadership of women, girls and marginalised groups, what alternative mechanisms have you used to reach these?**

The response was fully coordinated by the Nutrition Cluster at national level with membership of all stakeholders in nutrition. At national level, WFP collaborated with other partners in the development of 4Ws for nutrition cluster response where the earmarked CERF activities were included. At the local level, District Executive Committees (DEC) worked very closely with NGO partners through the District Nutrition Coordination Committees for updates on implementation of nutrition programmes within the districts and identify key issues to assist the district managers in their support to the implementing facilities. At local level, the project utilised care-groups and the village nutrition coordination committees for discussions with all community members (including women, girls and other marginalized groups) on Nutrition programming within the community.

### 6.b IASC AAP Commitment 3 – Information, Feedback and Action

**How were affected people provided with relevant information about the organisation, the principles it adheres to, how it expects its staff to behave, and what programme it intends to deliver?**

As the programme is embedded in the Ministry of Health's systems, clients received messaging on the intervention upon admission into the Malnutrition intervention in Health facilities within their communities

**Did you implement a complaint mechanism (e.g. complaint box, hotline, other)? Briefly describe some of the key measures you have taken to address the complaints.**

Yes ☒ No ☐



WFP has a Complaint and Feedback Mechanism (CFM) that utilizes a hotline managed by Youth Net and Counselling (YONECO), a third-party to guarantee independence and accountability). In addition, suggestion boxes, helpdesks and face to face meetings managed by Cooperating Partners were also included as channels for handling complaints with these three generally ranked as the most commonly used channels during distributions. Cases are escalated to and resolved in collaboration with partners, district councils and WFP. All cooperating partners in the Districts are required to orient all their project staff on CFMs, Accountability to Affected Populations (AAP), gender and protection, including sexual exploitation and abuse and also appoint a designated focal person for gender and protection who leads on CFMs for WFP supported programmes and finally provide a platform for receiving complaints from the affected communities at the distribution point e.g. helpdesk, suggestion box, pre-distribution talks etc. Data from all partners on WFP related concerns are collated in the WFP data base in the SUGAR CRM.

Furthermore, at district level, an ombudsperson is placed to handle all gender and protection issues at the district council. Additionally, protection committees have been set up at community and area levels to ensure that community members have a platform for complaints management.

**Did you establish a mechanism specifically for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints? Briefly describe some of the key measures you have taken to address the SEA-related complaints.** Yes ☐ No ☒

Internally, WFP has a Protection on Sexual Exploitation and Abuse (PSEA) focal point both at country office and field office levels who provide sensitization and guidance on handling PSEA. All Cooperating partners were also sensitized on PSEA and were all obligated to appoint a PSEA focal point who was trained to handle all issues of protection and sexual exploitation and abuse.

**Any other comments (optional):**

WFP is in the process of revising the Standard Operating Procedures for its partner in handling complaints and feedback mechanisms Youth Net and Counselling (YONECO) on case follow-up and harmonizing of the CFMs of all UN agencies for easy referrals, following up of cases and better coverage

## 7. Cash Transfer Programming

### 7.a Did the project include one or more Cash Transfer Programmings (CTP)?

Planned	Achieved
No	No

**7.b Please specify below the parameters of the CTP modality/ies used.** If more than one modality was used in the project, please complete separate rows for each modality. Please indicate the estimated **value of cash** that was transferred to people assisted through each modality (best estimate of the value of cash and/or vouchers, not including associated delivery costs).

CTP Modality	Value of cash (US\$)	a. Objective	b. Cluster/Sector	c. Conditionality	d. Restriction
Mobile money	US\$ 1,332,342	Sector-specific	Food Security - Food Assistance	Unconditional	Unrestricted
Cash in Transit	US\$3,546,780	Sector-specific	Food Security- Food Assistance	Unconditional	Unrestricted

**Supplementary information (optional):**

WFP contracted financial services providers who worked with NGO partners for implementation of cash-based transfers in targeted districts. The response used the electronic/ mobile money platform with Malawian smartphone network provider Airtel and cash in envelopes with Group4 Secure Solutions (G4S) to manage transfers to beneficiaries. Mobile money was used to promote use of e-money among beneficiaries which gave them the flexibility to withdraw at varied times as needed. Mobile money was therefore used in locations where there was good coverage of mobile network. On the other hand, cash in envelopes was used in locations with mobile network challenges so that beneficiaries had timely access to food assistance. NGO partners played the role of coordinating with financial services providers through development and verification of pay-out lists that were used by the service providers.

8. Evaluation: Has this project been evaluated or is an evaluation pending?	
<p>The project intervention improved household food security of targeted households as compared to non-beneficiaries. This is evident from key outcome indicators that show improved results at end line as compared to baseline. For example, use of consumption-based coping mechanisms reduced significantly by 11.4 percent (from 23.9 at baseline to 12.5 at end-line). Similarly, the percentage of households not using livelihood-based coping mechanism i.e. selling of assets etc remained at 31 percent with more cash beneficiaries (49 percent) than in-kind beneficiaries (45 percent); On dietary diversity, the percentage of households consuming more than 4 food groups increased by 12 percent from baseline (78 percent to 90 percent) with more cash beneficiaries than in-kind beneficiaries.</p> <p>In addition to the outcome evaluation that WFP conducted, the Government in collaboration with UN Resident Coordinator's Office commissioned a response review which is currently ongoing with purpose to learn from the way the response was implemented as it was fully led by the government for the first time. The review will document lessons and best practices but also actionable recommendations for future responses.</p>	EVALUATION CARRIED OUT <input checked="" type="checkbox"/>
	EVALUATION PENDING <input type="checkbox"/>
	NO EVALUATION PLANNED <input type="checkbox"/>

## 8.6. Project Report 19-RR-WHO-005 - WHO

1. Project Information			
1. Agency:	WHO	2. Country:	Malawi
3. Cluster/Sector:	Health - Health	4. Project Code (CERF):	19-RR-WHO-005
5. Project Title:	Health Emergency Response to Peak Lean Season 2019		
6.a Original Start Date:	05/02/2019	6.b Original End Date:	04/08/2019
6.c No-cost Extension:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	If yes, specify revised end date:	N/A
6.d Were all activities concluded by the end date? (including NCE date)		<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (if not, please explain in section 3)	
7. Funding	a. Total requirement for agency's sector response to current emergency:		US\$ 750,000
	b. Total funding received for agency's sector response to current emergency:		US\$ 750,000
	c. Amount received from CERF:		US\$ 506,523
	d. Total CERF funds forwarded to implementing partners		US\$ 460,246
	of which to:		
	Government Partners		US\$ 460,246
	International NGOs	US\$ 0	
	National NGOs	US\$ 0	
	Red Cross/Crescent	US\$ 0	

## 2. Project Results Summary/Overall Performance

Through this CERF RR grant, WHO procured lifesaving medicines and medical supplies for six districts (Balaka, Blantyre, Chikwawa, Machinga, Mangochi and Phalombe) ensuring access to health services; trained 600 health care workers (100 per district) on early disease outbreak detection, investigation and response and supported in conducting 480 mobile outreach clinic sessions providing equitable access to health services. The project was implemented over a three- month period from March to May 2019.

WHO reached out to 86,231 people with different primary health care services through integrated outreach clinics. Of the people reached; 26,177 were children under the age of five years who received immunization and growth monitoring services, 243 were pregnant women who received antenatal services, 2,486 were people who were on treatment for chronic conditions such HIV and AIDS, epilepsy, hypertension and diabetes who lost their treatment cards and medicines during floods and were put back on treatment, 25,092 were ill and received different outpatient services. Over 29,000 people received family planning services the most common of which was male condoms. No disease outbreak occurred thanks to, among others, early detection and treatment of the cases.

## 3. Changes and Amendments

The project was implemented from March to May 2019 instead of January to April (the lean peak season) as earlier planned, because of delays in the disbursements of the funds and the occurrence of the flood disaster in March 2019.

4.a. NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (PLANNED)					
Cluster/Sector	Health - Health				
Planned	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Host communities	9,376	10,158	43,410	45,581	108,525
Refugees	0	0	0	0	0
Returnees	0	0	0	0	0
Internally displaced persons	0	0	0	0	0
Other affected persons	0	0	0	0	0
Planned	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people planned")	N/A	N/A	N/A	N/A	N/A

4.b. NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (REACHED)					
Cluster/Sector	Health - Health				
Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Host communities	7,450	8,071	34,493	36,217	86,231
Refugees	0	0	0	0	0
Returnees	0	0	0	0	0
Internally displaced persons	0	0	0	0	0
Other affected persons	0	0	0	0	0
Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	0
In case of significant discrepancy between figures under planned and reached people, either in the total numbers or the age, sex or category distribution, please describe reasons:	There was no significant discrepancy between number of people planned and reached. The number of people planned was 108,525. Number of people reached was 86,231 representing 79.46% coverage. In health, this is a high coverage because not everyone can become sick to receive treatment, not all children have to receive the vaccines because some have already received all the vaccines and the vaccines are given at a specified interval and not everyone required family planning.				

5. CERF Result Framework	
Project Objective	To contribute to reduction of morbidity and mortality due to the impact food insecurity among affected people and children with acute severe malnutrition in six targeted districts during the peak lean season (January- April 2019).

Output 1	108,252 people have equitable, timely access and available emergency primary health care services during the peak lean season (January- April 2019) in six targeted districts.			
Indicators	Description	Target	Achieved	Source of Verification
Indicator 1.1	Proportion of health facilities and clinics with no stock outs of emergency primary	100% (234 health facilities in six districts)	100%	Pharmacy stock cards in the target districts

	health care drugs and supplies during the peak lean season			
Indicator 1.2	Proportion of comprehensive outreach clinics during the peak lean season are maintained (no cancellation of clinics)	100% (2,106 outreach clinic sessions in 702 outreach clinic sites in 3 months)	100% (480 outreach clinic sessions)	Outreach clinic schedule and reports
Indicator 1.3	Proportion of outreach clinics producing and sharing weekly comprehensive outreach clinic report	100% (234 health facilities in six districts)	100% (234 health facilities in six districts)	District weekly outreach clinic reports
<b>Explanation of output and indicators variance:</b>		N/A		
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		
Activity 1.1	Procure drugs and supplies (kit) for emergency primary care services in the targeted districts.	WHO		
Activity 1.2	Transport the drugs and supplies to the targeted districts, facilities and NRUs.	Ministry of Health		
Activity 1.3	Conduct/maintain comprehensive outreach clinics during the peak lean season to ensure equitable and timely access to health services by the affected communities.	Ministry of Health		

<b>Output 2</b>	Capacity for 100 health workers in each of the six targeted districts (total 600 health workers) on disease surveillance, outbreak detection and response strengthened.			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 2.1	Number of health workers trained on early detection, investigation, reporting and response of disease outbreaks	600	600	Activity reports submitted by districts
Indicator 2.2	Proportion of disease outbreak rumours investigated and reported within 48 hours	95%	100%	District weekly IDSR reports
<b>Explanation of output and indicators variance:</b>		For indicator 2.2, we achieved more than we estimated because the rapid response teams were trained during the disease surveillance trainings and resources (fuel and allowance were readily available from CERF funds.		
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		
Activity 2.1	Train health workers on disease surveillance to enhance early detection, investigation, reporting and response of disease outbreaks during the peak lean season in the targeted districts.	Ministry of Health		
Activity 2.2	Produce weekly disease surveillance reports	Ministry of Health		

<b>Output 3</b>	Critical health information including access to and availability of life saving health services developed, used and monitored			
<b>Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Achieved</b>	<b>Source of Verification</b>
Indicator 3.1	Number of critical information packages developed by target population	2	2	District weekly reports
Indicator 3.2	Proportion of health facilities supervised monthly	100% (234 health facilities in 6 districts)	100%	District supervision reports
<b>Explanation of output and indicators variance:</b>				
<b>Activities</b>	<b>Description</b>	<b>Implemented by</b>		

Activity 3.1	Develop/prepare IEC messages and materials for critical health information to facilitate awareness creation	Ministry of Health
Activity 3.2	Conduct supportive supervision to monitor availability and use of life saving health services	Ministry of Health

## 6. Accountability to Affected People

### 6.a IASC AAP Commitment 2 – Participation and Partnership

**How were crisis-affected people (including vulnerable and marginalized groups) involved in the design, implementation and monitoring of the project?**

A series of consultations were done with District Health Management Teams (DHMTs) of the six target districts to get their inputs and comments on the design, planning and implementation of the project. At the planning stage, four members of DHMT namely District Health Officer (DHO), District Environmental Officer (DEHO), District Pharmacy Technician and District Integrated Disease Surveillance and Response (IDSR) Coordinator from each of the six target districts were called for a meeting in Liwonde where they informed of the project, discussed and agreed on the composition and size of the mobile clinic teams, the reporting tools and the standard list of medicines and supplies for mobile outreach clinic and NRUs. Quantification of the medicines and supplies was by districts depending on the number of clinics and target populations. Partners including UNICEF and UNFPA were involved in the coordination meetings. In fact, some of the coordination were funded by UNICEF and were set up in Blantyre.

On behalf of the affected people with whom they interacted through their existing structures, DHMTs made input on number of type of and quantity of medicines and supplies to be procured and used, size and composition of the integrated outreach clinic teams and the implementation arrangement.

DHMTs were involved in monitoring and evaluation of the project through supportive supervision, collection of reports from the sites, data analysis and reporting to WHO and partners. WHO conducted fortnightly monitoring supervision to districts and health facilities including Nutrition Rehabilitation Units (NRUs) to assess how the services were being provided and interacted with beneficiaries to get their perceptions on the health services they were receiving. Health Surveillance Assistants (HSAs) monitored disease occurrences, distributed household water treatment products such chlorine and provided awareness messages on availability of services, preventive and control measures for disease outbreaks and other health conditions.

**Were existing local and/or national mechanisms used to engage all parts of a community in the response? If the national/local mechanisms did not adequately capture the needs, voices and leadership of women, girls and marginalised groups, what alternative mechanisms have you used to reach these?**

Health Surveillance Assistants (HSAs) who are based in the communities were engaging and informing the communities about the project. Through community mobilization and engagement, HSAs were distributing household water treatment products such chlorine and raising community awareness on availability of health services from the Project.

### 6.b IASC AAP Commitment 3 – Information, Feedback and Action

**How were affected people provided with relevant information about the organisation, the principles it adheres to, how it expects its staff to behave, and what programme it intends to deliver?**

The mobile outreach clinic teams and Health Surveillance Assistants provided the information to the affected people including the support received from WHO CERF Project and the Humanitarian principles and how WHO expected the Ministry of Health staff and community leaders to behave and deliver the support.

**Did you implement a complaint mechanism (e.g. complaint box, hotline, other)? Briefly describe some of the key measures you have taken to address the complaints.**

Yes ☐ No ☒

The Protection Cluster had structures (community protection committees) which was receiving all complaints be it on health services or others. Once received, the protection cluster informed the relevant organizations/providers involved to address the complaint. No complaint on delivery of health services was raised/received from the community protection committees. WHO CERF Project did not set up its own on a complaint mechanism but used the existing one e.g. community protection committees.

**Did you establish a mechanism specifically for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints? Briefly describe some of the key measures you have taken to address the SEA-related complaints.** Yes ☐ No ☒

As above. Protection structures e.g. community protection committees were sensitizing and empowering people to report and any abuse and addressed them by involving the perpetrators/organizations involved. No complaint was raised/received from community protection committees about any abuse including SEA by a health worker committed during the delivery of WHO CERF Project.

**Any other comments (optional):**

N/A

## 7. Cash Transfer Programming

**Did the project include one or more Cash Transfer Programmings (CTP)?**

Planned	Achieved
No	No

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

No evaluation was planned because it was not mandatory.	EVALUATION CARRIED OUT <input type="checkbox"/>
	EVALUATION PENDING <input type="checkbox"/>
	NO EVALUATION PLANNED <input checked="" type="checkbox"/>

## ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US\$
19-RR-CEF-007	Water, Sanitation and Hygiene	UNICEF	INGO	371,664
19-RR-CEF-006	Nutrition	UNICEF	GOV	11,924
19-RR-CEF-006	Nutrition	UNICEF	GOV	43,027
19-RR-CEF-006	Nutrition	UNICEF	GOV	34,583
19-RR-CEF-006	Nutrition	UNICEF	GOV	50,147
19-RR-CEF-006	Nutrition	UNICEF	NNGO	77,539
19-RR-CEF-006	Nutrition	UNICEF	GOV	18,536
19-RR-CEF-006	Nutrition	UNICEF	GOV	33,297
19-RR-CEF-006	Nutrition	UNICEF	GOV	44,673
19-RR-CEF-006	Nutrition	UNICEF	GOV	42,099
19-RR-WFP-006	Food Assistance	WFP	INGO	24,104
19-RR-WFP-006	Food Assistance	WFP	INGO	53,901
19-RR-WFP-006	Food Assistance	WFP	INGO	25,988
19-RR-WFP-006	Food Assistance	WFP	INGO	8,554
19-RR-WHO-005	Health	WHO	GOV	460,246



## ANNEX 2: Success Stories

### WFP (Food Security) – 19-RR-WFP-006

It's a hot afternoon like any other in the lake district of Mangochi in Malawi. There is a flurry of activity at a school in the village, its distribution day. Groups of people are in lines leading to desks where money is being distributed.

About USD 12 is given to each beneficiary. This money is to be used to buy additional food to complement the maize that has been distributed by the Government. Akunda Abile is one such beneficiary, she is an old woman of 65 years. She has three grandchildren at home waiting expectantly for her to come with food.



*"I used last month's transfer to buy food and to take my grandson to the hospital when he fell ill. This time, I want to try and buy a goat so at least I have livestock that can bring me some income" she says full of hope.*



In 2018, when 3.3 million people were projected to be food-insecure between November 2018 to March 2019 (otherwise known as the Lean Season), the United Nations Central Emergency Response Fund (UNCERF) gave the World Food Programme (WFP) USD 6 million to provide food assistance to affected people. Since the Government of Malawi led the response with maize distributions, WFP provided cash-based transfers to affected people to buy additional food like beans and oil to complement the maize. With CERF support, WFP reached over 800,000 people in five districts with cash transfers for food.

#### Links to social media visibility:

- [https://twitter.com/WFP\\_Malawi/status/1092402431282036736?s=20](https://twitter.com/WFP_Malawi/status/1092402431282036736?s=20)
- <https://twitter.com/UNReliefChief/status/1101851625151479810?s=20>
- <https://twitter.com/mtorresmacho/status/1102538085219356672?s=20>
- [https://twitter.com/WFP\\_Malawi/status/1126728615951921157?s=20](https://twitter.com/WFP_Malawi/status/1126728615951921157?s=20)
- [https://twitter.com/WFP\\_Malawi/status/1126426660528631808?s=20](https://twitter.com/WFP_Malawi/status/1126426660528631808?s=20)
- [https://www.facebook.com/873196236039040/posts/2935265046498805/?substory\\_index=0](https://www.facebook.com/873196236039040/posts/2935265046498805/?substory_index=0)

### ANNEX 3: ACRONYMS AND ABBREVIATIONS (Alphabetical)

<b>AAP</b>	Accountability to Affected Populations
<b>AAR</b>	After Action Review
<b>ANCC</b>	Area Nutrition Coordination Committee
<b>CBCM</b>	Community-based Complaints Mechanism
<b>CFM</b>	Complaint and Feedback Mechanism
<b>CHD</b>	Child Health Days
<b>CMAM</b>	Community-based Management of Acute Malnutrition
<b>CSB</b>	Corn-soy blend
<b>CTP</b>	Cash Transfer Programming
<b>DEC</b>	District Executive Committees
<b>DEHO</b>	District Environmental Health Officer
<b>DHIS</b>	District Health Information System
<b>DHMT</b>	District Health Management Team
<b>DHO</b>	District Health Officer
<b>DNCC</b>	District Coordination Committee
<b>DNHA</b>	Department of Nutrition, HIV and AIDS
<b>DoDMA</b>	Department of Disaster Management Affairs
<b>FAW</b>	Fall Armyworm
<b>FDG</b>	Focusgroup discussion
<b>FEEC</b>	Female Empowerment and Education Centre
<b>G4S</b>	Group4 Secure Solutions
<b>GBV</b>	Gender-based Violence
<b>HIV</b>	human immunodeficiency virus
<b>HSA</b>	Health Surveillance Assistant
<b>HCT</b>	Humanitarian Country Team
<b>iCCM</b>	Integrated Community Case Management
<b>IDP</b>	Internally Displaced People
<b>IDSR</b>	Integrated Disease Surveillance and Response
<b>IEC</b>	Information, Education and Communication
<b>IP</b>	Implementing partner
<b>IPC</b>	Integrated Food Security Phase Classification
<b>JEFAP</b>	Joint Emergency Food Assistance Programme
<b>MAM</b>	Moderate Acute Malnutrition
<b>MDHS</b>	Malawi Demographic and Health Surve
<b>MHM</b>	Menstrual Hygiene Management
<b>MISP</b>	Minimum Initial Services Package
<b>MIYCN</b>	Maternal Infant and Young Child Nutrition
<b>MoH</b>	Ministry of Health
<b>MT</b>	Mega tonne
<b>MVAC</b>	Malawi Vulnerability Assessment Committee
<b>NCST</b>	Nutrition Care Support and Treatment
<b>NFI</b>	Non-Food Item
<b>NRU</b>	Nutrition Rehabilitation Unit
<b>OTP</b>	Post-exposure prophylaxis
<b>PACHI</b>	Parent and Child Health Initiative Trust
<b>PDNA</b>	Post-Disaster Needs Assessment

<b>PEP</b>	Post-exposure prophylaxis
<b>PLHIV</b>	People Living with HIV
<b>PLW</b>	Pregnant and Lactating Women
<b>PSEA</b>	Protection from Sexual Exploitation and Abuse
<b>RC/HC</b>	Resident Coordinator/Humanitarian Coordinator
<b>RH</b>	Reproductive Health
<b>ROSEA</b>	Regional Office for Southern and Eastern Africa
<b>RR</b>	Rapid Response
<b>RTE</b>	Real-Time Evaluation
<b>RUTF</b>	Ready-to-USE Therapeutic Food
<b>SAM</b>	Severe Acute Malnutrition
<b>SEA</b>	Sexual Exploitation and Abuse
<b>SFP</b>	School feeding programme
<b>SRF</b>	Strategic Result Framework
<b>SRH</b>	Sexual and Reproductive Health
<b>STI</b>	Sexually transmitted infection
<b>ToT</b>	Training of Trainers
<b>WASH</b>	Water, Sanitation and Hygiene
<b>YONECO</b>	Youth Net and Counselling