United Nations CERF Central Emergency Response Fund

GLOBAL
RAPID RESPONSE
COVID-19
2020

20-RR-GLB-41473
20-RR-GLB-42285

PART I – OVERVIEW

Reporting Process and Consultation Summary:	
Please indicate when the After-Action Review (AAR) was conducted and who participated.	N/A

The global pandemic, which created unprecedented challenges for the humanitarian system, called for a flexible and innovative approach.

CERF was instrumental in facilitating the humanitarian community's response to COVID-19, by adopting an innovative approach: multi-country block grants totaling $120m. This innovative approach to allocating resources was introduced to increase speed and flexibility in light of the challenges posed by the global pandemic. Rather than disbursing funds directly to country teams, CERF provided resources to UN agencies, allowing them to prioritize distribution to contexts with the greatest needs.

CERF has relied on a modified final report template, given the unique nature of the allocations. Firstly these report covers two allocations for COVID-19 (20-RR-GLB-41473 and 20-RR-GLB-42285). Secondly, the project chapters were compiled at headquarters-level by each of the 9 UN agencies. Thirdly each project chapter comprises information on multiple countries.

1. STRATEGIC PRIORITIZATION

Statement

Please see the individual project chapters for statements from each of the 9 recipient UN agencies.

CERF's Added Value:

Of the nine UN agency recipients of CERF COVID-19 funds, FAO, UNICEF, and WHO said that CERF provided their first COVID-19 allocation, enabling agencies to fast track the delivery of assistance to people in need.

Regarding **health and learning**, CERF funds enabled UNICEF to kickstart of the agency's COVID-19 relief response, ensuring continuity of established health services and the procurement and provision of health-related commodities such as PPE and IPC supplies, as well as COVID-19 test kits. CERF supported UNICEF's provision of oxygen cylinders and concentrators, emergency health kits, equipment, medicines, and consumables, as well as the establishment of over 10,000 handwashing spaces. CERF allocations also enabled UNICEF to ensure the continuity of learning for over 9 million children, both in-person and remotely, and the creation of cash transfer programs to mitigate economic hardships caused and exacerbated by the pandemic. WHO utilized CERF funding to quickly provide time-critical assistance to target populations, enabling the agency to bridge severe gaps in testing capacity, stop COVID-19 transmission and provide care for those who were critically ill. CERF allocations additionally allowed for improved coordination, fostering greater collaboration between WHO and UNICEF at the global, regional, and country levels, strengthening the health cluster mechanisms to leverage available resources to overall humanitarian response, and enabling a more coherent and synchronized response from the two agencies. UNDP used CERF-allocated funds to procure health material in order to ensure the expedited delivery of assistance, providing masks and ventilators to target states. UNDP's support of frontline workers and its provision of much needed health material, aided through CERF allocations, allowed for the continued operation of healthcare efforts even throughout the worst of the pandemic, as well as the increased ability of states to respond and coordinate pandemic responses. At the inception of the pandemic, the shift of UNFPA resources towards addressing the COVID-19 pandemic resulted in the neglect of GBV and SRH services. The swift allocation of CERF funding allowed for support and protection to be ensured to frontline workers delivering maternal care and essential services to survivors of GBV on the ground, in turn assisting the overall COVID-19 response through the support of healthcare structures. CERF's allocations also worked to mobilize funding from other donors and to facilitate coordination between UNFPA and other agencies.

CERF allocations contributed to **WASH** efforts; the expedient nature of CERF funding allowed for UN-Habitat to ensure efficient and timely delivery of humanitarian assistance and relief, allowing the agency to respond effectively to the evolving COVID-19 pandemic through the implementation of an urban lens and expertise. CERF funds directly contributed to UN-Habitat's strategic goals to offset economic hardship and enhance hygiene conditions, focusing on intersectional issues including gender, human rights, and the prioritization of the most vulnerable populations.

The pandemic severely disrupted global supply chains and transport markets, hindering the delivery of essential humanitarian assistance. CERF supported WFP's **common services**, enabling UN agencies, international and national NGOs, and civil society organizations to provide humanitarian assistance to vulnerable populations and to support frontline staff. Thanks to the contributions from CERF and other donors, WFP's common services delivered assistance and/or passengers to 162 countries – 82 percent of the world – and at one point was the largest airline operating globally at the time. WFP provided crucial cargo delivery services to 48 organizations, and transported 29,000 passengers between May 2020 and March 2021. Destinations were defined in line with partial or full suspension of commercial services in countries or regions, with regional passenger services established as needed, as well as a long-haul connection between Rome and Accra (Ghana) to link the continents at a time when no other options were available.

CERF-provided funds enabled the preservation of **food security**; CERF allocations enabled FAO to provide much appreciated life-saving agriculture and food security assistance, allowing country teams to implement time-critical

livelihood safeguarding actions in Afghanistan, disperse protection kits, unconditional cash transfer, and agricultural and livestock inputs in Burkina Faso, and build the capacity of rural communities to prevent the spread of COVID-19 while continuing emergency agricultural assistance in Haiti.

CERF contributions allowed for increased **refugee assistance.** Due to the timely dispersal of CERF funds, IOM was able to promptly launch interventions to ensure the reduction of COVID-19 exposure in camps as well as the increased awareness of public health awareness, resulting in increased preparedness in target countries to prevent, detect, and respond to COVID-19 cases. CERF contributions to UNHCR empowered the agency to respond quickly and effectively to the most critical needs of refugees in response to the COVID-19 pandemic, ensuring that displaced populations had access to health assistance and essential services and mitigating the spread of the virus. CERF funds also allowed UNHCR to play a significant role in the UN interagency response to returns as well as to co-chair a COVID-19 Emergency Taskforce in Jordan, both efforts that fostered effective assistance for refugees.

Considerations of the ERC's Underfunded Priority Areas[1]:

Regarding support for women and girls, the FAO established projects prioritizing assistance to female-headed households. FAO promoted protection messages related to PSEA, GBV and complaints-grievance mechanisms; provided assistance in the form of cash, agricultural kits and livestock protection packages; provided COVID-19 sensitization information; and promoted activities to allow women to become increasingly financially autonomous. IOM aimed to integrate gender and inclusion in its interventions, ensuring that sensitization of GBV was incorporated throughout its response. Support for women and girls was the priority area for the UNFPA projects. Given the exacerbation of GBV and SRH risks throughout the pandemic, UNFPA prioritized funding to strengthen the empowerment of women and girls, as well as community resiliency and accountability to prevent GBV. UN-Habitat's distribution of hygiene kits adopted strict transparent criteria in order to prioritize female-headed households, persons with disabilities and the elderly, adding awareness raising components that contributed to tackling GBV through the prevention of sexual abuse and exploitation. UNICEF took gender into consideration during the design, implementation, and monitoring phases of all projects, specifically targeting and supporting women at the community level where they are the most vulnerable. WHO supported women and girls by ensuring that half of community health workers and social mobilizers were women, gathering women and girls separately from men to enable their active participation, and giving financial incentives to reduce the economic vulnerability of women and girls. The key challenges to these efforts is the attitude towards the evolution of women's status in target countries, as well as access to land and financial resources for women.

Concerning programs targeting disabled people, the FAO gave priority to households headed by persons with disabilities and vulnerable households with a dependent disabled person and/or elderly. UNICEF interventions also took into consideration the needs of people with disabilities, working to establish equity in the reach, impact, and targets of programs, and ensuring that children requiring assistance due to their disabilities were supported. In its work, WHO emphasized the importance of ensuring access to persons with disabilities to hospitalization and home visits to those whose access to healthcare facilities was challenged.

Regarding other aspects of protection, IOM ensured that its response prioritized the safety and dignity of all persons, including those with disabilities, special needs, and the elderly by involving these populations in community consultation meetings. Assistance provided by UNHCR contributed primarily towards section 4, mitigating adverse coping strategies such as transactional sex, early marriage, GBV, and human trafficking that arose from lockdowns and economic decline through enabling vulnerable populations to meet their basic needs for health, food, and shelter. UNICEF took into

[1] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

consideration protection of all beneficiaries in all its CERF-supported interventions, for example, ensuring that mobile health and nutrition services were made safer by their provision during daylight hours.

Table 1: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
FAO	20-RR-FAO-019	Food Security - Agriculture	3,000,000
IOM	20-RR-IOM-011	Health - Health	1,485,001
IOM	20-RR-IOM-011	Camp Coordination and Camp Management - Camp Coordination and Camp Management	891,000
IOM	20-RR-IOM-011	Protection - Protection	324,000
UN Habitat	20-RR-HAB-001	Water, Sanitation and Hygiene - Water, Sanitation and Hygiene	49,996
UNDP	20-RR-UDP-003	Health - Health	3,200,000
UNFPA	20-RR-FPA-022	Health - Health	2,240,000
UNFPA	20-RR-FPA-022	Protection - Gender-Based Violence	960,000
UNHCR	20-RR-HCR-017	Multi-sector refugee assistance - Multi-Sector Refugee Assistance	4,623,019
UNHCR	20-RR-HCR-017	Water, Sanitation and Hygiene - Water, Sanitation and Hygiene	1,656,006
UNHCR	20-RR-HCR-017	Shelter and Non-Food Items - Shelter and Non-Food Items	345,001
UNHCR	20-RR-HCR-017	Health - Health	276,001
UNICEF	20-RR-CEF-025	Health - Health	2,700,000
UNICEF	20-RR-CEF-025	Education - Education	1,250,000
UNICEF	20-RR-CEF-025	Protection - Child Protection	1,050,000
UNICEF	20-RR-CEF-030	Health - Health	4,380,000
UNICEF	20-RR-CEF-030	Water, Sanitation and Hygiene - Water, Sanitation and Hygiene	3,285,000
UNICEF	20-RR-CEF-030	Protection - Child Protection	1,642,500
UNICEF	20-RR-CEF-030	Education - Education	1,642,500
WFP	20-RR-WFP-023	Common Services - Logistics	20,000,000
WFP	20-RR-WFP-025	Common Services - Logistics	20,000,000
WHO	20-RR-WHO-017	Health - Health	10,000,000
WHO	20-RR-WHO-022	Health - Health	10,000,000
Total			**95,000,024**

Table 2: Breakdown of CERF Funds by Type of Implementation Modality (US$)

Total funds implemented directly by UN agencies including procurement of relief goods	**84,555,600**
Funds sub-granted to government partners*	3,867,610

Funds sub-granted to international NGO partners*	3,826,409
Funds sub-granted to national NGO partners*	2,445,736
Funds sub-granted to Red Cross/Red Crescent partners*	304,670
Total funds transferred to implementing partners (IP)*	**10,444,424**
Total	**95,000,024**

* Figures reported in table 3 are based on the project reports (part II, sections 1) and should be consistent with the sub-grants overview in the annex.

Of the $95m allocated by CERF, roughly 11% ($10.4m) was sub-granted to implementing partners, including government, NGOs, and Red Cross/Crescent partners.

It is worth bearing in mind that of the $95m allocated by CERF, $40m was specifically for common services, which typically do not include sub-grants to partners. Of the remaining $55m then, roughly 19% ($10.4m) was sub-granted. Four of the UN agencies sub-granted funds:

- UNICEF: $7.6m
- WHO: $1.5m
- UNFPA: $0.9m
- FAO: $0.4m

2. OPERATIONAL PRIORITIZATION:

Overview of the Humanitarian Situation:

The COVID-19 pandemic was an unprecedented public health emergency affecting all countries worldwide. While the scope of the epidemic differed between countries at the time the allocations were made (March-April 2021), the disease was rapidly propagating, affecting an increasing number of people. At the time of the allocation, few cases had been reported in countries with humanitarian response plans, this situation had the potential to change very quickly. In a span of just 11 weeks from January to mid-March 2020, the virus had progressed from a discrete outbreak in Wuhan, China, to clusters of cases in many countries, and then to a pandemic with most countries reporting cases, and many experiencing significant outbreaks. For further details on the impact of COVID-19 on humanitarian crises, please refer to the *Global Humanitarian Response Plan: COVID-19* including the monthly updates.

Operational Use of the CERF Allocation and Results:

The ERC announced the first of CERF global block grant on 1 March, ahead of the declaration of a global pandemic, when he released $15 million to help fund global efforts by WHO and UNICEF to contain the virus. Later in March, CERF allocated $80 million in multi-country block grants to jump-start UN agency responses, focusing on health care, water and sanitation, and logistics.

The project chapters provide further details on the achievements of each agency. It is worth highlighting that cash and voucher assistance played an important role in the global response to COVID-19. Three UN agencies – FAO, UNHCR and UNICEF – used a portion of the CERF funding to provide cash and voucher assistance to vulnerable communities in Afghanistan, Bolivia, Burkina Faso, Haiti, Jordan, Peru, oPt and Venezuela. In total, the agencies provided $3.58m to 186,357 people (compared to an original plan of $3.27m for 145,667 people). The largest CERF-funded CVA operation was for refugees in Jordan, where UNHCR provided $2.22m to 55,573 people.

People Directly Reached:

Assessing the total number of people directly reached with the CERF funding is challenging for a number of reasons. Firstly the $95m in CERF global block grants was used to provide assistance in 36 different countries. Secondly the nature of the pandemic called for a heavy emphasis on reaching communities through awareness-raising as part of infection prevention and control measures. Accurately recording the number of people reached through traditional media (print, TV, radio) as well as social media can be complex. Thirdly, some of the CERF-funded agency-specific projects overlapped with one another, raising the possibility of double-counting. The figures presented below represent CERF's and the agencies' best possible estimates.

In total, agencies reached some 71 million people across 36 countries thanks to CERF's support, including 17.5 million women, 35.2 million children, and 2.5 million persons with disabilities.

CERF funding allowed the FAO to directly assist a total of 188,913 vulnerable people in Afghanistan, Burkina Faso, and Haiti, mitigating the negative impact of the pandemic on health and the economy. The exact number of individuals directly benefitted by the agency's work was taken from the beneficiary profile survey databases.

Projects implemented with CERF funding by the IOM reached 652,066 people in refugee and host communities in Nigeria, Burundi, Libya, and Somalia, a significant increase from the estimated reach of 398,060. This addition came as a result of the reorientation of support provision in POCs to POEs in Burundi. The overall number of beneficiaries from these programs was calculated through the aggregation of project targets from target countries.

The UNDP estimates that it was able to distribute 160,000 masks to beneficiaries in Bangladesh's Khulna, Satkhira, Patuakhali and Barguna Districts, as well as in Cameroon, Ethiopia, Chad, Mali, Venezuela, and Afghanistan. UNDP also estimates that the 26 ventilators it distributed throughout five countries will be able to treat a total of 1,450,000 people throughout the lifetime of these machines.

CERF funding allowed UNFPA's efforts to reach 651,591 individuals, providing home and remote service to people in need of Covid 19 testing and GBV and SRH care including CMR, STI prevention and treatment, FP services, deliveries, prenatal and postnatal care, case management and psychosocial support. This number is drawn from data provided from targeted service points, such as safe spaces, border lines, and hospitals, as well as home visit and remote service counting.

UN-Habitat, strengthened by CERF funding, provided life-saving assistance to 4,421 vulnerable people in Sabra and Daouk Ghawash neighborhoods within Tarik el Jdideh in Beirut. UN-Habitat projects reached 92% of people under the life-saving component, distributing a total of 992 hygiene kits, a moderate increase from the initial estimated distribution of 500 kits.

Aided by CERF funding, UNHCR provided assistance through the common distribution platform known as the Common Cash Facility (CCF) to 11,115 families / 55,573 beneficiaries in Jordan, distributed PPE to 65 medical universities in Iran estimated to benefit 20,000 health care staff, and distribute water tanks to an estimated 105,706 individuals in Venezuela. Estimated impact in Venezuela has been based off figures calculated by implementing partners and Field Offices and Unit reports because UNHCR was not authorized nor able, due to COVID-19 restrictions, to distribute aid directly.

Through CERF support, UNICEF reached over 51 million people - some of whom were reached directly with access to services but most of whom were reached indirectly by way of messages on COVID-19 prevention. 4.5 million people spread across 14 countries were reached with critical WASH supplies, and essential healthcare services in CERF and UNICEF supported facilities served 2.7 million women and children. 14,600 healthcare staff were trained in 9 countries in COVID-19 case detection and management, and over 7,000 healthcare workers in 7 countries were trained in IPC measures to reduce COVID-19 transmission. Over 18 million children were provided with distance learning educational

programs, primarily through TV and radio broadcasts and through online courses, and more than 230,000 individuals were reached with community-based psychosocial and mental health support.

Although the WFP Common Services do not directly reach beneficiaries, CERF-provided funding allowed WFP to enable partners to achieve their goals in regard to implementation of activities. WFP facilitated access to significant cargo delivery services for 48 organizations, allowing them to reach their program targets. WFP transported 29,070 passengers to 68 destinations on behalf of 436 organizations in order to bring health and humanitarian personnel to the front lines of the crisis.

WHO, through the assistance of CERF funding, was able to reach over 16 million individuals, reducing the transmission of COVID-19 in target countries, decreasing mortality, and mitigating the impact of the outbreak. Estimates of direct beneficiaries were determined through tracking of number of COVID-19 cases detected and treated, number of healthcare workers trained on IPC norms or case investigation, medical staff trained in oxygen therapy and respiratory rehabilitation, and number of people benefitting from available health services.

People Indirectly Reached:.

FAO estimates that, with CERF assistance, it has been able to reach nearly 3,164,422 people through training, provision of protection equipment, and indirectly through radio and television messaging and messages through visual materials. These estimates have been based on daily marketplace trends in Afghanistan, and audiences of national television and radio channels in Burkina Faso and Haiti.

IOM assistance is estimated to have indirectly benefitted displaced populations in IDP camps and host communities in Nigeria, as well as communities residing in cross-border areas in Burundi, Libya and Somalia through the establishment of waiting areas and the dissemination of IEC materials, primary and secondary screening triage mechanisms, and public information campaigns for COVID-19.

UNDP's provision of IIR masks enabled key aid, health, and community workers to safely continue regular operations during the height of the COVID-19 pandemic, enabling healthcare workers to retain their role in the prevention and mitigation of COVID-19.

CERF grants allowed UNFPA to indirectly reach an approximate total of 6,937,982 individuals, using TV and radio broadcasts to spread information and communication campaigns raising awareness for COVID-19 prevention and protection measures, as well as available SRH and GBV services. The number of people indirectly impacted includes service providers who were recipients of training and the children and extended families of women who received services.

UN-Habitat, with CERF funding, implemented the distribution of informational pamphlet and awareness material on the adequate use of hygiene kits and proper protection practices to prevent the spread of COVID-19, reaching approximately 8,000 individuals in Lebanon.

UNHCR's cash assistance program in Jordan has led to the benefit of the wider host community, contributing to the local economy through the injection of liquidity into the market. In Iran, CERF grants aided UNHCR's distribution of PPE to healthcare workers, indirectly benefitting thousands of refugees and host communities serviced by the 65 university hospitals. In Venezuela, first responders, medical personnel, and institutional counterparts and implementing partners have been indirectly benefitted as reception, health, and quarantine centers were provided with protective equipment and hygiene supplies.

The promotion of COVID-19 prevention messaging and information campaigns by UNICEF indirectly reached many, and support to the national health system through training of health workers in IPC detection and management of COVID-19

cases, fund support, the provision of medical supplies, and coordination and planning with national health authorities have benefitted millions of people. Within the WASH sector specifically, UNICEF established handwashing facilities, water storage tanks, and toilets, and distributed hygiene supplies and knowledge, benefitting recipients for years to come.

Aided by the provision of CERF funds, WFP worked to open transportation networks, laying the groundwork for governments and commercial airlines to reestablish travel that was in line with health and safety requirements. WFP efforts to sustain cargo and passenger movement was significant in alleviating access challenges, reducing the restrictions to movement for implementing partners.

WHO estimates that entire populations in beneficiary countries benefitted indirectly from CERF supported activities such as COVID-19 sensitization through communication awareness campaigns, expansion of delivery capacity, and increased infection and control measures in health facilities.

Table 3: Number of People Directly Assisted with CERF Funding by Sector/Cluster*

	Planned					Reached				
Sector/Cluster	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Camp Coordination and Camp Management - Camp Coordination and Camp Management	168,000	144,000	264,000	224,000	800,000	112,760	89,663	137,274	119,062	**458,759**
Common Services - Logistics	0	0	0	0	0	0	0	0	0	**0**
Education - Education	235,519	250,991	3,460,067	3,676,061	7,622,638	339,718	918,097	8,682,488	9,028,342	**18,968,645**
Food Security - Agriculture	45,209	46,126	26,487	25,578	143,400	52,830	43,430	46,705	45,948	**188,913**
Health - Health	18,277,466	17,586,977	10,061,686	10,223,801	56,149,930	16,590,337	16,248,750	7,810,345	7,045,944	**47,695,376**
Multi-sector refugee assistance - Multi-Sector Refugee Assistance	23,025	17,014	15,030	15,029	70,098	24,126	19,463	15,992	15,992	**75,573**
Protection - Child Protection	334,337	362,206	254,813	267,462	1,218,818	4,394,240	5,708,163	2,498,187	2,357,714	**14,958,304**
Protection - Gender-Based Violence	25,982	8,930	12,135	8,710	55,757	90,244	14,639	26,620	6,159	**137,662**
Shelter and Non-Food Items - Shelter and Non-Food Items	3,600	3,900	0	0	7,500	46,231	38,201	11,320	9,954	**105,706**
Water, Sanitation and Hygiene - Water, Sanitation and Hygiene	738,380	706,715	412,597	399,690	2,257,382	780,988	715,475	835,035	807,702	**3,139,200**
Total	**18,400,421**	**17,868,105**	**13,397,130**	**13,748,015**	**63,413,671**	**17,519,185**	**18,262,694**	**17,937,400**	**17,277,843**	**70,997,122**

Table 4: Total Number of People Directly Assisted with CERF Funding by Category*

Category	Planned	Reached
Refugees	2,907,464	2,091,232
Returnees	1,785,047	1,470,440
Internally displaced people	12,254,464	4,947,147
Host communities	20,106,032	21,172,891
Other affected people	26,360,664	41,315,412
Total	63,413,671	70,997,122

Table 5: Total Number of People Directly Assisted with CERF Funding*			**Number of people with disabilities (PwD) out of the total**	
Sex & Age	**Planned**	**Reached**	**Planned**	**Reached**
Women	18,400,421	**17,519,185**	1,800,504	657,103
Men	17,868,105	**18,262,694**	1,548,813	710,321
Girls	13,397,130	**17,937,400**	1,131,837	620,030
Boys	13,748,015	**17,277,843**	1,234,310	488,150
Total	**63,413,671**	**70,997,122**	**5,715,464**	**2,475,604**

PART II – AGENCY OVERVIEW: FAO

1. STRATEGIC PRIORITIZATION

Statement by the agency focal point:

Thanks to the CERF Rapid Response COVID-19 allocation of US$ 3,000,000 (ref. 20-RR-FAO-019) this emergency global project entitled "*Preventing and responding to the impact of COVID-19 outbreak on food security* "provided time-critical life-saving food security assistance (agriculture, livestock and cash transfers) to vulnerable households to protect their livelihoods, enhancing access to nutritious food at household level and contribute to local economy in Afghanistan, Burkina Faso and Haiti. The intervention also focused on providing critical information and awareness raising messages to individuals potentially at risk of being infected and transmitting COVID-19 thus contributing to saving their and their families. The three countries were among those targeted by the Global Humanitarian Response Plan for COVID-19 while at the same time having their respective country HRPs for 2020. The recipient countries were selected based on the risk of further deterioration of the food security situation being all of them already priority food crisis countries affected by the highest levels of food insecurity as per the Global Report on Food Crises 2020, and countries with a high risk of rapid spread of COVID-19. Other selection criteria included the geographical balance and the ability of the respective FAO country offices to operate within the countries specific lockdown measures.

FAO's CERF-funded intervention protected agriculture and livestock based livelihoods of **188,913 vulnerable people** through distribution of seeds, animal feed and other agricultural inputs; raised awareness about the transmission of COVID-19; provided protective equipment to prevent the transmission of the disease; mitigated the negative impact of the pandemic through cash distributions; and collected data on the impact of the pandemic on food value chains and agricultural systems.

The implemented activities are aligned with FAO's strategy to address the humanitarian effects of the COVID-19 pandemic: "*Addressing the impacts of COVID-19 in food crises, April - December 2020*" (http://www.fao.org/3/ca8497en/CA8497EN.pdf) which is in turn in line with the Strategic Priority 2 "*Decrease the deterioration of human assets and rights, social cohesion and livelihoods*" of the United Nations Global COVID-19 HRP.

In Afghanistan, the CERF allocation proved to be catalytic in mobilizing additional resources and implementing time-critical urgent actions to save lives and livelihoods of nomadic herding communities and other vulnerable food insecure households, as well as in transmitting urgent COVID-19 related key messages to avoid negative impacts on vulnerable food insecure communities.

In Burkina Faso, the CERF funding helped to provide strategic support to affected households -affected both from health and socio-economic points of view- by providing COVID-19 protection kits and unconditional cash transfer in order to help them to protect themselves from the disease and to have access to food. By providing agricultural and livestock inputs the vulnerable households could continue their production activities and avoid adopting harmful coping strategies.

Finally, in Haiti the intervention also allowed the protection and restoration of the livelihoods of vulnerable populations and safety nets support while raising awareness of the protective measures against the spread of COVID-19 in Grande Anse and North West departments.

CERF's Added Value:

The CERF Rapid Response COVID-19 allocation provided life-saving agriculture food security assistance. The allocation was timely since it was for FAO the first COVID-19 allocation. The initial minimum requirements to approve the CERF allocation (and differing details to a month later) enabled to anticipate the operational preparatory work and to fast track the delivery of the assistance to the people in need. The approval process, phased in two steps, was highly appreciated by FAO country teams; allowing for the fine-tuning of the planning to take place while finalizing commitments with implementing partners and suppliers.

In Afghanistan, the allocation helped in undertaking time-critical livelihoods safeguarding actions including sensitization on COVID-19 safety measures in agriculture and livestock markets -to mitigate the risk of COVID-19 transmission through these markets, in particular during crowded Eid celebrations-, as well as formulation of communiques to inform policy and response programming. Coordination was ensured with other UN Agencies (WHO and UNFPA) on the COVID-19 safety measures related messaging to ensure synergy with the Ministry of Public Health efforts on the same subject. Furthermore, through the Food Security and Agriculture Cluster (FSAC), coordination was ensured with WFP and other FSAC members as well as with the Provincial Government Authorities for humanitarian response in project areas.

FAO in Burkina Faso, in partnership with the National Volunteer Programme of Burkina Faso (PNVB), mobilized 300 young volunteers as part of its global response to COVID-19. This initiative for mass sensitisation on COVID-19 and nutrition helped to reinforce the gains made through CERF's financial support. The COVID-19 protection kits, unconditional cash transfer, agricultural and livestock inputs combined with large-scale sensitisation had a positive impact on the health and economic situation of affected households as they have better understood the disease's mode of transmission as well as the actions they can take to protect themselves.

In Haiti this CERF allocation was the first contribution to inform and build the capacity of rural communities on preventing the spread of COVID-19 in the country. It allowed FAO to continue its emergency agricultural assistance activities -which risked to be delayed without this CERF allocation- while respecting the measures taken by the Government for the prevention of COVID-19. It also enabled coordination between FAO, WHO and the Ministry of Health in the implementation of the awareness-raising activities for the prevention of COVID-19.

Did CERF funds lead to a fast delivery of assistance to people in need?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help respond to time-critical needs?		
Yes ☒	Partially ☐	No ☐
Did CERF improve coordination amongst the humanitarian community?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help improve resource mobilization from other sources?		
Yes ☐	Partially ☒	No ☐

Considerations of the ERC's Underfunded Priority Areas[2]:

[2] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

The four chronically underfunded humanitarian priority areas were addressed as crosscutting relevant issues as follows:

1) Support for women and girls, including tackling gender-based violence, reproductive health and empowerment:
- In Afghanistan the project prioritized the assistance to 2,859 female-headed households and promoted protection messages related to PSEA, GBV and complaints-grievance mechanisms. 2,736 of them received USD 50 each as cash transfer, while 96 were provided with the livestock protection package, consisting of 100 kg of concentrated animal feed as well as deworming medicines for their animals. All of these female-headed households were provided with COVID-19 sensitization information. Furthermore, all distribution of inputs and cash as well as technical training sessions and COVID-19 sensitization sessions were organized at locations and timings convenient for women beneficiaries.
- In Burkina Faso the project contributed to supporting the empowerment of women by benefiting female-headed households (58%) to support their usual production-oriented activities: poultry farming, market gardening, fattening and rabbit farming. In the context of Burkina Faso, where women have more and more responsibilities within the households and where the security crisis has brought many families to mourning, making women heads of household without any preparation, it is crucial to promote activities that may allow them to be more financially autonomous in order to meet their needs and those of their families. The main challenges include changes in attitudes towards the evolution of women's status and their access to factors of production - notably land and sources of finance. Access to land and financial resources is a major handicap to the development of rural women in particular. Programmes that facilitate women's access to these factors of production will be decisive for their development and, consequently, that of their families.
- In Haiti, FAO ensured that vulnerable pregnant and lactating women and girls as well as female-headed vulnerable households were considered as priority target of intervention. The provision of appropriate and participatory technical assistance to vulnerable women, especially those living in urban areas who have been assisted in vegetable production and cash, contributed to the restoration of their livelihood and improved the diet diversification of their families.

2) Programmes targeting disabled people: The project considered disability as a vulnerability-based beneficiary selection criteria. In Afghanistan, 679 households headed by persons with disability were selected to receive the Unconditional Cash Transfer, the livestock protection package and the COVID-19 sensitization information. In the same way, priority was given in Haiti to vulnerable households with a dependent disabled person and/or elderly when selecting the beneficiaries. The activities implemented by FAO to restore livelihood reached 191 households with a dependent disabled person (5%) out of the 4,000 vulnerable households assisted by the project. While out of 43,000 people benefiting from training / awareness and hygiene kits to protect against COVID-19, 1,099 are people with disabilities (3%). In Burkina Faso, assistance to people with disabilities was taken into account when targeting beneficiaries. The presence of a person living with a disability in a household was a sufficient criterion to select that household for project support. At the end of the targeting process, there were 658 selected households with at least one person living with a disability. Of these households, 387 were headed by women.

3) Education in protracted crises: Even if this project was not designed to address education concerns, the intervention provided time-critical and season-sensitive inputs and cash to vulnerable food insecure households, which enabled the households not to adopt negative coping actions like removing children from school or reducing consumption of nutritious food. Lastly, all the direct beneficiaries were sensitized on COVID-19 safety measures, including measures to be adopted at household, farm, livestock and markets levels, and in general in public spaces; all this was also intended to benefit children in these households and communities.

4) Other aspects of protection: The main protection aspect addressed by the intervention was the prevention and mitigation activities and distribution of personal protection equipment's against the spread of the COVID-19 disease. Moreover, the project prioritized households headed by women and/or persons with disability through the vulnerability-based beneficiary selection process. It also worth mentioning that all distribution of inputs and cash, as well as technical training sessions and COVID-19 sensitization sessions were organized at locations and timings convenient for women and persons with disabilities beneficiaries. Also, all direct beneficiaries were informed about the PSEA and complaints/feedback mechanisms. In Afghanistan, all project staff including those of the implementing partners were trained on humanitarian principles, AAP, PSEA, rights of beneficiaries, and COVID-19 safety measures. In Haiti, FAO informed the beneficiaries of its policy to combat child labour.

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
FAO	20-RR-FAO-019	FOOD SECURITY - AGRICULTURE (INCL. LIVESTOCK, FISHERIES AND OTHER AGRICULTURE BASED LIVELIHOODS)	3,000,000

2. OPERATIONAL PRIORITIZATION:

People Directly Reached:

The project directly assisted a total of **188,913** vulnerable **people** in the three countries to mitigate the negative economic and health impacts of the COVID-19 pandemic by protecting their livelihoods and decreasing the probability of contagion.

In Afghanistan, the household average size is considered to be 7 persons. The actual number of individuals was taken from the beneficiary profile survey databases. Gender/age disaggregated data for the market stakeholders could not be collected, therefore it was not possible but to do an estimation based on the actual data collected for the livestock-based intervention. Given that the COVID-19 safety measures' related sensitization and awareness building sessions were held on multiple occasions in the markets using public address / broadcast systems, the precise number of individuals -and disaggregation therein- from activities in these markets is difficult to estimate.

In Burkina Faso, the households were targeted directly in the field and the data was collected and recorded using the KOBO tool. For household size, it is estimated that the average household is composed of 7 individuals, making the 4,200 households a total 29,400 people. For the gender estimate, a rate of 53% of women was considered, reflecting the average proportion of women in households living in the peri-urban area of the Ouagadougou commune. The completion rate for indicator 1.5 (type and quantity of food harvested by beneficiary households) is 88.29%. This performance is linked to the fact that the targeting of beneficiaries concerned vulnerable people whose level of mastery of production techniques was not optimal, even though it must be acknowledged that the in-situ training carried out beforehand by the agricultural agents and the regular monitoring and supervision enabled them to substantially improve their technical capacities. Also due to their vulnerability, not all beneficiaries had the same level of access to good land and perennial water sources to ensure good production. The combination of these two factors explains the average level of production recorded. The variation (overachievement) in Output 2 products and indicators is related to the fact that, in addition to the support received from CERF, FAO mobilised other resources that enabled cascading training and large-scale awareness-raising campaigns for the project beneficiaries and, in general, for the population of the Ouagadougou Commune.

In Haiti, the project assisted urban and rural vulnerable households of the North West and Grande Anse departments, which were classified in IPC phase 4. The targeting of vulnerable households benefiting from the project assistance was carried out by local NGOs partners, in collaboration with the local technical and administrative authorities (Departmental Directorate of Agriculture, Board of Directors of the Communal Section, Communal Agricultural Office) and the Community Based Organizations (CBO) and validated by FAO. They set up a targeting committee. Under the supervision of the NGOs partners and FAO, the local community publicly confirmed the preliminary list of beneficiaries prepared by the targeting committee by checking whether the targeted households were the most vulnerable and whether there were no members of the same household on the list. The priority was given to vulnerable groups: single-parent households, households in charge of a disabled or chronically ill person, households run by elderlies and households with malnourished children under 5. The project proposal estimated the household average size as 5 people with an estimate of 52% of girls against 48% of boys in Haiti.

People Indirectly Reached:

Although it is rather difficult to estimate the number of indirect beneficiaries, mainly the ones indirectly reached by the COVID-19 awareness raising messages, FAO estimated that **around 3,164,422** people has been directly (training, protection equipment, etc.) and indirectly (messages through radio, television, visual materials, etc.) reached. This figure is the addition of the indirect beneficiaries estimated for each country: the number of direct beneficiaries has not been added to that figure in order not to overestimate it and to avoid any possible double-counting.

Another stream of indirect benefits derives from the production of analytical reports on the impact of the COVID-19 on the agriculture sector and agricultural livelihoods -including the food value chain and food systems- that constitute a valuable information source not only for FAO but also for other local stakeholders - Government institutions, other organizations in the food security sector, etc.- to inform their programmes and decision-making.

The number of indirect beneficiaries in Afghanistan is estimated at 304,422 persons. The initial target of 7 markets was increased to reach 17 markets, mostly through the public announcement systems. The figure provided regarding the estimated number of people indirectly reached is based on daily trends in the markets. It is also estimated that 20 to 30 percent of the direct audiences might have passed on the messages to their family members.

In Burkina Faso, TV and radio spots in French, Mooré, Dioula and Fulfulde languages were designed and broadcast on Radiodiffusion Télévision du Burkina (RTB). In view of the audience of this channel, which is national in scope, the population reached by these awareness-raising messages is estimated at around 2,800,000 people. To capitalize on the project's achievements, a documentary film is being finalized and will be broadcast on the same television channel. In addition to the CERF funding, FAO mobilized in Burkina Faso other resources (internal scale up funds) that enabled the deployment of 300 young volunteers from the National Volunteer Programme of Burkina Faso (PNVB) to support awareness raising directly in the field. These volunteers were deployed over a period of one month to ten highly frequented sites in the city of Ouagadougou to talk directly to the people they met with a view to encouraging them to adopt containment measures and appropriate nutritional practices in the context of COVID-19. In total, 262,515 people were reached by this awareness raising campaign.

In Haiti, thanks to the support of the project, the inhabitants of the towns of Port de Paix (North West) and Jeremie (Grande Anse), benefited from improved availability and accessibility of vegetables in the local markets that facilitates the diversification of their diets. The income of traders in the two towns was also improved as a direct effect of the US$ 200,000 distributed to vulnerable households that improved their purchasing power. At least 60,000 people (30,000 per department) in the North West and Grande Anse departments benefited from awareness raising information on the preventive measures against the spread of COVID-19 transmitted by trained people and through local radio stations messages.

PART III – PROJECT OVERVIEW: FAO

Project Report 20-RR-FAO-019

1. Project Information

Agency:	FAO	**Countries:**	Multi-country
Sector/cluster:	Food Security - Agriculture (incl. livestock, fisheries and other agriculture based livelihoods)	**CERF project code:**	20-RR-FAO-019
Project title:	Preventing and responding to the impact of COVID-19 outbreak on food security		
Start date:	07/04/2020	**End date:**	06/01/2021
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding		
	Total requirement for agency's sector response to current emergency:	**US$ 110,000,000**
	Total funding received for agency's sector response to current emergency:	**US$ 0**
	Amount received from CERF:	**US$ 3,000,000**
	Total CERF funds sub-granted to implementing partners:	**US$ 386,408.21**
	Government Partners	US$ 90,867.40
	International NGOs	US$ 222,567.90
	National NGOs	US$ 72,972.91
	Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through this CERF Rapid Response COVID-19 allocation, FAO and its partners provided the following assistance between April 2020 and January 2021:

- Output 1: Agriculture and livestock-based livelihoods of **63,963** vulnerable persons were protected; focusing on time-sensitive and season-critical protection of agriculture-based livelihoods as well as safeguarding the functioning of the main markets.
- Output 2: Awareness raising and preventions measures were taken to avoid the spreading of COVID-19; focusing on widespread information dissemination and awareness raising of the stakeholders of the food and labour-flow systems to prevent or minimize the transmission of the COVID-19, applying the guidance note on risk communication and community engagement elaborated by FAO (http://www.fao.org/3/cb0526en/CB0526EN.pdf). Even if it is difficult to estimate the number of people reached by the awareness raising campaigns, FAO estimates that **around 3,164,422** people have directly (training, protection equipment, etc.) or indirectly (messages through radio, television, visual materials, etc.) benefitted from the project under Output 2.
- Output 3: The negative impact of the crisis on vulnerable households' incomes were mitigated and productive safety nets were supported, including by the provision of unconditional cash transfers for **13,366** vulnerable **households** (**87,782 persons**).
- Output 4: Data collection and analysis was carried out to assess the impact of the COVID-19 outbreak on food security, in the agriculture sector, including on food value chain and food systems.

The project directly assisted **188,913** vulnerable **people** in the three countries to mitigate the negative economic and health impacts of the COVID-19 pandemic by protecting their livelihoods and decreasing the probability of contagion. This is the detailed description of the outputs obtained in the three countries:

Afghanistan

FAO and its implementing partner directly assisted **124,443** vulnerable **people** and 304,422 people indirectly benefitted from project activities.

Output 1:

The agriculture and livestock-based livelihoods of **26,463** of the most vulnerable Kuchi nomadic **people** (3,500 households) were protected in Balkh, Faryab, Kandahar and Herat provinces, overachieving the initially planned number of 24,500 individuals. The beneficiaries received a livestock protection package consisting of 100 kg of concentrated animal feed and de-worming medicines, training on best practices in livestock feeding and keeping. 350 metric tonnes of concentrated animal feed were distributed. Moreover, COVID-19 awareness information was provided to the beneficiaries in the form of information, education and communication (IEC) materials on preventing and minimizing the transmission of the virus.

Output 2:

To safeguard the functioning of the main markets of the targeted provinces **43,365 individuals** in **17** main agricultural and livestock **markets** in the provinces of Herat, Kabul, Nimruz, Balkh, Faryab, Kandahar and Nangarhar provinces were sensitized on relevant COVID-19 safety measures, as well as provided with pertinent IEC materials. The overall aim was to adopt COVID-safe practices and preventive measures at the markets, namely: physical distancing at all stages of agriculture produce/input handling, loading and unloading at the market; appropriate spacing between stalls, space and movement planning for customers; meetings for market management; and information dissemination and awareness building - using appropriate IEC materials - to customers, traders, vendors, and loaders at the market to prevent/minimize the transmission of COVID-19 through the food and labour-flow systems. This output was also overachieved as it had planned to reach 27,750 people in 7 markets.

Output 3:

7,166 vulnerable landless and marginal farmer **households** received Unconditional Cash Transfers (UCT) worth US$ 50, out of which 2,763 households were female-headed households. In total **48,382 individuals** benefitted from the UCT together with COVID-19 sensitization through IEC materials. This output has also been overachieved in terms of individuals reached since it had planned to reach 36,750 individuals. In addition, 6,233 vulnerable farming households, living in the same villages where the UCT intervention was implemented, received information and awareness for preventing and minimizing transmission of the COVID-19 within their households, local communities, villages and agriculture markets.

Output 4:
The project contributed to the following: i) FAO and the Ministry of Agriculture, Irrigation and Livestock (MAIL) jointly undertook a rapid impact assessment of COVID-19 on food security, agriculture production and marketing. This assessment undertaken in the summer of 2020 was one of the first primary data source to inform response programming of the MAIL as well as FAO and FSAC members. ii) FAO along with MAIL's CLAP (Community Livestock and Agriculture Project) team undertook a rapid assessment of COVID-19 on the dairy sector and nomadic Kuchi herders. This assessment, also carried out in the summer of 2020, was the first primary data source to inform COVID-19 response programming of the MAIL and FAO in the dairy sector and for nomadic herders. iii) FAO followed the rapid impact assessment (done jointly with MAIL) with another round of assessment on COVID-19 impacts on food security and agriculture security through the remote data collection modality during August-October 2020 to further inform the policy and response / recovery programming in Afghanistan. iv) FAO actively contributed to the FSAC-led Seasonal Food Security Assessment (SFSA) in August-September 2020 that helped in providing evidence on the impacts of COVID-19 on food and livelihoods security along with key needs of the impacted people. The data collection was done using KOBO toolbox whenever the assessments used in-person data collection modality while remote data collection modality used a mix of KOBO and paper based questionnaires. Based on the data collected and analysed FAO Afghanistan actively contributed to the FSAC led analyses and HCT briefing processes on the People In Need (PIN), Humanitarian Needs Overview (HNO) and Humanitarian Response Plan (HRP) in October-December 2020 to bring in the COVID-19 impacts and response programming priorities going into 2021.

Burkina Faso

CERF funding enabled FAO and its partners to contribute significantly to the fight against the spread of the virus and to the reduction of its impact on the most vulnerable populations in the Commune of Ouagadougou, the epicentre of the disease in Burkina Faso. The intervention enabled 4,200 vulnerable households (**29,400 people**) in the Commune of Ouagadougou to protect their members against COVID-19 contamination, to help them meet their needs, to improve their nutritional practices and to carry out agricultural production activities (including animal production).

Output 1:

1,500 households (**10,500 people**) -selected from UCT beneficiaries (see Output 3 below)- benefited from agricultural kits (each kit consisting of: 155 g of tomato, cabbage, onion, lettuce seeds; 1 bag of 50 kg of NPK fertilizer, 1 hoe, 1 rake, 1 can of bio-pesticide).

1,000 households (**7,000 people**) -selected from UCT beneficiaries (see Output 3 below)- benefited from livestock kits (Poultry kit [200]: 10 hens, 1 breeding cock, 50 kg of poultry feed, 1 hutch, disease control; Rabbit farming kit [100]: 4 rabbits, 1 breeding rabbit, 50 kg of rabbit feed, 1 hutch, disease control; Fattening/milking kit [700]: 200 kg of cattle feed).

In addition, training in market gardening and animal husbandry techniques was provided to the above two categories of beneficiaries respectively, as well as local awareness-raising on nutritional education and protection measures against COVID-19, which concerned all beneficiaries.

Output 2:

1,500 posters to raise awareness among beneficiaries about COVID-19 containment measures were produced and distributed; 1,000 stickers with the logos of the various project partners were produced and affixed to the COVID-19 protection kits before the distribution to direct beneficiaries.

TV and radio spots in French, Mooré, Dioula and Fulfulde languages were designed and broadcast on Radiodiffusion Télévision du Burkina (RTB). In view of the audience of this channel, which is national in scope, the population reached by these awareness-raising messages is estimated at **around 2,800,000 people**.

300 young volunteers from the National Volunteer Programme of Burkina Faso (PNVB) were deployed to support awareness raising directly in the field. These volunteers were deployed over a period of one month to ten highly frequented sites in the city of Ouagadougou to talk directly to the people they met with a view to encouraging them to adopt containment measures and appropriate nutritional practices in the context of COVID-19. In total, **approximately 262,515 people** were **reached** by this awareness raising campaign. Out of these, **261,000 individuals** were **trained**. It was estimated –based on a survey- that 60% of the sensitized people i.e. **157,509 people** has **adopted the good practices**. In addition, **90,050** persons were sensitized on **good eating habits** during the COVID-19 pandemic.

Output 3:

The incomes of **4,200** vulnerable **households** (**29,400 people**) benefitted from Unconditional Cash Transfer -electronic transfer modality- worth US$ 56 per household that allowed increasing their purchasing power for food supplies or other life-saving needs. Follow-up shows that most of the cash was used to purchase food. These beneficiaries' households also received COVID-19 protection kits consisting of 3 reusable masks, 1 hand washing device, 3 soap balls, 1 awareness poster.

Output 4:

FAO provided technical and financial support to the Government of Burkina Faso to assess the impact of COVID-19 on food security and agriculture. The evaluation was carried out through qualitative data collection and a household survey. Multidisciplinary teams (Government structures, NGOs, UN agencies, projects and programs, civil society, the Red Cross) travelled to the 13 regions to collect data using qualitative assessment tools. The sampling for the household survey was done in a way to allow for rapid feedback and ensure better accuracy of the indicators. It was carried out through a stratified sampling plan -according to place of residence- with two levels. The sample was composed of 5,843 households from 488 villages spread over the 13 regions of the country. Data collection was done using mobile data collection tools. The field phase was conducted in two different ways depending on the collection area. In the more secure regions (8 regions) the data collection lasted 7 days and involved 85 interviewers and 8 supervisors. On average, each interviewer was responsible for administering the actual collection in 3 to 4 villages with approximately 48 households. For the other 5 regions considered to be highly challenging, the data collection was carried out using the MVAM tool, through telephone calls to sample households in order to manage the questionnaire. The data from this survey fed into the special session on food insecurity analysis through the "Cadre Harmonisé" tool held in July 2020. The results of the analysis showed that COVID-19 and the restrictive measures had a considerable impact on food security. Indeed, approximately 3.3 million people in Burkina, or 15% of the total population, are facing acute food insecurity.

Haiti

In Haiti, **35,070 people** are direct beneficiaries of the intervention. The project enabled 4,000 vulnerable households (20,000 people) to protect and revive their livelihoods. Moreover, 2,650 community leaders/actors benefited from the transmission of knowledge through awareness campaigns and training. Additionally, 12,420 vulnerable people received hygienic protective kits. Finally, around 60,000 people were sensitized on preventive measures against the spread of COVID-19 through radio messages.

Output 1:

Seeds of early and climate-resilient varieties of maize (5 kg chicken corn variety) and pulses beans (10 kg of DPC 40 variety), agricultural tools (1 hoe) and grain conservation bags (1 bag) per household were provided to 2,000 vulnerable households (**10,000 persons**) of Baie de Henne and Les Irois including 866 women heads of households (43%) and 156 households with a dependent disabled person (7.8%). Three months after sowing in August-September each beneficiary harvested (October-November) between 325 and 350 kg of cereals and pulses. This food allowed feeding each beneficiary family for around 3 months. In addition, other **10,000 persons** (2,000 households) living in urban and peri-urban areas of Port de Paix and Jérémie received vegetable seeds (80 g. per household) and technical support (see below Output 3).

Output 2:

100 community leaders, including 46 women and 3 disabled people, were trained as trainers on preventing and awareness against the spread of COVID-19. In addition, **2,550 civil and religious leaders** including 1,632 women (64%) and 121 disabled people (4.7%), benefited from the transmission of knowledge through awareness campaigns carried out by the trained leaders.
12,420 people, including 7,949 women (64%) and 903 disabled people (7.3%), benefited from preventive/safety hygiene kits in the departments of Grande Anse (6,320 people) and North West (6,100 people).
6 radio stations, distributed in the departments of Grande Anse (3 radios) and North West (3 radios), broadcasted awareness messages on prevention against the spread of COVID-19 every day during December 2020, through a 40-minute debate and an audio report of 4 minutes. These information and awareness messages reached at least **60,000 people** (30,000 per department).
All FAO staff and its implementing partners of emergency agricultural assistance interventions received protective equipment against COVID-19 (masks, soaps and hand sanitizer).

Output 3:

Vegetable seeds (80 g. per household) and technical support were provided to **2,000 households** (**10,000 persons**) living in urban and peri-urban areas of Port de Paix and Jérémie including 1,217 women heads of vulnerable households (61%) and 207 household with a disabled dependent (10.35%). In parallel, the same households received Unconditional Cash Transfer equivalent to US$ 100 to meet his basic needs while awaiting the harvest and sale of vegetables. Depending on the types of vegetable crops sowed, each household harvested between 750 and 1,000 kg of vegetables. Moreover, 200 beneficiaries (64% of women) were trained in good agricultural practices associated with vegetable production and nutritional education.

Output 4:

With the technical and financial support of this CERF project and in collaboration with WFP, the National Coordination of Food Security (CNSA) carried out in June 2020 an assessment on the impact of COVID-19 on food security, livelihoods and agricultural production ("Evaluation Rapide de l'Impact du COVID-19 sur la Sécurité Alimentaire, Moyens d'Existence et Production Agricole – SAMEPA"). The survey carried out with a representative sample of the Haitian population made up of 3,062 households including 2,097 households in rural areas of Haiti and 898 in the metropolitan area of Port-au-Prince. The results of the study, presented in August 2020, fed the latest IPC analysis for Haiti carried out in August 2020 and provided evidence-base data for the HNO/HRP process.

3. Changes and Amendments

In Afghanistan, based on funds availability and due to economies made thanks to cost-effective procurement procedures, the project increased its target from 5,250 to 7,338 vulnerable or marginalized households in Herat, Nimruz, Nangarhar, Balkh, Faryab and Kandahar province (2,088 additional households). The following districts were added to the Unconditional Cash Transfers (UCT) and COVID-19 information dissemination interventions:

- Karukh district of Herat province: 100 Kuchi households and 264 settled livestock keepers were targeted and achieved.
- Zaranj district of Nimruz province: 356 households.
- Bati Kot district of Nangarhar province: 364 households.
- Nahr-e-Shahi district of Balkh province: 320 households.
- Pashtoon Kot district of Faryab province: 320 households.
- Daman district of Kandahar province: 364 households.

FAO overachieved the UCT target by 36.5 percent (1,916 additional households) and a total of 7,166 households were assisted with UCT. The 172 households missing from the amended target mentioned above (7,338 households) were not allowed by Anti-Government

Elements (AGEs) to collect their cash at the distribution centre in Pashtoon Kot district of Faryab province, located in an area controlled by the Government (the Government did not allow the implementing partner to move the distribution centre to an AGEs controlled area due to the deteriorated security situation). Also in Afghanistan, the project managed to reach 17 main agriculture and livestock markets with COVID-19 sensitization and implementation of safety measures, instead of the 7 markets originally planned.

In Burkina Faso, in addition to the COVID-19 pandemic, the year 2020 was marked by the resurgence of insecurity and politically it was an electoral year with presidential and legislative elections preceded by a month-long electoral campaign. Combined with the measures taken by the Government to contain the spread of the virus (closure of markets, quarantine of certain towns, border closures, physical distancing) these factors made it difficult to implement activities in the field. Specifically, the methodology for targeting project beneficiary households had been designed based on the existence of lists of households impacted by COVID-19 in principle available from the Social Action, Social Nets and Health Cluster departments. At the start of the project, these lists proved to be inaccessible, so this fact led FAO and its partners to carry out direct targeting in the field. These factors contributed to slowing down the implementation of the activities. Finally, it had been planned to acquire 3,000 watering cans to be distributed to the project beneficiaries in Burkina Faso for market gardening activities, but the watering cans eventually could not be delivered due to multiple price changes by the supplier following the negative impact of COVID 19 on market prices. Unfortunately, as this cancellation occurred close to the end of the project, the funds dedicated to this order were not used.

In Haiti, the increase of seed prices because of the restrictions measures for the prevention of COVID-19 led to the reduction of the quantity of bean seeds provided to each beneficiary from 10 kg to 7.5 kg. This is one of the causes of the reduction in the average harvest obtained by the beneficiaries combined with a poor distribution of the rainfalls recorded in the commune of Baie de Henne.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Food Security - Agriculture (incl. livestock, fisheries and other agriculture based livelihoods)									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Returnees	0	0	0	0	**0**	**47**	**31**	**56**	**70**	**204**
Internally displaced people	0	0	0	0	**0**	**468**	**365**	**757**	**704**	**2,294**
Host communities	17,640	11,760	0	0	**29,400**	**23,193**	**19,697**	**11,617**	**11,329**	**65,836**
Other affected people	27,569	34,366	26,487	25,578	**114,000**	**29,122**	**23,337**	**34,275**	**33,845**	**120,579**
Total	**45,209**	**46,126**	**26,487**	**25,578**	**143,400**	**52,830**	**43,430**	**46,705**	**45,948**	**188,913**
										People with disabilities (PwD) out of the total
	570	550	659	640	**2,419**	**949**	**768**	**1,418**	**1,349**	**4,484**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

Although it is rather difficult to estimate the number of indirect beneficiaries, mainly the ones indirectly reached by the COVID-19 awareness raising messages, FAO estimates that **around 3,164,422 people** have been directly (training, protection equipment, etc.) and indirectly (messages through radio, television, visual materials, etc.) reached. This figure is the addition of the indirect beneficiaries estimated for each country: the number of direct beneficiaries has not been added to that figure in order not to overestimate it and to avoid any possible double-counting.

Another stream of indirect benefits derives from the production of analytical reports on the impact of the COVID-19 on the agriculture sector and agricultural livelihoods -including the food value chain and food systems- that constitute a valuable information source not only for FAO but also for other local stakeholders - Government institutions, other organizations in the food security sector, etc.- to inform their programmes and decision-making.

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In Haiti, thanks to the support of the project, the inhabitants of the towns of Port de Paix (North West) and Jeremie (Grande Anse), benefited from the improvement of the availability and accessibility of vegetables in the local markets that facilitates the diversification of their diets. The income of traders in the two towns was also improved as a direct effect of the US$ 200,000 distributed to vulnerable households in the form of Cash+ that improved their purchasing power. At least **60,000** people (30,000 per department) the North West and Grande Anse departments benefited from awareness raising information on the preventive measures against the spread of COVID-19 transmitted by trained people and through local radio stations messages.

6. CERF Results Framework

Project objective	Prevent and respond to the impact of COVID-19 outbreak on food security
Output 1	Protect agriculture and livestock-based livelihoods of most vulnerable households Select an item from drop-down
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Food Security - Agriculture (incl. livestock, fisheries and other agriculture based livelihoods)

Indicators	Description	Target	Achieved	Source of verification
Indicator 1.1	Number of people benefiting from agricultural or livestock inputs Afghanistan: 24,500 persons, Burkina Faso 17,500 persons, Haiti 20,000 persons).	62,000	Total 63,963 Afghanistan: 26,463 persons Burkina Faso: 17,500 persons	Afghanistan: Profile Survey Report / Profile Survey Database / PDM Report / Final narrative report of implementing partner /Distribution Lists Burkina Faso: Partner distribution report.

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

			Haiti: 20,000 persons	Haiti: Partner reports / FAO Haiti Report
Indicator 1.2	Number of kits distributed Burkina Faso: 1,500 agricultural kits, 1,000 livestock kits. Haiti: 4,000 kits	6,500	Total 6,500 Burkina Faso: 1,500 agricultural kits and 1,000 livestock kits. Haiti: 4,000 kits	 Burkina Faso: Partner distribution report. Haiti: Partner reports / FAO Haiti Report
Indicator 1.3	Amount of animal feed distributed Afghanistan: livestock protection package (100 kg of animal feed and veterinary supplies).	100	Afghanistan: 350 metric tonnes were distributed. 100 kg per beneficiary household.	Afghanistan: Profile Survey Report / Profile Survey Database / PDM Report / Final Narrative Report / Distribution Lists
Indicator 1.4	Amount of seeds distributed (MT) Haiti: cereals 10 MT, beans 20 MT, vegetables 160 kg	30.16	Haiti: 25.16 (maize: 10 MT; bean: 15 MT and vegetables: 160 kg)	Haiti: Partner reports / FAO Haiti Report
Indicator 1.5	Type and quantity of food harvested by beneficiary households (MT) Burkina Faso: 9,125 tons of vegetables (1,500 tons of tomatoes, 5,000 tons of lettuce,1,125 tons of onion and 1,500 tons of cabbage).Haiti: 500 kg of cereals and beans, 400 kg of vegetables.	9,125.8	Burkina Faso: 9,125 tons of vegetables (2,884.8 tons of tomatoes, 2,747.8 tons of lettuce, 1,027.5 tons of onion and 1,397.2 tons of cabbage). Haiti: A total of 750 tons of vegetable plus 675 tons of corn and beans. 350 kg of cereals and beans per household. 750 kg of vegetables per household.	Burkina Faso: Partner report (Final report by Direction Régionale de l'Agriculture, des Aménagements Hydroagricoles et de la Mécanisation (DRAAH) Centre. Haiti: Partner reports / FAO Haiti Report
Explanation of output and indicators variance:		Burkina Faso: The completion rate for indicator 1.5 is 88.29%. This performance is linked to the fact that the targeting of beneficiaries concerned vulnerable people whose level of mastery of production techniques was not optimal, even though it must be acknowledged that the in-situ training carried out beforehand by the agricultural agents and the regular monitoring and supervision enabled them to substantially improve their technical capacities. Also due to their vulnerability, not all beneficiaries had the same level of access to good land and perennial water sources to ensure good production. The combination of these two factors explains the average level of production recorded. Haiti: The higher price of bean seeds due to the low production of the 2020 spring season and the COVID-19 prevention measures was the cause of the reduction of the quantity of seeds actually purchased and distributed from planned 20 tons to actual 15 tons. This in turn caused the reduction in the		

	average production of each beneficiary (500 kg. planned vs. 350 kg. actually harvested by household).

Activities	Description	Implemented by
Activity 1.1	Selection and contracting of partners	FAO.
Activity 1.2	Identification of vulnerable beneficiary households	Afghanistan: Dutch Committee for Afghanistan (DCA) and FAO. Burkina Faso: NGO HOPE'87; technical partners (Direction Régionale des Ressources Animales et Halieutiques (DRRAH) du Centre; Direction Régionale de l'Agriculture, des Aménagements Hydroagricoles et de la Mécanisation (DRAAH) Centre) and FAO. Haiti: GRADEH for Grande Anse, CEDERCALH for the North West, BAC, CBO, local authorities, and FAO.
Activity 1.3	Procurement of agricultural and livestock inputs	FAO.
Activity 1.4	Strengthen technical capacity of partners and beneficiaries	Afghanistan: Dutch Committee for Afghanistan (DCA) and FAO. Burkina Faso: DRAAH Center, DRRAH Center, Ministère de la Santé, Programme National du Volontariat du Burkina (PNVB) and FAO. Haiti: FAO.
Activity 1.5	Distribution of agricultural and livestock inputs	Afghanistan: Dutch Committee for Afghanistan (DCA) and FAO. Burkina Faso: HOPE'87, DRAAH and DRRAH Centers. Haiti: GRADEH for Grande Anse, CEDERCALH for the North West, FAO, BAC, CBO and local authorities.
Activity 1.6	Monitoring and evaluation of the impact / Post Distribution Monitoring (PDM)	Afghanistan: Adroit Associates Consulting Services (AACS) – Third Party Monitoring (TPM). Burkina Faso: General Department of Studies and Sectoral Statistics of the Ministry of Agriculture (DGESS/MAAHM), iMMAP. Haiti: GRADEH for Grande Anse and CEDERCALH for the North West with technical support of FAO.

Output 2	Awareness raising and preventions measures to avoid the spreading of COVID-19
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Food Security - Agriculture (incl. livestock, fisheries and other agriculture based livelihoods)

Indicators	Description	Target	Achieved	Source of verification
Indicator 2.1	Number of individuals and number of agriculture produce/inputs' markets adopting social distancing and hygiene related practices by country and gender TOTAL: 61,150 individuals. Afghanistan: 27,750 individuals in 7 markets. Burkina Faso: 29,400	61,150	Total 215,944 Afghanistan: 43,365 individuals Burkina Faso: 157,509 individuals.	Afghanistan: Final narrative report of implementing partner / PPE Distribution List Burkina Faso: Final report on sensitization of COVID-19 in Ouagadougou, by PNVB.

	individuals. Haiti: 4,000 individuals.		Haiti: 15,070 individuals (2,650 trained + 12,420 persons who preventive/safety hygiene kits).	Haiti: Partner reports and FAO Haiti Report.
Indicator 2.2	Number of actions taken on prevention of COVID-19 spreading (i.e. rural radios broadcasting messages, flyers and communication tools developed, etc.) by country. Afghanistan: 3 Guidelines on COVID-19 safety practices to be followed in agriculture and live animal markets,10 types of pictorial Information, Education and Communication materials, public broadcasting of COVID-19 safety messages at 17 markets, radio broadcasts in 7 provinces and 4 types of pictorial flyers / posters for pastoralists, farmers, poultry keepers, and labourers. Burkina Faso: 2 radio shows - 1 awareness TV spot / Cities / months / 7 months and 500 posters. Haiti: 3 rural radios.	TBC	Afghanistan: **10** types of pictorial IEC materials were distributed along with public broadcasting of COVID-19 safety practices to be followed in agriculture and live animal markets messages was systematically conducted at **17** agriculture and live animal markets on the public announcement systems. **4** types of pictorial flyers/posters for pastoralists, farmers, poultry keepers, and labourers resulting in at least 3 practices like (i) spacing between stalls; (ii) physical distancing by loaders/customers/traders/vendors and (iii) use of disinfectants for cleaning the markets and stalls. The disinfection was scheduled for 12 times a month. Burkina Faso: 2 radio and TV spots designed in French, Mooré, Dioula and Fulfulde languages and broadcasted on RTB. Production and distribution of 1,500 posters and 1,000 stickers. Haiti: **7** rural radio broadcast awareness messages.	Final narrative report / PPE Distribution List / Photos / Invoices Burkina Faso: Script of the spots / Posters and stickers produced. Haiti: Radio reports, Radio spots registrations / FAO Haiti report
Indicator 2.3	Number of people trained on prevention against the spread of COVID-19 (i.e. field development agents, community actors, civil and religious leaders, etc.) by country and gender TOTAL: 58,150 individuals. Afghanistan: 27,750 individuals. Burkina Faso: 29,400 individuals. Haiti: 1,000 individuals.	58,150	Total 307,015 Afghanistan: 43,365 individuals Burkina Faso: Out of the 262,515 people reached by the campaign, 261,000 individuals were trained. Haiti: 2,650 individuals	Afghanistan: Final narrative report of implementing partner / PPE Distribution List Burkina Faso: Final report on sensitization of COVID-19 in Ouagadougou, by PNVB. Haiti: Training report and FAO report.
Indicator 2.4	Number of households benefiting from nutritional and hygiene education activities (incl. number of beneficiaries of hygiene kits) by country 344,900 persons. Afghanistan:	344,900	Total 458,672 Afghanistan: 304,422 individuals (the figure of indirect beneficiaries).	Final narrative report.

	255,500 persons benefiting from training / information dissemination on COVID-19 safety and nutritional practices of which 14,000 households receiving safety / hygiene kits. Burkina Faso: 29,400 persons. Haiti: 60,000 persons.		Burkina Faso: 90,050 individuals sensitized on good eating habits during the pandemic. Hygiene kits distributed to 4,200 families. Haiti: 60,000 persons (30,000 per department), including 12,420 people who benefited from preventive safety/hygiene kits.	Burkina Faso: Final report on sensitization of COVID-19 in Ouagadougou, by PNVB / Partner distribution report. Haiti: FAO Haiti report.

Explanation of output and indicators variance:	Afghanistan: The target for indicator 2.1 (27,750 individuals) was overachieved. FAO and its implementing partner were able to reach 17 market stakeholders during the awareness interventions, which ended up directly benefitting 43,365 individuals. FAO did not conduct radio broadcasting; instead, public awareness interventions were conducted directly at the markets through the public announcement systems. Burkina Faso: The variation in outputs and indicators is linked to the fact that, in addition to the support received from CERF, FAO mobilized other resources that made possible to carry out cascade training and large-scale awareness-raising campaigns for project beneficiaries and, in general, for the population of the Ouagadougou Commune. Haiti: The target for indicator 2.2 (3 rural radios) was overachieved. FAO signed a contract with Radio Magik 9, which has a partnership with many radio stations in all the departments of the country. They agreed to broadcast the messages to all partner radio stations in the departments of Grande Anse (Lambi, Orbite and Extension) and the North West (Fidelité, New Star and Excell) to reach as many people as possible. Haiti, Indicators 2.1. and 2.3: under the supervision of FAO's social mobilization consultant, the 100 community leaders trained by FAO were motivated and encouraged by the departmental directorates of health of Grande Anse and North West to raise awareness among as many people as possible on preventing the spread of COVID-19. Therefore, they trained and sensitized more people than expected and they continued this activity even after the end of the project.

Activities	**Description**	**Implemented by**
Activity 2.1	Preparation of communication tools on good hygiene practices to control the transmission of COVID-19 and procurement of hygiene kits	Afghanistan: FAO. Burkina Faso: FAO. Haiti: FAO in collaboration with WHO and the Ministry of Health.
Activity 2.2	Training field development agents, community-based trainers and meetings with local stakeholders on COVID-19 prevention measures	Afghanistan: Dutch Committee for Afghanistan (DCA) and FAO. Burkina Faso: DRAAH and DRRAH Centers, PNVB, Ministry of Health, HOPE'87 and FAO. Haiti: FAO.
Activity 2.3	Information, dissemination and awareness raising on good practices to prevent COVID-19 spreading (radios broadcasting messages, flyers and others communication tools)	Afghanistan: Dutch Committee for Afghanistan (DCA) and FAO. Burkina Faso: FAO and Contractors: Mediaprod, RTB, BMS Informatique Plus. Haiti: FAO, community leaders and radios.
Activity 2.4	Distribution of hygiene kits (sanitizers, disinfectant, masks, gloves) to targeted population	Afghanistan: Dutch Committee for Afghanistan (DCA) and FAO. Burkina Faso: HOPE'87. Haiti: FAO and its Partners.

Output 3	Mitigate the negative impact of the crisis on vulnerable households' incomes and support productive safety nets

Was the planned output changed through a reprogramming after the application stage?		Yes ☐	No ☒	
Sector/cluster	Food Security - Agriculture (incl. livestock, fisheries and other agriculture based livelihoods)			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	Number of households benefiting from the unconditional cash transfers disaggregated by country and by gender TOTAL: 76,150 persons (11,450 households out of which 5,130 i.e. 45% are women-headed households). Afghanistan: 36,750 persons (5,250 households out of which 2,250 i.e. 43 % are women-headed households). Burkina Faso: 29,400 persons (4,200 households out of which1,680 i.e. 40% are women-headed households).Haiti: 10,000 persons (2,000 households out of which 1,200 households i.e. 60% are women-headed households).	76,150	Total 87,782 people. Afghanistan: 48,382 individuals (7,166 households – out of them 2,763 households are female headed). Burkina Faso: 29,400 persons (4,200 households - Out of them 2,423 are women-headed households. Haiti: 10,000 persons (2,000 households, including 1,217 women-headed households (61%)	Afghanistan: Profile Survey Report/ Profile Survey Database / PDM Report / Final Narrative Report / UCT Distribution Lists Burkina Faso: Partner distribution report. Haiti: Report of the Financial Service Provider (Sogebank)
Explanation of output and indicators variance:		Afghanistan: The initial target for Unconditional Cash Transfer (UCT) was 5,250 households (36,750 individuals) but due to the availability of funds achieved thanks to the cost-effective procurement procedures, FAO added an additional 2,088 households. However, due to critical security situations in Faryab province, the cash could not be delivered to 172 households in Pashtoon Kot district (more information can be found above under the section Changes and Challenges). Finally, FAO assisted 1,916 of these additional households, which represents a 36.5 percent more than planned. A total of 7,166 households were supported through UCT.		

Activities	**Description**	**Implemented by**
Activity 3.1	Selection and contracting of Financial Service Providers or Electronic money operators for the payment of cash	FAO.
Activity 3.2	Identification of beneficiaries	Afghanistan: Dutch Committee for Afghanistan (DCA) and FAO. Burkina Faso: HOPE'87, DRAAH and DRRAH Centers. Haiti: FAO, his partners and local authorities and CBOs.
Activity 3.3	Provision of Unconditional Cash Transfer to beneficiaries	Afghanistan: Financial Service Provider: Salim Jawid Transportation and Logistics Services; and FAO. Burkina Faso: Financial Service Providers: YUP Burkina. Haiti: HAITI: Financial Service Provider: Sogebank.
Activity 3.4	Post Unconditional Cash Transfer completion monitoring	Afghanistan: Adroit Associates Consulting Services (AACS) – Third Party Monitoring (TPM) Burkina Faso and Haiti: FAO.

Output 4	Data collection and analysis to assess the impact COVID-19 outbreak on food security

Was the planned output changed through a reprogramming after the application stage?		Yes ☐	No ☒	
Sector/cluster	Food Security - Agriculture (incl. livestock, fisheries and other agriculture based livelihoods)			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 4.1	Number of analytical reports and/or policy briefs by country Afghanistan: 5 reports. Burkina Faso: 3 reports (one every 3 months).Haiti: 1 report.	9	Afghanistan: 4. Burkina Faso: 3. Haiti: 1 report: COVID-19 Rapid Assessment on Food Security, Livelihoods and Agricultural Production (*SAMEPA*).	Afghanistan: Reports enumerated above under Output 4 (Section 2. Project Results Summary/Overall Performance). Burkina Faso: Communication sheet for the July 2020 "Cadre Harmonisé" update session. / iMMAP Situation Analysis Reports. Haiti: *SAMEPA* Report (FAO-WFP-CNSA).
Explanation of output and indicators variance:		Afghanistan, Indicator 4.1: The initial target of five (5) reports was tentative and set up at the proposal stage. This target included various assessments and policy briefs, one of which was eventually not developed because: (i) The FAO-MAIL assessment report already contained clear policy and programmatic recommendations; and (ii) WB, ADB, UNDP and other actors had already been providing specific policy advice to the Government of the Islamic Republic of Afghanistan on the COVID-19 response. Burkina Faso, Indicator 4.1: instead of the three evaluation reports planned at the project formulation phase, given the importance and scope of the evaluation of the impact of COVID-19 on agriculture and food security that planned by the Government, FAO-Burkina chose to take the lead in this evaluation, particularly with regard to the methodological aspects. The data from this assessment fed into the special session on the analysis of food insecurity through the "Cadre Harmonisé" held in July 2020.		

Activities	**Description**	**Implemented by**
Activity 4.1	Data collection (remote data collection when possible), and revue of secondary information.	Afghanistan: FAO, Ministry of Agriculture, Irrigation and Livestock (MAIL), Food Security and Agriculture Cluster (FSAC). Burkina Faso**:** DGESS/MAAHM, WFP, IMMAP. Haiti: CNSA.
Activity 4.2	Development of analytical reports of the emerging impacts of COVID-19 on the agriculture sector and agricultural livelihoods, including the food value chain and food systems, as well as on the social and economic impacts.	Afghanistan: FAO, MAIL and FSAC. Burkina Faso**:** DGESS/MAAHM, WFP, IMMAP. Haiti: CNSA, FAO and WFP

Activity 4.3	Dissemination of reports and findings emerging impacts of COVID-19 on the agriculture sector and agricultural livelihoods, including the food value chain and food systems	The assessments and reports were disseminated, in the three countries, in multiple fora. Afghanistan: FSAC, HCT, UNCT, Donor Briefings, Regional Dialogue on Food Security and COVID-19 organized by FAO RAP on the World Food Day 2020, and MAIL Technical Directorates. Burkina Faso**:** DGESS/MAAHM, WFP, IMMAP. Haiti: CNSA, FAO, WFP, FSC.

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[3] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP)[4]:

FAO makes significant efforts to comply with the five IASC Commitments to Accountability to Affected Populations in the implementation of its projects. Below there is a description of how AAP have been mainstreamed in this project in the three countries.

In Afghanistan, FAO together with a third-party monitoring (TPM) company, regularly conducted monitoring and evaluation of the intervention. Both parties worked towards reinforcing the quality of the project as well as the organizational accountability. Furthermore, different stakeholders – Directorate of Agriculture, Irrigation and Livestock, the Kuchi Directorate, Community Shuras (Community Development Council and District Development Council) and Community members – were involved in mobilization, beneficiaries' selection and inputs distribution. Specific questions on AAP were included in the TPM data collection tools and the findings were shared with FAO in the form of survey reports.

In Burkina Faso, the targeting method -the community approach according to the HEA criteria- made it possible to target all social strata (men, women, children and people living with a disability). To do this, specific targeting criteria were drawn up and shared with the partners in charge of targeting so that all components of the population, particularly the most disadvantaged, were taken into account. In addition, targeting and complaints committees, made up of resource persons from the site or the sector, were set up in order to fully involve the beneficiaries in the choice of the support.

In Haiti, during the formulation of the project -in collaboration with the Departmental Directorates of Agriculture of the North West and Grande Anse- FAO organized consultations with the Community Based Organizations (CBOs) that represent the populations of the beneficiary communes, for the analysis of their priority needs taking into account the prevalence of food insecurity. Then, at the beginning of the intervention, FAO and its partners informed the administrative and technical authorities and local CBOs about the objective and planned activities. The selection of beneficiaries for all project components was performed in collaboration with the local administrative and technical authorities and heads of the CBOs, while respecting the gender balance. To ensure participation and transparency, in each beneficiary commune, a Joint Beneficiary Targeting Committees was set up and its members were informed of the targeting criteria, giving priority to vulnerable women-headed vulnerable households, vulnerable families with elderly dependents, disabled persons or with children

[3] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[4] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

under 5 years-old suffering from malnutrition. After the selection of beneficiaries, partner NGOs, in collaboration with the Community Based Organizations, Board of Directors of the Communal Section, Communal Agricultural Office and FAO field teams, informed the beneficiaries of the schedule of planned activities (nature, type and quantities of seed or hygiene products to be distributed, training). A post distribution/training monitoring assessment was conducted interviewing a sample of beneficiaries to collect their feedback on the assistance received.

b. AAP Feedback and Complaint Mechanisms:

Afghanistan: FAO and its implementing partner established a Complaint and Feedback Mechanism for this project in the project areas, and regularly responded to the complaints received through either these mechanisms or field visits. AWAAZ Afghanistan – a toll-free Complaint and Feedback System implemented by UNOPS in the country – was also widely communicated to all beneficiaries and partner staff throughout the implementation of the project, during the market baseline assessment before and after the intervention, community mobilization, and beneficiary selection as well as during the distribution of inputs and the provision of trainings. Information on the purpose and how to engage with the system were communicated to beneficiaries both orally and through pamphlets in national languages, ensuring that both literate and illiterate members of the community were reached. Moreover, the TPM prepared specific reports on complaints they registered, and the findings were shared with FAO. There complaints received were about the quantity of inputs: thorough investigations were conducted by the implementing partner and different types of verification documents (photos, community confirmation letters, videos where applicable and other) were provided. Consequently, the cases were closed.

Burkina Faso: The role of the complaints committees, set up by consensus and composed essentially of resource persons from each locality or sector, was to collect complaints and carry out a first level of processing. If complaints would not be resolved at the local level, the project coordination team had to be contacted through the implementing partners and a joint "Implementing Partners and Coordination Team" mission would had to be dispatched to the field to resolve the problems.

Haiti: FAO and its partners set up a Complaint and Feedback Mechanism for the beneficiaries of the project, with the promise to respond to each complaint that might be received. At the start of each activity, the beneficiaries were informed orally and visually (kakemonos/banners displayed) written in Creole language, on how to file a complaint against any person presumed at fault. Heads of CBOs received a telephone number and name of an independent local person, in charge to inform FAO, to be contacted in the event of any problem encountered during the implementation of project activities. FAO also informed the beneficiaries of the confidentiality of the information received and that FAO and its partners were committed to register, analyse and respond to complaints received. No complaints were received.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

In Afghanistan, FAO has settled PSEA committees at Kabul and Regional Offices' levels. These committees also acted as PSEA committees for this project, whose information was shared with all project staff. FAO project management team provided contact cards including their mobile phone number to all beneficiaries to be reached out directly to record and handle any Sexual Exploitation and Abuse related complaints in a confidential way. IEC materials were also distributed. These materials also explained how to contact AWAAZ to report this kind of issues.

FAO Burkina Faso has made a number of training courses mandatory for its staff, including one on Protection from Sexual Exploitation and Abuse (PSEA). Given the importance given to this subject the FAO Representative in the country is the PSEA focal point. In addition to the fact that the memoranda of understanding and contracts signed with partners clearly mention a zero tolerance provision for SEA, every opportunity is used to raise awareness among implementing partners. No complaints were reported during the implementation of the project.

In Haiti, FAO organized Prevention of SEA training for partners staff and local authorities. A PSEA local grievance mechanism was set up. Before starting each activity, beneficiaries and heads of local CBOs were informed on PSEA grievance mechanism and the confidentiality of the information received. A telephone number of the PSEA Focal Point of the United Nations Integrated Office (BINUH) was provided to them so that they could contact him in case of violation of the PSEA rules during the implementation of project activities.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

FAO integrates gender equality issues in its interventions in order to address the needs of women and men of different ages and socio-economic groups in line with the requirements of FAO's Policy on Gender Equality.

In Afghanistan the project assisted 2,859 female headed households and promoted protection messages related to PSEA, GBV and complaints-grievance mechanisms. 2,736 of them received USD 50 each in the form of UCT, while 96 were provided with the livestock protection package consisting of 100 kg of concentrated animal feed as well as deworming medicines for their animals. All of these female-headed households were provided with COVID-19 sensitization information. Furthermore, all distribution of inputs and cash as well as technical training sessions and COVID-19 sensitization sessions were organized at locations and timings convenient for women beneficiaries.

In the Burkina Faso beneficiary selection strategy, clear guidelines were given to the partners in charge of targeting. Therefore, 58% of the project's beneficiaries are female-headed households. Support for poultry and rabbit farming was provided mainly to women to enable them to have income-generating activities as a way to boost women's empowerment.

In Haiti, a crosscutting vulnerability criterion was integrated into the beneficiary targeting criteria to give priority to women heads of vulnerable households. FAO collaborated with the decentralized services of the Ministry for the Status of Women and Women's Rights (MCFDF) in the two departments to ensure that vulnerable women were targeted by project activities. Women and girls heads of households represent at least 52% of the beneficiaries of the project activities.

e. People with disabilities (PwD):

In Afghanistan the project did not focus specifically on persons with disability but considered disability as part of a larger vulnerability-based beneficiary selection criteria. Thus, 679 households headed by persons with disability were selected to receive UCT and the livestock protection package as well as they were provided with COVID-19 sensitization information.

In Burkina Faso, the presence of a person living with a disability was consider a criterion to target these households as project beneficiaries. In this sense, people with disabilities were among the beneficiaries of the Unconditional Cash Transfers provided by the project.

In Haiti, a crosscutting vulnerability criterion was integrated into the beneficiary targeting criteria to give priority to households with a disabled or elderly person. Some associations that regularly assist people with disabilities were involved in the targeting exercise, especially for the activities of urban gardening and Cash+.

f. Protection:

The main protection aspect addressed by the intervention was the prevention and mitigation activities and distribution of personal protection equipment's against the spread of the COVID-19 disease.
In Afghanistan the project prioritized households headed by women and persons with disability through the vulnerability-based beneficiary selection process. Furthermore, all distribution of inputs and cash, as well as technical training sessions and COVID-19 sensitization sessions were organized at locations and timings convenient for women and persons with disabilities beneficiaries. Also, all direct beneficiaries were informed about the FAO PSEA committees, AWAAZ, and complaints-grievances mechanisms through distribution of pamphlets, IEC materials and cards with pertinent contacts' details apart from being informed about the details of inputs and cash distribution (beneficiaries' entitlements) and COVID-19 safety measures. All COVID-19 safety measures were strictly followed at all the inputs and cash distribution sites. Lastly, all project staff including those of the implementing partners were trained on humanitarian principles, AAP, PSEA, rights of beneficiaries, and COVID-19 safety measures apart from distribution of pertinent COVID-PPE to all project staff and direct beneficiaries.

Burkina Faso: one of the first activities of the project was to acquire and provide beneficiaries, partners and FAO staff with COVID-19 kits to protect them from the transmission of the virus. In parallel, training sessions on containment practices and nutrition in the context of COVID-19 were organized for the benefit of beneficiaries and implementing partners.

In Haiti, as explained in sections e. and d. above, the most vulnerable categories at risk i.e. women and girls head of households, disabled and elder people were given priority to receive the project assistance in order to improve their food security and their awareness to face the COVID-19 crisis and in this way reduce their vulnerability.

g. Education:

Even if this project was not designed to address education concerns, the intervention provided time-critical and season-sensitive inputs and cash to vulnerable food insecure households, which enabled the households not to adopt negative coping actions like removing children from school or reducing consumption of nutritious food. Moreover, the sensitization on COVID-19 safety measures including those to be adopted at household, farm, livestock, markets levels, and in general in public spaces; contributed to maintaining an acceptable level of hygiene and thus avoiding illnesses within the households.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
Yes, CVA is a component of the CERF project	Yes, CVA is a component of the CERF project	13,366 households (87,782 people)

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

Afghanistan: FAO and Implementing Partner provided Unconditional Cash Transfer (UCT) to 7,166 landless or marginal farming households (48,382 people), equivalent to 55 per cent of the monthly food basket for a seven-member household as per the Food Security Agriculture Cluster (FSAC) norms. Households headed by women and persons with disabilities were prioritized as direct beneficiaries of this UCT.

In Burkina Faso, the 4,200 beneficiary households (29,400 people) received an UCT worth US$ 56 per household. The amount received per household was intended to enable beneficiaries, whose livelihoods were strained by the restrictions, to immediately meet their basic needs. Follow-up shows that most of the cash was used to purchase food. Given the health context, the electronic transfer modality was preferred. To operationalize this modality, FAO developed Standard Operating Procedures (SOPs). The financial services provider YUP Burkina was selected to manage the electronic transfer operations. In collaboration with the Permanent Secretariat of the National Council for Social Protection, 56 households listed in the Single Register of Vulnerable Persons were included in the list of project beneficiaries and were assisted.

Haiti: FAO and implementing partner provided agricultural inputs and technical support for vegetable production and Unconditional Cash Transfer to 2,000 vulnerable households (10,000 people) living in urban and peri-urban areas of cities of Jeremie and Port de Paix. Each beneficiary received 6,230 Haitian gourdes (equivalent to 100 US$) which is equivalent to 68 per cent of the monthly food basket for a five-member household according the CNSA report (9,130 Haitian gourdes, in December 2020).

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**

Afghanistan: Provision of UCT worth US$ 50 to 7,166 households	48,382	US$ 358,300	Unconditional	Unrestricted
Burkina Faso: Provision of UCT worth US$ 56 to 4,200 households	29,400	US$ 235,113	Unconditional	Unrestricted
Haiti: Cash+ (UCT worth US$ 100 plus agricultural inputs) to 2,000 households	10,000	US$ 200,000	Unconditional	Unrestricted

9. Visibility of CERF-funded Activities

Title	Weblink
@UNCERF supports @FAO in preventing and responding to the impact of #COVID19 on food security in #Afghanistan, #Haiti and #BurkinaFaso	https://twitter.com/FAOemergencies/status/1256940070478548993
A BIG thank you to @UNCERF for supporting @FAO in preventing and responding to #COVID19 outbreak, affecting food systems in #Afghanistan, #BurkinaFaso and #Haiti, already facing huge food crises	https://twitter.com/FAOemergencies/status/1255414014852558848
CERF supports FAO in preventing and responding to the impact of COVID-19 on food security	http://www.fao.org/emergencies/fao-in-action/stories/stories-detail/en/c/1273257/
FAO Afghanistan: Kuchi pastoralists are the most vulnerable group during the #pandemic. Thanks to @UNCERF funded project for ensuring the availability of and stabilizing access to food for the most food-insecure population.	https://twitter.com/FAOAfghanistan/status/1343529035331153920
FAO Afghanistan: 'Magical feed' and facemasks in times of need and pandemic How an FAO project increases the resilience of Kuchi nomadic communities through COVID-19 sensitization and anticipatory action in remote areas of Afghanistan.	https://twitter.com/FAOAfghanistan/status/1355828582342393857 http://www.fao.org/afghanistan/news/detail-events/en/c/1371666/
Afghanistan | Protecting livestock herders and markets in times of COVID-19	http://www.fao.org/emergencies/fao-in-action/stories/stories-detail/en/c/1314500/
Afghanistan | FAO supports agriculture-based livelihoods to mitigate the impacts of COVID-19	http://www.fao.org/emergencies/ressources/photos/photos-detail/fr/c/1332863/
OCHA Afghanistan Brief: COVID-19 No. 38 (23 April 2020) "The global Central Emergency Response Fund (CERF) has released new funding to support FAO Afghanistan (…)".	https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/daily_brief_covid-19_23_april_2020.pdf (page 2)
FAO Burkina Faso: Dans le cadre de la lutte contre la COVID-19, la FAO Burkina a bénéficié d'1 million USD, environ 550 millions de frcs CFA du Fonds (CERF) pour la mise en œuvre du projet «	https://twitter.com/FAOBurkinaFaso/status/1321503097991081986 Facebook of Ouagadougou Town Hall:

Prévenir et répondre à l'impact de l'épidémie de COVID-19 sur la sécurité alimentaire ».	https://web.facebook.com/mairie.ouagaofficiel/posts/2400795190229045 https://web.facebook.com/mairie.ouagaofficiel/posts/2400412546933976
Burkina Faso: Contribution of youth volunteers in raising awareness	https://youtu.be/xsKntfXCLxQ (mention of donors by FAO staff at 5:54)
Burkina Faso: La #FAO a outillé à travers une formation en ligne du 15 au 17 avril 2020, ses partenaires de mise en oeuvre sur l'amélioration du rapportage, l'enregistrement des bénéficiaires et des bénéfices des projets via Kobo, et les mesures de préparation et prévention contre le #Covid_19	https://twitter.com/FAOBurkinaFaso/status/1251169927391842305?s=08
FAO Haiti: La FAO remercie le CERF pour le financement additionnel d'un million de dollars des États-Unis destiné à renforcer son appui au Gouvernement Haïtien afin de prévenir et atténuer l'impact du COVID-19 sur la sécurité alimentaire des communautés rurales vulnérables en Haïti.	https://twitter.com/FAOHaiti/status/1248319023298654208?s=20
FAO Haiti: Ce financement additionnel du CERF va permettre à la FAO d'appuyer le Gouvernement dans la protection des moyens d'existence des ménages agricoles et la mise en œuvre d'activités de prévention et sensibilisation contre la propagation du COVID-19 dans les zones rurales ciblées.	https://twitter.com/FAOHaiti/status/1248320466361544704?s=20
FAO Haiti: La @FAO, en collaboration avec le Ministère de l'agriculture, a fourni des semences et boutures de différentes cultures vivrières à 2200 ménages vulnérables affectés par les impacts du #COVID19 dans la Grand'Anse en vue de renforcer leur résilience. Action financée par @UNCERF	https://twitter.com/FAOHaiti/status/1326956441186553859
FAO Haiti: En collaboration avec le Ministère de l'#agriculture, la @FAO a fourni une assistance en semences et matériels de plantation de cultures vivrières à 2200 ménages vulnérables du département de la Grand'Anse pour les semis d'hiver 2020. Action financée par @UNCERF	https://twitter.com/FAOHaiti/status/1327244564432908292
FAO Haiti: La @FAO a distribué des semences maraîchères et du cash+ à 1000 ménages vulnérables dans la zone urbaine et périurbaine de la ville de Port-de-Paix et leur a fourni un appui technique pour la production de légumes dans des jardins de case. Action financée par l'@UNCERF	https://twitter.com/FAOHaiti/status/1344044956692967425?s=20
FAO Haiti: À date, la FAO a mobilisé 3,75 millions de dollars des États-Unis (fonds propres et fonds CERF) pour apporter une assistance agricole à 30 300 ménages (151 500 personnes) dans le Nord'Est, Nord'Ouest, Nippes et Grand'Anse, et limiter l'impact du COVID-19 sur l'agriculture.	https://twitter.com/FAOHaiti/status/1248321969759625218?s=20
FAO Haiti: Pour renforcer la productivité & compétitivité dans le secteur agricole en Haïti, @FAO prône égalité des sexes dans les systèmes alimentaires respect principe de recevabilité tolérance 0 pour exploitation et abus sexuels	https://twitter.com/FAOHaiti/status/1324747537396486144?s=20
FAO Haiti: Thanks to @UNCERF's generous support, @FAO will improve the food security and nutrition of 4 000 vulnerable households in #Haiti by providing them with seeds, agricultural	https://twitter.com/FAOemergencies/status/1339235825318555648

tools, training, poultry and cash for work: http://bit.ly/3moT0uI #InvestInHumanity #ZeroHunger	
FAO Haiti: Bilan des interventions de la FAO en réponse à la crise humanitaire en 2020 « Ces actions ont bénéficié du support financier (…), du CERF (…) et des fonds propres de la FAO »	http://www.fao.org/haiti/actualites/detail-events/en/c/1367957/
Haiti : COVID-19 et Sécurité Alimentaire : Appui de la FAO au Gouvernement Haïtien pour en atténuer l'impact "(...) un financement additionnel (CERF) dans le cadre du Plan de Réponse Humanitaire des Nations Unies à la pandémie COVID-19".	http://www.hpnhaiti.com/nouvelles/index.php/societe/102-hpn-covid-19/7364-covid-19-et-securite-alimentaire-appui-de-la-fao-au-gouvernement-haitien-pour-en-attenuer-l-impact
Haïti - Agriculture : Appui de la FAO pour atténuer l'impact de l'insécurité alimentaire « (…) Fonds Central d'Intervention d'Urgence des Nations Unies (CERF) pour apporter une assistance agricole à 26,300 ménages (131,500 personnes) dans les Départements du Nord'Est, du Nord'Ouest, des Nippes et de la Grand'Anse ».	https://www.haitilibre.com/article-30574-haiti-agriculture-appui-de-la-fao-pour-attenuer-l-impact-de-l-insecurite-alimentaire.html

PART IV – AGENCY OVERVIEW: IOM

1. STRATEGIC PRIORITIZATION

Statement by the agency focal point:

The strategic and prioritized response funded by the CERF contributed significantly to the timely delivery of life-saving assistance to internally displaced persons (IDPs), host communities and other affected persons including persons with disabilities who were affected by the COVID-19 pandemic in Burundi, Libya, Nigeria and Somalia. The CERF allocation was instrumental in providing life-saving health, Camp Coordination and Camp Management (CCCM), and protection assistance to vulnerable women, men, girls, and boys. From April 2020 to January 2021, IOM was able to contribute to reducing the transmission of the spread of COVID-19, mitigating the humanitarian and health impacts of the outbreak, and ensuring that adequate preventative practices were implemented in camps and camp-like settings and prioritised Points of Entry (POE) in Burundi, Libya, Nigeria, and Somalia.

CERF's Added Value:

CERF funds were made available for humanitarian response at the onset of the pandemic and disbursed within a short time frame after the allocation was made. As a result, IOM was able to launch the intervention in a timely manner, ensuring: the risk of exposure to COVID-19 in camps and camp-like settings was reduced and public health awareness was increased; targeted countries were better prepared and equipped to prevent, detect, and respond to suspected cases of COVID-19; and humanitarian responders had a more comprehensive understanding of the effect of COVID-19 on population mobility.

Did CERF funds lead to a fast delivery of assistance to people in need?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help respond to time-critical needs?		
Yes ☒	Partially ☐	No ☐
Did CERF improve coordination amongst the humanitarian community?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help improve resource mobilization from other sources?		
Yes ☒	Partially ☐	No ☐

Considerations of the ERC's Underfunded Priority Areas[5]:

This action aimed to integrate gender and inclusion in its interventions to maintain the dignity of affected populations. IOM ensured that sensitization of gender-based violence was incorporated throughout the response through targeted messaging to all community groups. Furthermore, IOM made certain that its response prioritised safety and dignity and delivered activities to vulnerable populations including the elderly, persons with special needs, and people with disabilities. For example, IOM made sure that persons with specific needs, including Persons with Disabilities as well as women and girls, were actively involved in community consultation meetings and information sharing sessions.

[5] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
IOM	20-RR-IOM-011	Health - Health	1,485,001
IOM	20-RR-IOM-011	Camp Coordination / Management - Camp Coordination and Camp Management	891,000
IOM	20-RR-IOM-011	PROTECTION - PROTECTION	324,000

2. OPERATIONAL PRIORITIZATION:

People Directly Reached:

Figures for Output 1 were derived from the camp population in the targeted IDP sites in Nigeria, and the host communities' numbers were based on IOM's Displacement Tracking Matrix (DTM) data. IOM reached a larger number of IDP sites than planned due to programme interventions being extended to additional sites managed by its implementing partners. To calculate the overall number of beneficiaries under Output 2, project targets from target countries (Burundi, Libya, and Somalia) were aggregated bringing the total number of persons targeted to 398,060. The significantly higher figure of people reached (652,066) than planned was due to the reorientation of providing support in POCs to POEs in Burundi which expanded the project's reach to all the existing POEs, as well as the distribution of personal protective equipment (PPE) donated by IOM by the state-level Ministry of Health in Somalia to POEs in catchment areas who were facing critical shortage.

People Indirectly Reached:

Populations of the targeted areas in the above-mentioned countries indirectly benefitted from IOM assistance. This included displaced populations in IDP camps and host communities in targeted areas in North-East Nigeria, as well as communities living in the cross-border areas in Burundi, Libya and Somalia, and those within central regions in Burundi covered by POE and awareness raising activities (please see Section 5 below for additional details).

PART V – PROJECT OVERVIEW: IOM

Project Report 20-RR-IOM-011

1. Project Information

Agency:	IOM	**Country:**	Multi-country
Sector/cluster:	Health - Health Camp Coordination / Management - Camp Coordination and Camp Management Protection - Protection	**CERF project code:**	20-RR-IOM-011
Project title:	Multi sectoral humanitarian assistance to prevent and respond to COVID-19		
Start date:	06/04/2020	**End date:**	05/01/2021
Project revisions:	No-cost extension ☐ Redeployment of funds ☐	Reprogramming ☐	

Funding

Total requirement for agency's sector response to current emergency:	**US$ 100,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 10,195,532**
Amount received from CERF:	**US$ 2,700,001**
Total CERF funds sub-granted to implementing partners:	**US$ 0**
Government Partners	US$ 0
International NGOs	US$ 0
National NGOs	US$ 0
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through this CERF Rapid Response grant, IOM was able to contribute to reducing the spread of COVID-19, mitigating the humanitarian and health impacts of the pandemic, and ensuring that adequate preventative measures were implemented in camps, camp-like settings, and prioritized POEs in Burundi, Libya, Nigeria, and Somalia.

Burundi

During project implementation, IOM in Burundi provided transportation fees to 81 health screeners, trained 180 health screeners stationed at 35 POEs, and supported two services (MoH's Emergency Service and Migration Service) from the Central Level coordination mechanisms with capacity building and operational equipment. A total of 358,020 travellers crossing the borders were screened, and 1,560 community members were supported through a 109 hotline with guidance and information on COVID-19.

Furthermore, IOM in Burundi supported the government through the creation of an operational committee on POEs designed to coordinate and align interventions at POEs and the enhancement of the capacity of POEs and frontline workers to operate in compliance with Infection and Prevention Control (IPC) standards and the International Health Regulation (IHR 2005).

While the project successfully supported health and immigration services at the 15 POEs initially targeted, where traffic is estimated at 150,000 travellers per month (including the international airport), the project's reach expanded to all the existing POEs in the country, with

20 additional POEs supported (in accordance with the 35 mentioned above). To enable surveillance based on data collection and information-sharing, 30 POEs were provided with tablets.

Libya

IOM, in collaboration with the National Centre for Disease Control in Libya, enhanced the preparedness level of three POEs (Ras Jedir, Wazin crossing points, and Misrata Airport) to better prevent, detect and respond to COVID-19 in line with the IHR. To ensure appropriate referral mechanisms, three health facilities near the POEs with isolation centres were strengthened to serve as first level responders for suspected COVID-19 patients referred from Misrata, Wazin and Ras Jedir POEs, and equipped with all necessary PPE, medicines and medical equipment enabling the screening and referrals of positive COVID-19 cases of 129,061 travellers.

IOM also completed interventions in four migrant detention centres (Abusliem, Shara Zawaiya, Triq al Sika, and Zliten) through the provision of PPE, rehabilitating and installing Water, Sanitation and Hygiene (WASH) infrastructures and facilitating the improvement of hygiene practices in detention centres managed by the Directorate for Combatting Illegal Migration (DCIM). To enhance COVID-19 preparedness and response efforts in detention centres, IOM in Libya distributed PPE comprising 200 boxes (50 pieces in each) of protective masks, 3,000 pairs of protective gloves, 150 protective suits, 150 googles, 2,700 hand sanitisers and 120 disinfectants to the detention centres, with a total estimated population of 1,393 migrants. Additionally, IOM facilitated the maintenance of a desalination water system with a capacity of 8,000 litres per day at Triq al Sika detention centre to respond to the urgent need for clean water in the facility. Furthermore, IOM facilitated WASH rehabilitation and maintenance activities at the Zliten detention centre to improve minimum living standards for detained vulnerable migrants and to help stop the spread of COVID-19 and other common infectious diseases such as scabies, among others. IOM financed 49 per cent of the critical rehabilitation and maintenance work at the detention centre through CERF funding. Notable WASH rehabilitation work conducted at the detention centre included the installation of a water purification system with a capacity of 8,000 litres per day, ventilation fans, water taps and shower sets.

Lastly, under this project, IOM's DTM team implemented dedicated mobility tracking exercises to collect systematic data on mobility restrictions in all regions of Libya, covering major points of entry and migration routes.

Nigeria

This project strengthened COVID-19 preparedness and response efforts across IOM's CCCM efforts, reaching a total of 458,759 individuals in internal displaced persons (IDP) sites and in host communities in Adamawa and Borno states in north-east Nigeria. Moreover, 90 twin-roomed Self Quarantine Shelters (SQS) were constructed in 12 local government areas (LGAs) during the reporting period. Funds received under this project enabled site preparation for SQS construction, including drainage improvements.

In addition, IOM conducted risk communication and community engagement (RCCE) through the dissemination of information, education and communication (IEC) materials, sharing of key health and WASH messages, and awareness-raising sessions on preventive measures for COVID-19. All these activities were guided by health and WASH partners and followed Government of Nigeria policies in relation to COVID-19. Site level and LGA level referral mechanisms were strengthened through mapping of available health services for the IDPs specific to COVID-19.

Overall, 48,000 individuals benefited from the WASH component in Borno and Adamawa states. IOM contributed to improved access to safe and functional sanitation facilities in camps through the repair of broken water systems, chlorination of water points/handwashing stations, repair of latrines, and daily care and maintenance of sanitation facilities as well as the desludging of full latrines. IOM also installed additional hand washing stations in all entry points and focal areas in the camps and host communities.

Somalia

IOM in collaboration with the Ministry of Health (MoH), strengthened the capacity of 167 frontline health workers/screeners and border officials (115 males and 52 females from Jubaland, Southwest State, Somaliland and Puntland) on COVID-19 screening, detection and referrals. Additionally, IOM in coordination with the Federal MoH and states MoH selected seven priority POEs across the country in Banadir, Jubaland, Puntland, Southwest State, and Somaliland and supported these POEs with PPE and IPC materials including masks,

gloves, and soap. The PPE and IPC material were donated to the state-level MoH and distributed to the priority POEs. Since there was a critical shortage of PPE and IPC material at other POEs in the catchment area of the seven priority POEs, the MoH on state-level decided to distribute a part of the PPE and IPC material to 14 additional POEs. Through this, a total of 21 POEs (Banadir, Jubaland, Puntland, Southwest State, Somaliland Galmadug, and Hirshabelle) were equipped with highly needed PPE and IPC supplies.

In coordination with the states' MoH, IOM supported monetary incentivization of 32 MoH-nominated POE health screeners and Regional Coordinators/data persons (21 males and 11 females) in priority POEs from Jubaland (Kismayo, Dollow, Dhobley) and Southwest state (Baidoa and Hudur). A total of 161,574 persons (96,807 males and 64,767 females) were screened at the supported POEs. In addition, in collaboration with the MoH, IOM provided support to three ambulances for transportation of travellers with suspect COVID-19/with COVID-19 symptoms from POEs to the designated isolation/ referral hospitals in Jubaland, Southwest state, and Somaliland. IOM paid for the cost of vehicle rental with a driver, and also covered the maintenance and fuel cost at each location.

IOM also provided support to the De Martino Hospital in Mogadishu, identified as a quarantine and isolation facility for COVID-19 cases within the national response plans. The support included the distribution of PPE and IPC materials to increase the capacity of the facility to respond to COVID-19 cases and mitigate disease spread.

3. Changes and Amendments

Burundi

The project activities were achieved during the COVID-19 outbreak in Burundi, even with the temporary closure of borders, the 2020 Presidential election period, the demise of the sitting president, and the establishment of a new government with a new, significantly altered, COVID-19 response strategy.

The MoH called for strengthened support for POE preparedness and response capacities marked by the occurrence of imported cases (the majority of new cases in Burundi), rather than to the Points of Control (POCs) between provinces, as initially planned. Therefore, in line with the MoH's strategy, IOM Burundi re-oriented the implementation of five checkpoints towards equipping five additional entry points with PPE, office equipment, IT equipment, solar electricity, motorcycles, hand sanitizers, thermoflashes, etc., although this modification did not require a project revision request as it did not result in changes in the objective or budget line items (same equipment needed for POEs).

Additionally, the eight COVID-19 response pillars were under the overall coordination of the MoH's emergency department, significantly delaying implementation. As a result, IOM supported the establishment of a POEs Pillar Committee to coordinate and align all interventions pertaining to POEs and cross-border coordination. This was not initially planned but was required to ensure an appropriate response to COVID-19, gathering all stakeholders involved in POE preparedness and response.

Libya

The initial plan was to establish a prefabricated isolation unit in Misrata airport, as Misrata was operational while the main international airport, Mitiga international airport, was closed due to active conflict. IOM had just started interventions there when, on 3 August 2020, the Misrata airport was set on fire, flights cancelled, and authorities discussed whether to demolish or refurbish the existing structure of the airport.

In the meantime, the main airport of the country, Mitiga international airport, re-opened and, upon government request, IOM shifted the intervention under this project to Mitiga airport and proceeded to establish a prefabricated isolation unit there.

No deviations were made from the original proposal. A delay in procurement of additional PPE for the three detention centres caused underspending in that budget line, however, funds available for three POEs were fully utilized, and all targets were achieved accordingly.

Nigeria
IOM completed the SQS units ahead of schedule, partially due to the support received from the federal MoH, state authorities and local authorities, most notably in identifying suitable land for construction. However, during the implementation period of the project, no patients were admitted into the SQS constructed under the project. This can mainly be attributed to the fact that there were very few COVID-19 cases reported in the IDP camps. However, the SQS remain available and operational to address occurring needs under any potential outbreak in the coming months.

IOM reached a smaller section of the host population with public information campaigns than initially planned. There was streamlining of tasks in the CCCM Sector Working Group in relation to public information campaigns for COVID-19. IOM efforts were concentrated in IDP camps because of its leading camp management role, while other partners took the lead in most of the host communities.

IOM reached a larger number of IDP sites than planned because programme interventions had been extended to additional sites managed by its implementing partners. One additional site was set up during the implementation period of the project.

Somalia
Delayed appointments followed by the change of the national and state POE focal persons by the MoH and the virtual meetings/communication between IOM and MoH has been a challenge. This affected the initiation of activities and decision making for example on trainings of the POE health workers and border officials there was no MOH focal persons both at FMoH and State levels to support and endorse the selection of the POE health workers / borders officials to be trained and the selection of priority POEs to be supported through donation of PPE. To address this, IOM held several virtual coordination meetings with the MoH and finally, a POE coordinator was appointed after the inception of program activities. Unfortunately, in November 2020, there was another change within the MoH and a new POE coordinator was appointed. IOM continued to work closely with the MoH POE focal point to implement program activities.

Furthermore, the restriction of movements including the cancellation of local flights between March and July 2020 meant that some selected POE staff from remote and highly insecure areas were not able to travel and attend the planned program trainings. Once flight restrictions were lifted, additional trainings were planned and conducted.

Additionally, security issues resulted in the inability of IOM to physically be present to support training for POE frontline health workers and immigration officials in a few locations of the targeted states (including Hudur in South West State). For both lockdown and security issues that restricted movements of participants to major towns, IOM coordinated and managed to support in situ trainings through local MoH appointed training of trainers (TOT) trainers for areas like Hudur.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Camp Coordination / Management - Camp Coordination and Camp Management									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	105,000	90,000	165,000	140,000	**500,000**	112,571	89,521	136,861	118,758	**457,711**
Host communities	63,000	54,000	99,000	84,000	**300,000**	189	142	413	304	**1,048**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**168,000**	**144,000**	**264,000**	**224,000**	**800,000**	**112,760**	**89,663**	**137,274**	**119,062**	**458,759**
People with disabilities (PwD) out of the total										
	75	50	35	55	**215**	**258**	**190**	**244**	**204**	**896**

Sector/cluster	Health - Health									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	2,916	6,318	194	292	**9,720**	0	0	0	0	**0**
Internally displaced people	41,855	58,275	5,170	7,200	**112,500**	0	0	0	0	**0**
Host communities	100	100	20	20	**240**	65,688	97,645	0	0	**163,333**
Other affected people	102,195	143,705	12,415	17,285	**275,600**	154,012	286,706	23,274	24,741	**488,733**
Total	**147,066**	**208,398**	**17,799**	**24,797**	**398,060**	**219,700**	**384,531**	**23,274**	**24,741**	**652,066**
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

Sector/cluster	Protection - Protection									
	Planned					**Reached**				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**0**	**0**	**0**	**0**	**0**	0	0	0	0	**0**
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	0	0	0	0	**0**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

Burundi

Through the establishment of waiting areas and the dissemination of IEC materials at 35 POEs, the project indirectly reached 358,020 travellers crossing borders in an improved and safer manner, limiting their exposure to communicable diseases through the establishment of waiting areas according to IHR requirements, in which distance was maintained between passengers and suspected cases could be isolated. Additionally, border communities and vulnerable migrants benefited as the project addressed humanitarian needs of vulnerable stranded migrants solving the issue of migrants left in border areas, without shelter or other measures for protection, exposing themselves and nearby border communities to the contamination of diseases such as the Ebola Virus Disease (EVD) or COVID-19, as well as the potential to be infected by and transmit other communicable diseases such as cholera. With the support provided to the testing campaign, a total of 38,445 Burundians were tested for COVID-19, resulting in 324 positive cases detected and redirected to the designated treatment centres.

Libya

In the POEs, 129,061 individuals (and their families as indirect beneficiaries) benefited from primary and secondary screening triage mechanism in place in the three POEs.

In addition, DTM's information products – including the ones published under this report – were shared with a mailing list of over 500 readers. Apart from the mailing list, DTM's reports and studies were published on the DTM website and received several hundred clicks each.

Nigeria

IOM also included host communities adjacent to IDP sites in its targeting during public information campaigns for COVID-19 because IDP sites that had no reported COVID-19 cases still depend on safe practices in adjacent host communities. IEC materials were also distributed in these host communities.

Somalia

A total of 231,393 persons were reached through COVID-19 awareness raising and sensitization sessions providing key messages within the surrounding catchment areas.

6. CERF Results Framework

Project objective	Reduce the spread of COVID-19, mitigate the impact of the outbreak and ensure that adequate preventative measures are implemented in camp and camp-like settings and prioritized points of entry (POE)
Output 1	The risk of exposure to COVID-19 of the camp population is reduced and public health awareness is increased

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Camp Coordination / Management - Camp Coordination and Camp Management			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	# of displacement sites reached with hygiene promotion activities and sensitization	80	90	IOM Weekly Sitreps; CCCM Sector Working Group Site Tracker Reports
Indicator 1.2	# of WASH facilities repaired and maintained in camp and camp-like settings	1,200	1,200	IOM WASH program weekly reports, pictures from the field. Field reports. IOM WASH

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

				Knowledge, attitude, and practice (KAP) survey report
Indicator 1.3	# quarantine facilities constructed, managed and maintained in camp and camp-like settings	90	90	IOM Construction Service Completion Reports.
Explanation of output and indicators variance:		IOM reached a larger number of IDP sites than planned because programme interventions had been extended to additional sites managed by its implementing partners. One additional site was set up during the implementation period of the project.		

Activities	**Description**	**Implemented by**
Activity 1.1	Produce and distribute IEC materials and conduct hygiene promotion activities and sensitization	IOM
Activity 1.2	Repair and maintain water and sanitation facilities in camps	IOM
Activity 1.3	Construct quarantine/isolation centres sites in camps and camp-like settings	IOM

Output 2	Targeted countries are better prepared and equipped to prevent, detect and respond to suspected cases of COVID-19

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health - Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	# of temporary quarantine/isolation facilities established and/or supported at POEs	5	22	Deeds of donation (DoDs)
Indicator 2.2	# of POEs/POCs, including disembarkation points, supported with sufficient equipment and material, including PPE	24	59	DoDs
Indicator 2.3	# of detention centres with increased WASH facilities	2	2	IOM field reports
Explanation of output and indicators variance:		IOM in Burundi was able to achieve more than what was initially targeted due to the reorientation from POCs to POEs which expanded the project's reach to all the existing POEs. Additionally, IOM in Somalia supported 21 priority POEs with PPE and IPC materials. At first, 7 priority POEs were selected by IOM in coordination with the Federal MoH and the states MoH to be equipped with essential materials. IOM donated these materials to the state-level MoH, who used a rationalization process to distribute a part of these materials for 14 additional POEs in the catchment areas who were facing a critical shortage of PPE. Through this, more POEs with limited resources and equipment were supported with essential supplies in a period where the country was experiencing high demands and needs with critical shortages of PPE and IPC materials at the POEs for COVID-19 response.		

Activities	**Description**	**Implemented by**

Activity 2.1	Support frontline border health workers on screening and IPC	IOM
Activity 2.2	Procure equipment and materials for POEs, isolation or quarantine facilities at POEs	IOM
Activity 2.3	Improvement of WASH facilities in Detention Centres	IOM

Output 3	Humanitarian responders have a more comprehensive understanding of the effect of COVID-19 on population mobility to, from and within Libya.

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Protection - Protection			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	# of mobility restriction dashboards published	8	8	Dashboards published
Indicator 3.2	Frequency of country DTM COVID-19 information packages on mobility trends impacted by COVID-19 in Libya	Bi-monthly	4	Mobility restrictions analysis published
Indicator 3.3	# of rapid assessment reports published	4	4	rapid assessment reports published
Explanation of output and indicators variance:		n/a		

Activities	**Description**	**Implemented by**
Activity 3.1	Map restrictions COVID-19 crisis, covering both cross-border travel restrictions and internal mobility restrictions in Libya	IOM
Activity 3.2	Tracking and monitoring IDPs, returnees and/or migrants mobility trends in Libya	IOM
Activity 3.3	Conduct rapid assessments to identify critical barriers to required assistance triggered by COVID-19 related measures and availability of services in Libya	IOM

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[6] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

[6] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

a. Accountability to Affected People (AAP) [7]:

Burundi

IOM ensured to address the suffering and the humanitarian needs of vulnerable migrants crossing the borders and those living in border areas, with particular attention to vulnerable migrants finding themselves stranded in border areas without shelter, other measures of protection or basic dignity, awaiting transfer to quarantine areas. Activities were gender-responsive and ensured that equal opportunities and activities were provided for, and pertained to women, men, boys, and girls so as not to reinforce existing inequalities. To the extent possible, gender parity was sought in ensuring equal participation in the Committee, the National Contingency Plan development process, in the provision of equipment and support to health screeners.

The project activities indirectly benefited various categories of people living in the targeted areas; host populations, border communities living in the cross-border areas of the targeted provinces and IDPs (within host communities), through the waiting areas established at the POEs designed to ensure enhanced monitoring and detection of COVID-19, hence helping protect additional persons from COVID-19 infection. Additionally, data collection and timely information-sharing in the communities by community health workers (CHW) where IDPs and other vulnerable communities resided, enabled health districts to provide appropriate assistance whenever suspected cases were flagged.

Libya

The interventions of strengthening the triage mechanism at POEs and nearby health facilities' isolation centres supported all individuals irrespective of their vulnerability status. The project activities were fully adherent to do-no-harm principles, non-discrimination, zero tolerance for sexual abuse, principled humanitarian action, protection, and data protection. IOM honoured its operational commitment and objectives by ensuring continuous monitoring through the deployment of staff to the project activity site and regular assessments. IOM engaged all the stakeholders from the planning phase till the final execution of the activities and shared basic information with partners, governments, donors and other stakeholders through bilateral or sectoral meetings and by sharing weekly, biweekly, and monthly updates. IOM also acknowledged complaints and relevant feedback (as appropriate) in a timely manner, promoted collective approaches to AAP, referral pathways, and the protection of personal data of affected populations when collaborating with implementing partners, cluster members and operational partners within Humanitarian Country Teams (HCTs). Finally, IOM engaged in dialogue with donors to strengthen coordination with partners and promote the necessary flexibility to be able to adjust programmes according to the feedback and views of affected populations and communities.

IOM conducted needs assessments before intervening in migrants in the detention centres, to ensure that the interventions upheld international standards when dealing with migrants.

Nigeria

In the introductory phases of the project, IOM designed its assessment methodology with religious, cultural, and social norms and practices of the affected populations in mind. AAP structures, specific to the North East Nigeria context, were strengthened during the project implementation period. IOM implemented measures that were sensitive to the COVID-19 pandemic in gathering the views of the affected populations. Additional measures such as voice recorders were successfully implemented for sections of the population with literacy challenges. Activities were enhanced in accordance with outcomes from post-intervention surveys conducted with previous beneficiaries. AAP mechanisms were utilized to collate feedback on the response and inform project monitoring and implementation activities. Additionally, post distribution survey and monitoring reports were produced following the implementation of proposed activities. IOM made sure that Persons with specific needs, including Persons with Disabilities as well as women and girls, were involved in community consultation meetings and information sharing sessions.

Somalia

[7] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

The project was implemented in partnership with regional health authorities, who were engaged in the coordination and implementation of the activities. Health authorities were informed of the progress achieved throughout the project. Staff from the MoH were engaged in all project activities, which helped ensure quality control and continuity. Beneficiaries and target populations were consulted about the intervention and its progress through regular field visits. Attention was paid to engaging diverse beneficiaries, including local authorities, community leaders and members of vulnerable groups - such as IDPs, women, elderly persons, and persons with disabilities. Feedback was used to focus activities on addressing key needs and gaps in project implementation, which is in line with the Inter-Agency Standing Committee (IASC) principle of actively seeking the views of affected populations to improve policy and practice.

Furthermore, IOM field teams provided weekly updates and data showing beneficiaries served, allowing IOM's health management team and other partners to review progress and address any gaps. This ensured quality assurance and oversight of project implementation.

b. AAP Feedback and Complaint Mechanisms:

Burundi

IOM Burundi's implementation team conducted monitoring and evaluation of field missions during and after the implementation period, to ensure compliance with accountability. Additionally, the 109 Hotline number was posted on IEC produced for the POEs as the focal service to receive feedback or provide information on COVID-19. Populations were also sensitized on the use of the Hotline 109 to report events, and also provide their feedback on the situation and interventions. Furthermore, IOM staff regularly solicited information from community leaders, POE officials, and CHW.

Libya

As part of the 2019 Libya Humanitarian Response Plan (HRP) and on behalf of the HCT, the Emergency Telecommunications Sector (ETS) implemented a Common Feedback Mechanism (CFM) in connection with the delivery and impact of humanitarian assistance programs in Libya. The CFM takes the form of a toll-free, country-wide number that affected populations can call to obtain information on humanitarian assistance programs, submit their feedback and receive referrals to the humanitarian organizations that are best suited to handle their issue(s). IOM in Libya is part of the CFM and contributes to raising awareness about its services among migrant populations.

Nigeria

IOM received regular feedback from the targeted population during the implementation of the project. IOM relied to a large extent on feedback relayed through camp management committees during the lock down period when there was restricted access to the IDP camps. Affected populations provided feedback or submitted complaints through suggestion boxes or other elements of the existing community-based complaint and feedback mechanism, managed by the IOM CCCM teams. IOM temporarily suspended complaints and feedback mechanisms that involved significant human contact as part of COVID-19 preventative measures. During the period, those mechanisms/ tools requiring less human contact were used, such as suggestion boxes. Feedback and complaints were shared with other agencies in full observance of IOM`s data protection principles and standards, for their action. All complaints and feedback received were recorded in an online database for ease of tracking and referral. Protection related cases were handled directly by the Protection unit and referred to responsible protection agencies.

Somalia

A hotline number was provided in the local language and easily visible posted at strategic POEs billboards and posters. MoH/ Immigration and Naturalization Directorate (IND) was the focal point in managing the numbers, receiving and addressing the calls and responding to the calls. Furthermore, IOM field monitors regularly solicited information from the communities during the field visits, leveraging the community health committee structures.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

IOM has a mandatory Instruction: Policy and Procedures for Preventing and Responding to Sexual Exploitation and Abuse, which binds staff members to standards of behaviour when working with beneficiaries, including during emergency response. All staff members globally are required to take an online course on PSEA.

Sexual exploitation and abuse of affected populations constitute gross misconduct and are grounds for disciplinary action, including summary dismissal and referral for criminal prosecution. In addition to IOM's PSEA Instruction and the Standards of Conduct, IOM has also made PSEA commitments that include inter-agency coordination to prevent and address SEA incidents that may occur.

Gender Based Violence (GBV) and SEA risks were minimized in camps/ camp like settings through messaging targeting all community groups, POE staff were trained to handle the travellers/beneficiaries with dignity and ensure the safety of all travellers. Female POE staffs were also present at the POEs to support the screening of female and child travellers.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

Burundi

In collaboration with involved ministries, IOM ensured that the equipment procured would benefit equitably female and male immigration and health officials. It was agreed with both ministry representatives that the equipment will be distributed equitably to females and males – taking into consideration that gender balance in these sectors is difficult to ensure but distribution is equitable, and participation in consultative meetings actively seeks gender parity.

Considering the role of women in caregiving, they are considered one of the most affected groups in the event of an outbreak. Following an analysis of cross-border dynamics related to the EVD, women were identified as highly at risk considering their involvement in petty trade across the borders mostly on items such as food and clothes. Thus, this overall implementation positioned women as a key target for community engagement following the lessons learned from the EVD preparedness phase in Burundi and per response in the Democratic Republic of the Congo (DRC).

Libya

The project met vulnerable migrants' essential needs and made them accessible through the provision of basic WASH infrastructure such as rehabilitation of sanitary facilities, installation of ventilation fans, and electric generators to ensure a constant supply of power in the facility, and installation of doors and window fitted with locks to ensure the safety of migrants. Gender segregation was taken into consideration during the design of the rehabilitation work in the detention centres, with separate sanitary facilities, toilets and sleeping areas for males and females (children below 10 years are usually included with females).

Nigeria

The project ensured that the unique needs of women and girls were referred to various service providers through camp management teams. Women were incorporated into camp governance structures, which helped to articulate the concerns of women and girls to humanitarian actors. The teams of community-based animators, who were selected from the IDP community, were gender balanced. This contributed to empowering women and amplifying their voices throughout the programme implementation. IOM also deployed gender-balanced hygiene promotion teams to effectively engage/empower women and girls, given a similar understanding of their unique hygiene needs. IOM ensured that women and girls were also targeted in sensitisation sessions for COVID-19. Separate sessions were held for women and girls to ensure effective information sharing with this group which makes up more than 60 per cent of this displaced population.

Somalia

In the IOM-supported trainings and support to POE frontline health workers/screeners and border officials, 31 per cent of those trained constituted female staff members (52 females out of the total 167). In terms of POEs screeners incentivized, 34 per cent were female (11 females out of the 32 staff) to ensure that female beneficiaries would feel more comfortable talking to them and also provided a feedback mechanism where the female beneficiaries can reach out to.

e. People with disabilities (PwD):

Burundi

During the massive testing campaign, IOM through the POE weekly meetings with MoH, advocated for the inclusion of people with disabilities among the priority group of people. All the infrastructures installed at the level of the POEs considered the conditions of PwDs to ensure that all areas are easily accessible.

Libya
There were no reported cases of migrants living with disabilities in detention centres and individuals supported at POEs during the implementation of this project.

Nigeria
All the site improvement and repair activities conducted under this action aimed at ensuring accessibility across sub-groups with special needs. Needs of PwDs were accounted for in the design as well as repair of latrines and showers through the installation of handrails (outside and inside latrines and showers). The unique needs of PwDs were captured in assessments and all subsequent interventions took full consideration of their needs. This was also achieved through a camp committee for persons with specific needs, ensuring that PwDs contributed to all decision making at the site. PwDs were also included in information sharing sessions. All community consultation meetings ensured that PwDs were represented. Messaging through mobile devices also considered strategic locations that could reach all sections of the population including PWDs. Distributions also considered the mobility concerns of PwDs and communities facilitated the registration of PwDs for assistance and delivery of assistance materials for PwDs.

Somalia
Prioritization of those who could not stand in line for longer periods, such as older persons, persons with disabilities, children, pregnant and lactating women, was put in place during screening so that they needed to wait for shorter periods.

f. Protection:

Burundi
IOM ensured that protection was considered through the distribution of PPE equipment, screening material and established waiting areas at border points to ensure COVID-19 measures were respected at all POEs equipped. The material and equipment provided ensured health and immigration staff at the borders were protected and equipped to screen and identify potential COVID-19 cases thus mitigating the risk of transmission of COVID-19 amongst themselves, but also amongst travellers, including vulnerable migrants crossing the borders

Libya
IOM monitored protection risks throughout the implementation of this project given the large number of men, women and children who are vulnerable to violence and exploitation, particularly migrants in detention centres. The persons affected and at risk had been considered in the whole project implementation cycle period. All the passengers were screened as per protocol. Strengthening of POE clinics, placement of medical doctors, and awareness sessions facilitated support to suspected COVID-19 patients. Availability of timely referrals and strengthening of nearby health facilities having isolation centres further ensured the protection level of suspected COVID-19 patients. Strict adherence to the policy of notifying the COVID-19 case only to relevant authorities according to international health regulations protected the suspected or confirmed patients and their families from any possible stigma or discrimination.

Nigeria
IOM ensured that its response under the project was provided in a way that avoided any unintended negative effects and was delivered according to needs; prioritized safety and dignity, grounded in participation and empowerment of local capacities. IOM ensured that all the interventions implemented under this project ultimately held IOM accountable to affected populations. IOM achieved this by paying special attention to vulnerable families with elderly, PwD, persons with special needs, etc. IOM has protection staff who are mandated to ensure the incorporation of protection principles across the IOM emergency portfolio and these staff were active through the project cycle ensuring that all IOM interventions and actions preserved the safety and dignity of targeted communities. For instance, WASH repairs addressed protection concerns, i.e., by including locking mechanisms for doors (latrines and showers) and privacy screens (latrines and showers) and ensuring sex disaggregation (latrines and showers).

Somalia
Trainings on COVID-19 screening, detection and referrals including IPC were conducted to strengthen the capacity and skills of POE frontline health workers/border officials to screen, identify and refer people with COVID-19 symptoms for further management. The

increased knowledge enabled the staff to handle the travellers/beneficiaries with dignity and provided safety through utilising PPE, therefore minimizing exposure to themselves and the travellers thus causing no harm. IOM also supported ambulances to be used for transportations of people with COVID-19 symptoms to designated isolation/ referral hospitals/facilities. Female staff members were also trained and supported to ensure that female travellers were at ease during the screening. Female POE staffs were also present at the POEs to support the screening of female and child travellers.

g. Education:

n/a

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	n/a

9. Visibility of CERF-funded Activities

Title	Weblink
Burundi	
Donation of material and equipment to MoH (Nov 2020)	https://www.facebook.com/103811660139040/posts/682557922264408/
Validation of the operational plan for compliance with IPC standards (Aug 2020)	https://twitter.com/IOMBurundi/status/1296096101783699456?s=20
Needs assessment of POEs bordering the United Republic of Tanzania (Aug 2020)	https://twitter.com/IOMBurundi/status/1290635126196580352?s=20
Libya	
PPE and Medicine (Nov 2020)	https://twitter.com/IOM_Libya/status/1332308057448087555
Prefabs, furniture and medical equipment (Oct 2020)	https://www.facebook.com/IOMLibya/posts/1806047026222913
Mobility Restriction Dashboard 3 (May 2020)	https://migration.iom.int/reports/libya-%E2%80%94-mobility-restriction-dashboard-3-7-may-2020
COVID-19 Mobility Tracking 1 (May 2020)	https://migration.iom.int/reports/libya-%E2%80%94-covid-19-mobility-tracking-1-16-may-2020
Mobility dashboards on social media (May 2020)	https://twitter.com/IOM_Libya/status/1258864408345935883 https://www.facebook.com/IOMLibya/posts/1652704234890527
Nigeria	

Key messages on COVID-19 prevention messages (Mar 2020)	https://www.instagram.com/p/CM4f9XtFTxW/?igshid=1gx5a72os43c9 https://twitter.com/iom_nigeria/status/1375426888651378692?s=21
Testimonial	https://nigeria.iom.int/stories/fighting-covid-19-together
Somalia	
Screening at POEs (Dec 2020)	https://twitter.com/UNCERF/status/1338453687337795586?s=20
PPE Supplies (Apr 2020)	https://twitter.com/IOM_Somalia/status/1250767971737391104

PART VI – AGENCY OVERVIEW: UNDP

1. STRATEGIC PRIORITIZATION

Statement by the agency focal point:

UNDP decided to use the allocation from the CERF towards the procurement of PPE and other-COVID related equipment as a way to support health workers responding to the immediate life-saving and prevention efforts being undertaken by national and local authorities and partners in countries that appealed for funds through the GHRP. In total, UNDP identified 11 countries that had planned to support national and local authorities with the IIR masks and ventilators.

UNDP exploited its existing capacity in health procurement and supply chain management through its global procurement architecture – which had been built to deliver large-scale health programmes for the Global Fund and other partners in support of local Health authorities. This is ever more important in crisis and fragile contexts where health systems are inherently weaker and in some parts of the country that are at greatest conflict risk, often non-existent.

UNDP chose to procure masks and ventilators in Afghanistan, Bangladesh, Burkina Faso, Burundi, Cameroon, Chad, Ethiopia, Mali, Nigeria, South Sudan and Venezuela. In these countries UNDP collaborated closely with the Ministries of Health, local authorities and partners, as well as with other UN agencies in order to deliver the PPE and ventilators to the front-line workers and institutions.

CERF's Added Value:

UNDP's decision to procure health material was done specifically to ensure the fast delivery of assistance, using the existing in-house capacity in health procurement and supply chain management. While still hampered by the uncertainties in the global markets due to the pandemic, UNDP was nevertheless successful in providing masks in 7 countries and ventilators in 5 countries.

Needless to say the choice of masks was imperative and time critical, for UNDP to support front line workers in health facilities and other critical projects – for them to continue to operate in the midst of the pandemic and global shutdown. Equally importantly, it was clear that most crisis countries where UNDP was assisting government health efforts were severely lacking ventilators in relation to the size of their population. CERF funds were used to procure ventilators as part of a wider ventilator purchase and distribution.

In some instances, for example in Cameroon, the CERF-funded masks were distributed through key UN and NGO partners that allowed them to continue operating throughout the pandemic. In all cases where the masks were given to the local health officials, this contributed to the Government's ability to respond and coordinate the pandemic response and other health challenges.

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

Yes ☒ Partially ☐ No ☐

Did CERF funds help respond to time-critical needs?

Yes ☒ Partially ☐ No ☐

Did CERF improve coordination amongst the humanitarian community?		
Yes ☐	Partially ☒	No ☐
Did CERF funds help improve resource mobilization from other sources?		
Yes ☐	Partially ☒	No ☐

Considerations of the ERC's Underfunded Priority Areas[8]:

The generic nature of UNDP's CERF project meant that neither the masks nor the ventilators were specifically allocated towards the four chronically underfunded humanitarian priority areas. Nevertheless, by WHO estimates, masks distribution were roughly allocated 70% towards women and 30% for men in the context of the COVID-19 response.

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
UNDP	20-RR-UDP-003	HEALTH - HEALTH	3,200,000

2. OPERATIONAL PRIORITIZATION:

People Directly Reached:

Given the varied nature of the distribution of the masks in the 7 countries (Cameroon, Chad, Mali, Venezuela, Afghanistan, Bangladesh and Ethiopia), the best estimate for determining the breakdown of who received the masks is based on WHO estimates for health workers in the context of COVID 19 at 70% for women and 30% for men. This is based on the overall ratio of female to male healthcare and other front line workers.

Additionally, in Bangladesh, UNDP was able to more directly 160,000 masks were distributed among the 14,500 CERF Funded UNDP Beneficiaries in Khulna, Satkhira, Patuakhali and Barguna District enabling to tackle the pandemic and continue with their livelihood; in Cameroon, IIR masks were distributed through a number of partners including CRF, WHO, IMC, UNFPA, UNHCR, UNICEF and the African Humanitarian Agency in their programmes in the Far North and South West regions of Cameroon. Finally, in Ethiopia, masks were also distributed to UNDP Country Office and Regional Service Centre staff in order to keep our business continuity.

UNDP also estimates that the 26 ventilators distributed in 5 countries would be able to treat a total of 1,450,000 people through the lifetime of the machine.

People Indirectly Reached:

[8] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

UNDP's conscious decision to procure IIR masks was done with the purpose of enabling key health, community and aid workers to be able to continue to operate and work safely amid the pandemic. This includes enabling health workers to undertake their role in disease prevention, mitigation and response

PART VII – PROJECT OVERVIEW: UNDP

Project Report 20-RR-UDP-003

1. Project Information

Agency:	UNDP	**Country:**	Multi-country
Sector/cluster:	Health - Health	**CERF project code:**	20-RR-UDP-003
Project title:	Provision of PPE and other COVID-related protective and response equipment to Ministries of Health in countries covered by COVID-19 GHRP		
Start date:	01/04/2020	**End date:**	30/09/2020
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 120,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 20,000,000**
Amount received from CERF:	**US$ 3,200,000**
Total CERF funds sub-granted to implementing partners:	**US$ 0**
Government Partners	US$ 0
International NGOs	US$ 0
National NGOs	US$ 0
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through this unique CERF multi-country COVID-19 grant, UNDP was able to use its strength in health procurement to rapidly provide masks and ventilators to a total of 11 countries. This allowed UNDP to reach an estimated 186,000 people who directly benefited from this which included a mix of local heath workers, community and aid workers, as well as beneficiaries of humanitarian programmes that would otherwise be hard to reach by local authorities. In addition, the 26 CERF-funded ventilators immediately boosted preparedness and response capacity for COVID-19 cases in 5 countries that were significantly lacking in such instruments. It is estimated that this would be of immediate assistance to at least 1,200 acute cases, and over the lifetime of the ventilator be able to help hundreds of thousands other patients. UNDP primarily distributed the masks and the ventilators via the national health authorities. In some instances it coordinated the distribution of masks with the UN joint response in country to benefit beneficiaries of other humanitarian programmes (e.g. those affected by cyclones, as well as the Rohingya refugees in Bangladesh, as well as those aid recipients in the far north and south west part of Cameroon), The CERF grant was an important contribution to the broader UNDP response in crisis settings, which was bolstered by a significant amount of funding from Japan. Equally importantly, this was a great complement to UNDP's main thrust in the COVID-19 response to address the underlying socio-economic impact resulting from the pandemic and global economic slowdown which so impacted the poorest countries.

3. Changes and Amendments

N/A

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health - Health									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**					
Returnees	0	0	0	0	**0**					
Internally displaced people	0	0	0	0	**0**					
Host communities	0	0	0	0	**0**					
Other affected people	0	0	0	0	**0**					
Total	**130,100**	**56,100**	**0**	**0**	**186,200**	**129,975**	**55,975**	**0**	**0**	**185,950**
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	0	0	0	0	**0**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

UNDP's conscious decision to procure IIR masks was done with the purpose of enabling key health, community and aid workers to be able to continue to operate and work safely amid the pandemic. This includes enabling health workers to undertake their role in disease prevention, mitigation and response

6. CERF Results Framework

Project objective	Provision of PPE and other COVID-related protective and response equipment for Ministries of Health for use in COVID-19 response in GHRP countries
Output 1	

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	# of ventilators procured and distributed	26	26	UNDP
Indicator 1.2	Number of Healthcare Workers provided with PPEs	185,000	185,000	UNDP
Indicator 1.3	# of patients treated with ventilators	1,450,000	1,450,000	UNDP
Explanation of output and indicators variance:				

Activities	**Description**	**Implemented by**
Activity 1.1	UNDP centrally procures the equipment and distributes it to the requesting UNDP country offices for handover to respective Ministries of Health and other local partners	UNDP
Activity 1.2	Requests from Ministries of Planning and/or Health are met by the respective UNDP Country Offices	UNDP

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[9] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

[9] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

a. Accountability to Affected People (AAP) [10]:
N/A
b. AAP Feedback and Complaint Mechanisms:
N/A
c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:
N/A
d. Focus on women, girls and sexual and gender minorities, including gender-based violence:
N/A
e. People with disabilities (PwD):
N/A
f. Protection:
N/A
g. Education:
N/A

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	0

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

Given the global shortage of PPE and ventilators, UNDP chose to procure these items from abroad and distribute them to the 11 countries. CVA was not deemed to be able to fulfil this demand in the short time period of the CERF grant.

9. Visibility

[10] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

Title	Weblink
UN procures ventilators and other medical supplies to boost the Government of Nigeria's response to COVID-19	https://www.ng.undp.org/content/nigeria/en/home/presscenter/pressreleases/2020/un-procures-ventilators-and-other-medical-supplies-to-boost-the-.html
[UNDP hands over 10 ventilators and 3000 Xpert Xpress COVID-19 test kits to the Ministry of Health	https://www.ss.undp.org/content/south_sudan/en/home/presscenter/pressreleases/2020/hands_over_10_ventilators_3000_COVID19_testkits_to_MOH.html
[UNDP provids Covid-19 protective kits to the University of Yaounde II	https://www.cm.undp.org/content/cameroon/en/home/news-centre/undp-provids-anti-coronavirus-protective-kits-to-the-university-1.html

PART VIII – AGENCY OVERVIEW: UNFPA

1. STRATEGIC PRIORITIZATION

Statement by the agency focal point:

This grant responded to the most urgent needs and positioned the provision of GBV and SRH lifesaving interventions as a top priority during unprecedented pandemic. It allowed the focus on overcoming constraints of service provision and ensured the continuation of lifesaving SRH services through enabling UNFPA to bridge a critical shortage in supplies and PPEs to protect frontline workers to deliver essential services including antenatal and postnatal care, emergency obstetric and new-born care, skilled birth attendance (including home visits for critical cases), STI prevention and treatment, CMR and Family Planning services. This helped to avoid collapsing the health system where existing infrastructure is fragile with growing political and economic crises and fostered coordination especially with governments to strengthen SRH response in health institutions and border lines.

Similarly, priority was given to respond to and mitigate the anticipated and exacerbated risks of GBV during lockdown, for which service providers were equipped to deliver in-person and remote survivor-centered care including Dignity Kits, MHPSS and case management. This ensured support to GBV survivors and their referral to lifesaving care and contributed to longer-term quality of care through capacitating service providers and providing of science-based information to communities to limit spreading misinformation and rumors.

CERF's Added Value:

The shift towards a primarily COVID-19 response, meant SRH and GBV services were neglected. The CERF fund ensured the timely support and protection to frontline workers to continue delivering lifesaving services and address the most urgent needs including maternal care and essential services to GBV survivors to support their recovery, which in turn supported the overall COVID-19 response and avoided added burden of health structures. This grant allowed survivors' access to uninterrupted GBV/MHPSS services through hotlines in **Palestine and Venezuela** to support survivors with counseling and referral services contributing to reduce their stress and providing critical assistance and information.
Additionally, this funding contributed to increased funding efforts. **In South Sudan**, the information generated from needs analysis helped to mobilize funding from other sources such as the European Union and the government of Korea. Similarly, **in Chad**, following results of the CERF-funds, $USD 1.5 Million was mobilized from the World Bank Groups Pandemic Emergency Financing Facility to support maternal and newborn health positive outcomes in 4 humanitarian provinces and **in Venezuela**, additional resources were secured from DG-ECHO, the Canadian Government and BPRM.
Furthermore, reinforcing coordination was a crucial outcome of this project. **In Afghanistan**, UNFPA leveraged existing LTAs in addition to coordination efforts with MoPH and other actors to ensure the procurement of ERH preparedness. **In Haiti**, UNFPA's successful coordination with IOM, WHO/PAHO and the Centers for Development and Health and governmental authorities relieve the burden on health institutions at border entry points receiving an increased number of migrants living in the Dominican Republic returned to Haiti.

Did CERF funds lead to a fast delivery of assistance to people in need?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help respond to time-critical needs?		
Yes ☒	Partially ☐	No ☐
Did CERF improve coordination amongst the humanitarian community?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help improve resource mobilization from other sources?		
Yes ☒	Partially ☐	No ☐

Considerations of the ERC's Underfunded Priority Areas[11]:

The priority area for this project was the support for women and girls, including tackling gender-based violence, reproductive health, and empowerment. Women and girls face increased GBV and SRH vulnerability and risks, the insufficient and limited protection services were exacerbated during the COVID-19 pandemic due to persistent economic crisis, insecurity and interruption of prevention and response services resulting in an increase of maternal mortality and morbidity, unplanned and early pregnancy, rape, physical abuse, IPV, trafficking and/or sexual exploitation of children and adolescents. Addressing GBV and SRH concerns and reinforcing women and girl's empowerment requires prioritizing and allocating urgent funding to tackle the limited-service coverage due to low skilled birth attendance and female service providers and limited availability of equipment and supplies to contribute to strengthen the empowerment of women and girls and community resiliency and accountability to prevent and mitigate GBV.

In order for CERF to leverage efforts in tackling GBV and SRH and advancing women's empowerment, the GBV Accountability Framework, GBV and Gender concerns should be mainstreamed across all CERF projects. Similarly, the essential SRH needs in other sectors should be also addressed. Advocating for GBV and SRH prioritization, along with mobilizing and allocating more funds are essential to ensure the coverage of these humanitarian needs. Furthermore, to ensure quality and adequate response, more consideration is needed to context specific situations in timeline expectations for implementing, coordinating, achieving response and reporting, in addition to the need for funding for longer durations project to allow time for project development and bridge the gaps in delivery of services.

Some of challenges surrounding response efforts is the limited resources including sufficient funding, qualified service providers and technical capacity of government institutions and local partners, in addition to limited capacity related to data collection and analysis Furthermore, challenges persist regarding procurement and delivery of the RH and PPE supplies to cover the increased needs. Structural weakness of state institutions and drastic reductions in investment in the public sector and women's and community-based organizations poses challenges in accessing SRH and GBV services.

During the pandemic, limited guidance on safe service provision including remote services amid continued humanitarian crises, insecurity, movement restrictions and internet shutdown affected survivors as well as increased burden and pressure on service providers, particularly women.

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
UNFPA	20-RR-FPA-022	Health - Health	2,240,000
UNFPA	20-RR-FPA-022	Protection - Sexual and/or Gender-Based Violence	960,000

2. OPERATIONAL PRIORITIZATION:

People Directly Reached:

The number of people directly reached is drawn from data provided from targeted service points such as hospitals, safe spaces and border lines, in addition to home visit and remote service counting people receiving GBV and SRH care including STI prevention and treatment, CMR, FP services, deliveries, prenatal and postnatal care, Covid 19 testing, case management and psychosocial support.

Several monitoring strategies were designed to avoid double counting including developing data management tools and reporting templates, training of IPs and services providers on data collection and reporting, regular review and verification of reports on beneficiaries at different levels and the designation of M&E focal points to track people reached by service type, provider, delivery point, disability, displacement status, sex and age to ensure producing quality data and track progress against outcome and output indicators. However, double counting is only happening due to the overlap between indicator 1.3 and 1.4 considering that deliveries are part of MISP services.

[11] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

People Indirectly Reached:

With this grant, it was possible to reach approximately a total of 6,937,982 indirectly (400,000 in Afghanistan, 3,801,988 in Burkina Faso, 2,747,624 in Haiti, 3,280 in Palestine, 15,277 in South Sudan, 121,473 in Sudan, 248,340 Venezuela). This reach was achieved through different modalities including information and communication campaigns using media channels including Radio and TV broadcast and community-based awareness raising campaigns on COVID-19 prevention and protection measures and available GBV and SRH services. It also includes people who avoided infection thanks to more widespread use of PPE including children and extended families of the women who received services, in addition to training provided to service providers including midwives which has also impacted further providers indirectly through peer training and experience sharing reaching further population with information on COVID-19 when accessing services.

PART IX – PROJECT OVERVIEW: UNFPA

Project Report 20-RR-FPA-022

1. Project Information

Agency:	UNFPA	**Country:**	Multi-country
Sector/cluster:	Health - Health Protection - Sexual and/or Gender-Based Violence	**CERF project code:**	20-RR-FPA-022
Project title:	Mitigating and Responding to the COVID-2019 Outbreak in humanitarian settings		
Start date:	02/04/2020	**End date:**	01/01/2021
Project revisions:	No-cost extension ☐ Redeployment of funds ☐ Reprogramming ☐		

Funding

Total requirement for agency's sector response to current emergency:	**US$ 232,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 35,000,000**
Amount received from CERF:	**US$ 3,200,000**
Total CERF funds sub-granted to implementing partners:	**US$ 932,291**
Government Partners	US$ 94,459
International NGOs	US$ 259,999
National NGOs	US$ 496,720
Red Cross/Crescent Organisation	US$ 81,113

2. Project Results Summary/Overall Performance

Overview

This fund enabled the provision of direct support to 789,253 people in the targeted locations in the eight countries. 16,238 PPE materials were provided to frontline workers, supported 408 health facilities with reproductive health kits and other lifesaving pharmaceuticals, medical devices and supplies required to Implement MISP. This allowed for the support of a total of 263,166 deliveries in UNFPA-supported facilities, as well as provision of SRH services, under the Minimum Initial Service Package, in COVID-19 affected areas to 956,464 beneficiaries. Additionally, 506 of healthcare facilities providing lifesaving SRH services were orientated on standard precautions and Infection Protection Control (IPC), while 2,039 frontline health workers received an orientation for ensuring of PFA and safe and ethical referral of including those presenting GBV cases. Specialized GBV response in COVID-19 affected areas was ensured by supporting a total of 4,994 new and continuing GBV psychosocial and medical services, while also adapted Dignity Kits along with a communication package including COVID-19 related risk mitigation and availability of SRH and GBV services were delivered to 42,702 women and girls of reproductive age.

The overall interventions ensured the continuation and limited interruption of GBV and SRH lifesaving services, provided quality and timely adapted services and information, and supported the national protection and prevention efforts against COVID-19 pandemic.

Afghanistan

Through this fund, UNFPA provided 78 emergency reproductive health kits to 5 hospitals reaching 34,200 women with obstetric care services; provided 25,500 women, girls, men and boys with SRH and GBV prevention and response services and information; provided 231 healthcare workers and support staff with PPEs and orientation sessions on the use of PPEs; distributed 5,000 modified dignity kits to women and girls of reproductive age; reached 4,000 women and girls and 1,700 men and boys with in-person and remote PSS services and referral services.

The project reached 81,331 people in Kabul, Kandahar, Herat, and Nimruz provinces. The provision of goods and services through the CERF fund contributed to the prevention of COVID-19 spread among women and girls, especially women of reproductive age and pregnant women in major cities, while also ensuring the continuation of essential SRH and GBV services for an overburdened health system during the pandemic.

Burkina Faso

Thanks to this CERF grant, UNFPA and its partners, in 256 targeted health structure, trained 440 health workers on COVID-19 and Infection Prevention and Control (IPC), 80 GBV actors on first-line psychological support (PFA) and GBV referrals, and 80 health workers on the use of RH kits and management of rape cases; provided 342,952 SRH services including 32,354 new users of contraceptive methods and 71,483 assisted deliveries; reached 8,717 people from IDPs and host community (including 6,698 women and 2,019 men) with awareness raising activities.

The project reached a total of 11,385 people and was implemented in four (04) humanitarian regions in Centre-Nord (Bam, Sanmatenga), Nord (Loroum, Yatenga), Sahel (Oudalan, Soum) contributing to reducing the risks faced by women and girls due to the spread of COVID 19 in areas of sexual and reproductive health, as well as protection against gender-based violence, including sexual exploitation and abuse.

Chad

Through the CERF grant, UNFPA and partners trained 303 midwives and nurses from 94 public and private sector health facilities on IPC, PSS and clinical management of SGBV; supported the local production of 50,000 reusable masks and its distribution to 500 members of the union of associations of people living with handicaps; delivered 3400 reusable PPE to maternity and ancillary staff participating in IPC training; distributed over 500 adapted family kits with an integrated covid-19 prevention package to women in their immediate post-partum; supported the international and local procurement of PPEs to over 30 health facilities; delivered 1000 dignity kits to IDP women and girls between the ages of 15-49; distributed 5,000 hygiene kits to young people during a 2 week workshop on the pandemic, SGBV, SRH and available services; trained 60 youth ambassadors on the minimum package of SRH in the covid-19 context; reached over 2,000,000 people with information shared by religious leaders through radio and TV broadcast on the availability of adapted SRH and GBV services during the pandemic.

The project reached 6,500 people in N'Djamena, Lake, Hadjer Lamis, Kanem, Moyen Chari and Logone Orientale region which enabled the continuation of services and limiting COVID-19 risks. The project was informed on needs and priorities enabling decision making using information from conducting a rapid mixed study in N'Djamena province (epicentre of Covid-19); evaluating 18 health and social structures on trends in SRH and GBV service delivery and utilization, compared to the results in 2019 which revealed drop in service delivery and utilization, informing the proceeding interventions.

Haiti:

Through this CERF grant, UNFPA and its partners organized 4 Four workshops to build the capacity of 48 service providers on GBV case management PFA and data collection methods; deployed 30 teams accompanied by a health officer to provide information on Covid-19 mitigating measures; organized 83,733 households visits and sensitized communities through radio spots broadcasting, message dissemination via mobile "sound truck" on Covid-19 done; provided SRH Services to over 17,536 persons including 930 safe deliveries and GBV services to 84 persons; delivered HIV/AIDS counselling and testing services to 1,676 people; provided 3,561 new users with modern Family Planning methods; reached 7,689 people with communication package on COVID-19 risk prevention and mitigation measures and reached 18,412 persons on SRH thematic; distributed 700 dignity kits and 500 subsistence kits (hygiene and food items) to professional deployed at the border entry points; supported the procurement of 3,000 PPE and 34 hygiene installation systems, jointly with the office core funds.

The project was implemented in border entry points (West (Ganthier/Malpasse), South-East (Anse-à-Pitres), Centre (Belladère) and North-East) (Ouanaminthe) reaching 17,620 people in total. The project enabled the support of the operation of 2 quarantine centers in Belladère and Ouanaminthe and sensitization and epidemiological surveillance activities in the Northeast department. The provided support ensured the continuation of safe delivery of GBV and SRH services and protection from COVID-19 through providing the border posts, quarantine centers, and other institutions with PPE and hygiene kits. Furthermore, it supported the prevention of COVIS-19 through a work plan for epidemiological surveillance and functional investigation teams for the tracking of coronavirus cases, suspected cases and contact tracing and investigated Covid 19 suspected cases. This project reinforced coordination with inter-agency coordination bodies (IOM, UNDP, UNFPA, WHO) for the joint Coronavirus response at the border.

oPt

Through this CERF grant, UNFPA and its partners provided PPE to 1,466 frontline health and GBV providers; trained 242 sexual and reproductive healthcare workers on IPC; provided lifesaving SRH services to 7,399 women and girls; reached 1,379 GBV survivors and

women at-risk with MHPSS support and awareness sessions; and reached 17,724 people with risk communications messaging on COVID19.
The project supported a total of 28,635 people in the Gaza Strip and West Bank by ensuring the continuation of essential services that had been disrupted and/or halted due to COVID19, in addition to protecting essential health and protection workers. Due to the continuation of services, vulnerable women and girls were able to access lifesaving services including antenatal/postnatal care and GBV (ie. MHPSS and referral). The project also reinforced coordination among health and protection clusters.

South Sudan
Through the CERF grant, UNFPA procured and distributed PPEs to 20 health facilities; distributed 16,554 Dignity Kits to women and girls; reached 75,144 people with SRH (MISP) services, among which 24,513 women were delivered by skilled birth attendants in health facilities ; supported 352 healthcare providers and support staff with priority PPE; reached 76,231 women and girls of reproductive age and men and boys with communication package on COVID-19 related risk mitigation and availability of SRH and GBV services; delivered orientation to 156 frontline health workers on PFA and safe and ethical referral.
This project reached a total of 151,531 people in Central Equatoria State, Northern Barh El Ghazal State, Lakes State, Western Barh El Ghazal State, Warrap State, Western Equatoria State, Eastern Equatoria State Upper Nile State, Unity State and Jonglei State. The project provided support to 14 host community health facilities and 6 IDP health facilities, maintaining the delivery of critical reproductive health and GBV services within the context of the COVID-19 pandemic. The grant has also significantly enhanced the coordination between relevant humanitarian actors as part of the CERF needs analysis, allocation of funds, and monitoring of project implementation.

Sudan
Through this grant, UNFPA and its partners provided safe delivery services to 46537 women in health facilities; trained 555 HCP on infection prevention and control (obstetricians, PHC HCP and midwives); developed, printed and distributed COVID19 Infection prevention and control guidelines for PHC, and EmONC facilities to the 18 states of Sudan with additional focus on targeted states; supported 24/7 community based Active referral for obstetric complication, linking the communities and the targeted 25 EmONC facilities in Khartoum state; reached 121,473 individuals including 60,736 women and girls in reproductive age, and 15670 were refugees and IDPs with SRH and COVID19 risk communication through deploying Youth Networks (Y-PEER) and NGOs
Through this allocation, the project was implemented in the targeted 8 states; Khartoum, Red Sea, Northern, West Darfur, White Nile, Kassala, South Darfur, and South Kordofan, a total of 168,010 direct beneficiaries were reached with lifesaving SRH services and 34050 reached with GBV service including information, DKs, psychosocial and medical GBV response services. The support to facilities were in the form of provision of lifesaving SRH supplies, infection prevention and control materials, and personal protective equipment.

Venezuela
Through this CERF allocation, UNFPA and MoH health service providers provided SRH information to 29,118 women and girls and 8,781 pregnant women; distributed condoms to 22,559 individuals; delivered hygiene kits to 6,559 women and girls and 1,445 pregnant women; conducted capacity building to 1,726 health personnel on COVID-19 prevention and care for pregnant women and new-borns; provided 995 health personnel with PPE supplies; assisted 10,233 child births at four maternity wards; distributed 2,999 Dignity Kits to 2514 women and 485 adolescent girls; reached 283 persons (205 women and adolescents, 78 men and boys) with GBV & COVID-19 rights and protection inclusive messages; provided 796 women and girls with remote hotline GBV PSS services, referring 180 to additional response services; strengthened the GBV prevention and response capacities of 300 COVID-19 front line staff, including 169 from local institutions (134 women, 34 men) and 172 from NGOs and civil society (141 women and 31 men).
The project was implemented in six municipalities of Miranda state and reached 55,724 people, ensuring the provision of SRH services including family planning, SITs treatment, CMR services, in addition to GBV services including dignity kits, PSS and referral services during the COVID-19 pandemic.

3. Changes and Amendments

Chad:
The project experienced delays in implementation and disruption in GBV services due to different changes in the context including lockdown policies with shutdown of health and social structures from March to June 2020, the deadly attack by the Boko Haram group on 23 March 2020 in the Lake province which presented tighter lockdown measures and barriers to provision of covid-19 adapted services to victims of the attack and host communities, internet blockade in humanitarian zones with a complete shutdown in the Lake

province from July to September 2020 affecting communication, coordination and follow –up with the field, delays in international procurement which was addressed by leveraging local production of some quality PPE.

Haiti:
Due to political challenges and health crisis and given the action urgency and need for operational flexibility, the two initial identified IPs (the Ministry of Public Health and the Ministry for Women's Affairs and Women's Rights) were replaced with The Centers for Development and Health (CDS) to accelerate the implementation process and quickly receive the funds and use its existing field capacity.
Considering that the hospital in Ganthier in the West Department was not functional for several months and in order to ensure the availability and continuation of services on the border of Malpasse, Ganthier and its surroundings, UNFPA initiated discussions with the officials of the Hospital, in addition to intervening in other departments to support epidemiological surveillance. These decisions were in line with UNFPA commitment to implement the planned interventions while adapting to the challenges and constraints encountered in the response to the pandemic.

South Sudan:
Due to international procurement delays, UNFPA used its core funds to locally procure tents, standard hospital beds, bed sheets, bed screens, sterilizers, and stoves. Therefore, savings on this budget line were made which were utilized to procure much-needed dignity kits. This slight change was not reported to CERF as it came towards the end of the grant.

Palestine:
During the proposal writing stage, UNFPA anticipated to procure a mix of SRH medical supplies and PPE for MOH in Gaza. However, due to rapidly changing needs and support provided to MOH from other funds and donors, MOH requested that the entire CERF budget dedicated to supplies be used for PPE to cover the most urgent need to continue service provision. This was not a deviation from the proposal since the proposal specified SRH supplies and / or PPE based on the most urgent needs.

Venezuela:
The project experienced implementation delays due to COVID-19 related mobility restrictions, fear of infection which caused disruption of SRH services at health facilities. After awareness on the disease was raised and mobility restrictions became flexible, these services' reactivation increased women's access to SRH services in health facilities.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health - Health									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	16,645	7,145	8,721	7,159	**39,670**	12,430	2,212	764	0	**15,406**
Returnees	2,914	2,799	5,915	5,683	**17,311**	486	263	135	127	**1,011**
Internally displaced people	24,827	4,438	17,087	9,409	**55,761**	144,452	6,653	80,277	2,179	**233,561**
Host communities	117,311	38,412	32,882	18,483	**207,088**	171,800	24,905	43,280	6,911	**246,896**
Other affected people	88,232	9,970	1,744	0	**99,946**	89,323	5,261	58,379	1,754	**154,717**
Total	**249,929**	**62,764**	**66,349**	**40,734**	**419,776**	**418,491**	**39,294**	**182,835**	**10,971**	**651,591**
People with disabilities (PwD) out of the total										
	4,674	1,973	2,807	1,961	**11,415**	2,909	208	1,689	73	**4,879**

Sector/cluster	Protection - Sexual and/or Gender-Based Violence									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	4,444	1,192	1,981	1,826	**9,443**	6,028	1,018	691	409	**8,146**
Returnees	641	616	1,302	1,251	**3,810**	378	0	205	0	**583**
Internally displaced people	4,017	1,146	2,558	2,119	**9,840**	44,036	5,318	13,559	3,176	**66,089**
Host communities	13,017	5,883	5,151	3,510	**27,561**	38,389	7,733	10,738	2,170	**59,030**
Other affected people	3,863	93	1,143	4	**5,103**	1,413	570	1,427	404	**3,814**
Total	**25,982**	**8,930**	**12,135**	**8,710**	**55,757**	**90,244**	**14,639**	**26,620**	**6,159**	**137,662**
People with disabilities (PwD) out of the total										
	1,301	397	613	494	**2,805**	924	262	244	10	**1,440**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

With this grant, it was possible to reach approximately a total of 6,937,982 indirectly (400,000 in Afghanistan, 3,801,988 in Burkina Faso, 2,747,624 in Haiti, 3,280 in Palestine, 15,277 in South Sudan, 121,473 in Sudan, 248,340 Venezuela). This reach was achieved through different modalities including information and communication campaigns using media channels including Radio and TV broadcast and community-based awareness raising campaigns on COVID-19 prevention and protection measures and available GBV and SRH services. It also includes people who avoided infection thanks to more widespread use of PPE including children and extended families of the women who received services, in addition to training provided to service providers including midwives which has also impacted further providers indirectly through peer training and experience sharing reaching further population with information on COVID-19 when accessing services.

6. CERF Results Framework

Project objective	Reduce human-to-human transmission in COVID-19 affected countries in humanitarian settings and mitigate the impact of the outbreak among women and girls, especially women of reproductive age and pregnant women
Output 1	Ensure continuity of life saving sexual and reproductive health services (MISP) , by ensuring protection of frontline staff in health facilities providing SRH services through the provision of PPE and infection prevention and control (IPC) training and enforcement

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health - Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of healthcare providers and support staff providing /supporting the provision of SRH services provided with priority PPE	3260	16,238	IP reports: # of staff at facilities, training reports. UNFPA's monitoring database
Indicator 1.2	Number and proportion of targeted health facilities where reproductive health kits and other lifesaving pharmaceuticals, medical devices and supplies required to Implement MISP were provided	308	308	# of supported facilities, distribution plan, Delivery slips and waybills.
Indicator 1.3	Number of total deliveries in UNFPA-supported facilities in COVID-19 affected areas.	78,783	263,166	IPs reports: Register sheets from health services.
Indicator 1.4	Number of beneficiaries being provided with SRH services, under the Minimum Initial Service Package, in COVID-19 affected areas.	266,985	956,464	Work Plan Quarterly Progress Reports from health facilities.
Indicator 1.5	Number and Proportion of healthcare facilities providing lifesaving SRH services where orientation on standard precautions and IPC took place	367	506	Training attendance sheets

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

Explanation of output and indicators variance:	**Afghanistan:** indicator 1.1: Based on the urgent need and request of MoPH, UNFPA provided PPEs along with training/orientation to additional 81 (231 compared to target 150) health care providers and support staff in the targeted health facilities. **Burkina Faso:** The target indicators were greatly exceeded because the activities targeted all the health facilities in the beneficiary districts reaching a greater number of beneficiaries with SRH services considering the continuous massive influx of internally displaced people into these regions throughout project implementation. **Chad:** Indicator 1.1: By leveraging local production a greater number of service providers were reached with PPE (3,400 compared to the 300 target). Indicator 1.2: These funds served as a catalyst to the world bank's PEF in that based on the funds available, 31 of the 68 target health facilities in the most vulnerable situations were prioritized. **Haiti:** Indicator 1.1: (156 compared with target 100) were reached as the number of persons who received PPE kits including health professionals, members of the Ministry of Women Affairs, staff of the Centre pour le Développement et la Santé, staff of CODDEMIR (local organization involved in sensitization campaigns) and members of the police. Indicator 1.3: number of institutional deliveries dropped because of fear of sanitary facilities at the beginning of the pandemic (reached 930 out of planned 1597). Indicator 1.4: More people were reached (17,536 compared to target of 5,000) due to the deployment of midwives and the Centre pour le Développement et la Sante strategies to the field. **Palestine:** indicator 1.1 – due to variance in market prices and MOH request to procure PPE instead of SRH medical supplies to adapt to the crisis and meet the needs, more PPE were procured (1,466 compared to target 1,000). Indicator 1.2 – Based on the final distribution plan with updated needs from IPs, slightly more facilities were supported (78 compared to target 52). Indicator 1.5 – the project was planned to train more staff at fewer facilities. However, based on the request to respond to rapidly changing needs of MOH and NGOs, more dedicated SRH staff at more facilities were trained (84 compared to target 15). **South Sudan:** Indicator 1.3: More women benefited from delivery services in the 20 health facilities (24,513 compared to target 4,000) and indicator 1.4: more people were provided with SRH services, under the MISP, in COVID-19 affected areas (74792 compared to target 9,000) preferring health facilities because they think it has all the PPE to protect them and their newborns from Covid-19 infection. **Sudan:** Indicator 1.1: PPE distribution was part of orientation sessions. The minor under achievement (555 out of 600) was due to the reduced number COVID19 risk averting measure of reducing the number of participants per each training. indicator 1.4: The 80% achievement is due to under reporting from the states

Activities	Description	Implemented by

Activity 1.1	Provide specific PPE to frontline healthcare workers to prevent and control COVID-19 infections in targeted health facilities providing MISP services	**Afghanistan:** UNFPA, Agency for Assistance and Development of Afghanistan (AADA). **Burkina Faso :** Directions Régionales de la Santé du Centre Nord, du Nord et du Sahel et DS, - Programme d'Appui au Développement Sanitaire. **Chad :** UNFPA, MoH. **Haiti :** UNFPA. **Palestine:** Palestinian Medical Relief Society (PMRS). **South Sudan:** UNFPA. **Sudan:** UNFPA **Venezuela:** UNFPA
Activity 1.2	Provide Emergency Reproductive Health Kits and medical equipment for targeted health facilities to maintain life-saving SRH services in COVID-19 affected areas	**Afghanistan:** UNFPA, AADA, Afghan Red Crescent Society (ARCS). **Burkina Faso :** Directions Régionales de la Santé du Centre Nord, du Nord et du Sahel et DS, - Programme d'Appui au Développement Sanitaire. **Chad :** UNFPA. **Haiti :** UNFPA. **Palestine :** UNFPA. **South Sudan:** UNFPA. **Sudan:** UNFPA, Federal Ministry of Health (FMOH) **Venezuela:** UNFPA
Activity 1.3	Ensure continuity in the referral system for women and girls in need of MISP services (including clinical manegment of rape), with or without suspected or confirmed COVID-19	**Afghanistan:** ARCS, AADA, Health Net TPO, MOVE organization. **Burkina Faso :** Directions Régionales de la Santé du Centre Nord, du Nord et du Sahel et DS, - Programme d'Appui au Développement Sanitaire. **Chad:** MOH, The National House of Women under the Ministry of Women, Protection of Childhood and National Solidarity (MFPPESN). **Haiti:** UNFPA, Centers for Development and Health (CDS). **South Sudan:** UNFPA **Sudan:** UNFPA, FMOH, CAFA Development Organization **Venezuela:** UNFPA
Activity 1.4	Orient midwives and SRH personnel on protection, hygiene and infection control and management measures in maternity units in COVID-19 affected areas.	**Afghanistan :** AADA. **Burkina Faso :** Directions Régionales de la Santé du Centre Nord, du Nord et du Sahel et DS, - Programme d'Appui au Développement Sanitaire. **Chad:** MOH, Provincial Delegations of Health (from N'Djamena, Logone orientale, Moyen Chari, Salamat, Hadjer Lamis, Kanem and Lake). **Haiti:** UNFPA, CDS. **Palestine :** UNFPA, MoH. **South Sudan:** UNFPA **Sudan:** UNFPA, FMOH **Venezuela:** UNFPA

Output 2	Respond to the impact of COVID-19 on gender-based violence(GBV) through provision of life-saving responses services, risk mitigation and increased awareness
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒

Sector/cluster	Protection - Sexual and/or Gender-Based Violence			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Number of women and girls of reproductive age who have received a communication package including COVID-19 related risk mitigation and availability of SRH and GBV services along with adapted dignity kits.	32,855	42,702	Distribution sheet and activity reports.
Indicator 2.2	Number and proportion of new and continuing GBV psychosocial and medical services providing specialised GBV response in COVID-19 affected areas	14,470	4,994	Reports from health Facility reports and one Stop Centres.
Indicator 2.3	Number of frontline health workers who received an orientation for ensuring of PFA and safe and ethical referral of including those presenting GBV cases.	1313	2,039	Monitoring forms and training and progress reports from IPs, Health Facility reports and One Stop Centres.
Explanation of output and indicators variance:	**Afghanistan:** indicator 2.2: A higher number of people reached (4,000) compared to target (3,000) due to providing psychosocial counselling through phone and in-person. **Burkina Faso:** Midwives and nurses from different regions were also briefed on coronavirus infection, infection prevention and basic skills to ensure FPA and referral / care cases of GBV. **Chad:** indicator 2.1: 1,000 IDP women and adolescent girls received dignity kits and 5, 000 girls received hygiene kits with communication packages. **Haiti:** indicator 2.3: UNFPA organized 4 workshops but due to the reality on the ground, GBV service providers IOM protection focal points were also targeted in addition to health workers supporting the coordination mechanism and assisting migrant returnees. **South Sudan:** More women and girls of reproductive age have received communication on COVID-19 related risk mitigation and availability of SRH and GBV services from 14 host health facilities and 6 IDP health facilities. GBV actors, including those operating WGFSs and OSC, pass the message on the same during the distribution of dignity kits. Under indicator 2.1, additional 10,359 men and boys received a communication package on COVID-19 related risk mitigation and availability of SRH and GBV services. These are included in Table 4 (Protection/SGBV).			

Activities	Description	Implemented by
Activity 2.1	Strengthen and scale up availability of specialized psychosocial and case management services through a variety of modalities including static, remote and hotline modalities in WGSS, health centers, and home-based, including appropriate training, equipment, information management and SOPs for new working modalities.	**Afghanistan:** AADA. **Burkina Faso:** Plan International **Chad**: MoH. **Haiti:** CDS. **Palestine:** PMRS, SAWA, Red Crescent Society RCS Gaza.

		South Sudan: UNFPA **Sudan:** UNFPA, Ministry of Labor and Social Development **Venezuela:** PLAFAM
Activity 2.2	Update referral pathways based on ongoing needs assessments and available GBV multi-sectoral services and disseminate information on services to service providers and communities.	**Afghanistan**: AADA, ARCS. **Burkina Faso:** Plan International **Chad:** Provincial Delegations of Health, The National House of Women under the Ministry of Women, Protection of Childhood and National Solidarity MFPPESN **Haiti:** CDS, UNFPA. **South Sudan:** UNFPA **Sudan:** UNFPA, CVAW units Community-Based Protection Networks (CBPNs) **Venezuela:** UNFPA
Activity 2.3	Provide dignity kits to women and girls at risk of GBV, with awareness messaging adapted to the COVID 19 context, through service delivery points or other relevant entry points	**Afghanistan:** ARCS. **Burkina Faso:** Plan International **Chad :** UNFPA. **Haiti:** UNFPA. **South Sudan:** UNFPA. **Sudan:** UNFPA and CVAW units, Sudanese Family Planning Association, Ministry of Social Development, CAFA Organization, Global Aid Hand Organization. **Venezuela:** PLAFAM
Activity 2.4	Orient on GBV hotlines, psychosocial support and case management	**Afghanistan:** AADA. **Burkina Faso:** Plan International **Chad:** The National House of Women under the Ministry of Women, Protection of Childhood and National Solidarity (MFPPESN), AfriYAN and Réseau des Jeunes pour le Développement et le Leadership au Tchad. **Haiti:** CDS, UNFPA.

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[12] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP)[13]:

During the project design phase, UNFPA conducted consultations with direct beneficiaries, community members including family members of people affected by COVID-19 in the targeted geographical locations to identify the needs of affected population, assess GBV and SRH services and gather suggestions on ways to ensure the safe accessibility to services in the context of COVID-19.

[12] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[13] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

UNFPA's partners used different approaches to engage targeted communities in monitoring the project implementation, for example in **South Sudan** where social auditing was done by the young people.
Collected Feedback on project implementation was used to make adjustments. In **Palestine**, IPs used the results of a wide scale survey (1,000 people) and interviews with beneficiaries to understand the usefulness and adapt the information campaigns with topics of interest to the population, while in **South Sudan**, specific items were added to dignity kits based upon consultations with women and girls.

b. AAP Feedback and Complaint Mechanisms:

UNFPA maintained and established complaints and feedback mechanisms including feedback forms, anonymous-based complaints boxes at WGSS and health facilities, hotlines, and designated focal points to receive complaints on the project implementation. Targeted communities were sensitized on accountability standards and complaints mechanisms and were encouraged to provide their feedback and report wrongdoings.
Meetings and FGDs were held with community leaders and beneficiaries to provide information on the project components and solicit views on accessibility and quality of provided services.
Feedbacks on service provision, availability, accessibility were received and discussed with beneficiaries and corrective actions were taken to address identified challenges. In **South Sudan**, the number of outreaches was increased in a week after this being suggested by the community to expand coverage and access to services for the affected population. Similarly, in **Palestine**, online and hotline services were made available as a response to the feedback on WGSS accessibility during lockdowns.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

In-line with UNFPA's PSEA policy for reporting and handling SEA-related complaints, UNFPA conducted orientation sessions with all staff and implementing partners on PSEA and the requirements of compliance to PSEA and assigned IPs focal points to follow up on issues relevant to SEA, UNFPA also ensure conducting rigorous pre-employment checks of staff and personnel to prevent rehiring of known offenders. UNFPA investigates all allegations of SEA, imposes disciplinary and/or administrative sanctions when allegations are proven.
Awareness-raising about SEA as a violation and information on available assistance and support were provided through the existing GBV referral pathway to respond to SEA survivors, encouraging survivors to report using a PSEA hotline or email. In **Venezuela**, UNFPA has also established PESA community-based complaint mechanisms, adapted to the needs of women, adolescent, PwD and indigenous persons.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

This projects' SRH and GBV interventions were designed according to human rights and survivor-based approaches to contribute to attaining gender equality and empowerment of women and girls and LGBTI persons. To achieve this, all service providers were capacitated on safe service delivery while also ensuring female social workers are recruited in COVID-19 hospitals. The delivery of SRH and GBV services (and supplies) ensured the availability of lifesaving response to enable women and girls to thrive during crises such as the COVID19 pandemic. Awareness raising activities on SRH and GBV rights to prevent and mitigate GBV aimed at empowering survivors to seek help from available services. The distribution of dignity kits ensured the promotion of women and girls' dignity and mobility and contributed to GBV prevention. WGSS also provided a safe space for women to empower each other and obtain new skills which contributed to their healing process and empowerment.

e. People with disabilities (PwD):

PwD's GBV and SRH needs were considered including specific GBV risks and potential barriers to accessing services and participating in awareness-raising activities. Orientation sessions were delivered to service providers to prioritize and address these needs, particularly when referrals are made. Awareness raising materials were designed in various modalities including audio-guided and sign language supported videos, and the use of TV and radio for campaigns to make IEC materials more accessible. Services were adapted to remote modality/ home visits to increased access of PWD with limited ability to leave their homes. Additionally, regarding supplies distribution like contraceptive, MH items, PEE, and DKs, PWD were given a place to sit where they can be seen easily and accessed by service providers and distributors to serve first. Finally, **in Haiti,** the washing points installed at the health facilities took into consideration PwD so that they can use hygiene facilities while being autonomous.

f. Protection:

The project considered at risk groups such as GBV survivors and pregnant women, ensuring coordination with relevant sectors and actors to allow maximum benefit and address the needs of the most vulnerable. Interventions such as the distribution of DKs that contained PEE and IEC materials were designed to address dignity concerns as a significant component for protection from GBV. WGSS which provided PSS support, referral services, awareness-raising and skills learning to women and girls, especially those affected by COVID-19 pandemic, supported the mitigation of the risks of GBV associated with food insecurity and protection from PSEA. Additionally, the establishment of a toll-free PSS hotline ensured provision of care for people at risk. Furthermore, protection concerns related to accessibility to health facilities and response services were addressed by ensuring safe and confidential access and training service providers on safe referral to mitigate any potential risk associated with the provision of services.

g. Education:

Non-Applicable

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	N/A

9. Visibility of CERF-funded Activities

Title	Weblink
Afghanistan - Kadahar Regional Maternity Hospital	*Here is the link*
Afghanistan -Herat Regional Maternity Hospital	Link
Afghanistan -Rabia-Balkhi National Maternity Hospital	*https://www.facebook.com/RBHComplex/posts/2855137121389631*
Burkina Faso - Bulletin d'information COVID-19	https://burkinafaso.unfpa.org/sites/default/files/pub-pdf/vf_bulletin_covid_05_aout.pdf
Burkina Faso - UNFPA dans la riposte face au COVID19	https://burkinafaso.unfpa.org/fr/news/unfpa-dans-la-riposte-face-au-covid19-au-burkina-faso
Burkina Faso - UNFPA fait don de Kits de protection	https://burkinafaso.unfpa.org/fr/news/lutte-contre-le-covid-19-unfpa-fait-don-de-kits-de-protection
Chad - Provision of locally made PPE and training on IPC in COVID-19 context.	https://www.facebook.com/UNFPACHAD/photos/pcb.3312119405499348/3312117928832829/?type=3&theater
Chad: Distribution of Covid-19 prevention material to the National Union of Associations of People Living with Disabilities	https://www.facebook.com/UNFPACHAD/photos/pcb.3278971345480821/3278970558814233/?type=3&theater
Chad: Distribution of adapted dignity kits to IDP women and girls attending SRH and GBV services.	https://twitter.com/UNFPATCHAD/status/1277020554382450689/photo/2
Haïti: Les sages-femmes sur le front de la réponse à la Covid-19 en Haïti	https://haiti.unfpa.org/fr/news/les-sages-femmes-sur-le-front-de-la-r%C3%A9ponse-%C3%A0-la-covid-19-en-ha%C3%AFti

Haïti: Vers une meilleure gestion des cas de violence basée sur le genre sur les points frontaliers officiels - L'UNFPA vient en appui aux migrants-es	Link 1 Link 2
Haïti/Covid-19: Les personnes âgées ont besoin de nous plus que jamais	Link 1 Link 2
Palestine: Gender-based violence is a crisis within a crisis.	https://t.co/837GP6opqQ
Palestine: Educational video series	Link 1 , Link 2, Link 3, Link 4
Palestine: Red Crescent Society Gaza	https://www.facebook.com/RCS4GS/photos/a.409245305944792/1359415024261144
Venezuela: Access to SRH services and supplies in indigenous communities	https://www.instagram.com/p/CF2yw3eHUYP/
Vital information for pregnant women on COVID-19 and contraceptive dispensing are part of UNFPA's contribution to the "house-to-house" visits made with the Ministry of Health.	https://venezuela.unfpa.org/es/news/informaci%C3%B3n-vital-para-mujeres-embarazadas-y-madres-lactantes-sobre-covid-19-y-dispensaci%C3%B3n-de

PART X – AGENCY OVERVIEW: UNHabitat

1. STRATEGIC PRIORITIZATION

Statement by the agency focal point:

In April 2020, UN-Habitat received a grant from CERF with a geographic focus on the city of Greater Beirut. The grant aimed to support vulnerable families, host, and refugees, residing in vulnerable neighbourhoods across the city to overcome dense urban challenges presented by COVID-19. More specifically, in supporting them to adopt adequate hygiene and sanitation practices, protecting them against the virus. The project targeted Sabra and Daouk Ghawash, part of Tariq el Jdideh, and considered as overcrowded neighbourhoods in Beirut, that include poor Lebanese and large numbers of Palestinian and Syrian refugees in addition to thousands of migrant workers. Nearly 1,000 families, 50% of which were refugees, were assisted by receiving hygiene and protection kits. In addition to awareness components dedicated to hygiene practices as a response to achieve SDG 3.3 (By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases). The intervention also raised awareness among vulnerable groups on the protection from sexual exploitation and abuse and standards of conduct expected of the humanitarian community, which is reflected on SDG 5.1 (End all forms of discrimination against all women and girls everywhere). The grant enabled UN-Habitat to meet critical needs and minimize human suffering within a short time.

CERF's Added Value:

The main added value of CERF was the ability to deliver assistance quickly to people in need through efficient and fast funding modalities and flexible administrative procedures that ensure efficient and timely delivery of humanitarian assistance and relief, contributing to minimizing human suffering. Consequently, CERF enabled UN-Habitat to respond flexibly to the evolving emergency caused by COVID-19 and initiate and implement an immediate life-saving response.

The timely administered CERF grant enabled UN-Habitat to demonstrate, from an urban lens and expertise, the importance of applying an urban response to respond to Covid-19 challenges. The grant further positioned UN-Habitat within the Humanitarian Country Team, thereby allowing for enhanced contribution to strategic decisions at the country level.

CERF funds contributed directly to UN-Habitat's strategic goals and global mandate, particularly its Strategic Plan 2020-2023. The funds were targeted in urban dense and slum-like conditions, offsetting economic hardships and enhancing hygiene conditions – fully in line with UN-Habitat's global COVID-19 Policy and Programme Framework and focus. The grant also supported UN-Habitat towards achieving SDG11 on cities, SDG5 and 3 related to gender equality and good health and wellbeing. It also focused on cross-cutting issues, including gender/SGBV, human rights, including prioritization the most vulnerable – women headed households, elderly, people with disabilities and such.

Did CERF funds lead to a fast delivery of assistance to people in need?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help respond to time-critical needs?		
Yes ☒	Partially ☐	No ☐
Did CERF improve coordination amongst the humanitarian community?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help improve resource mobilization from other sources?		
Yes ☒	Partially ☐	No ☐

Considerations of the ERC's Underfunded Priority Areas[14]:

The CERF grant contributed directly to mainstreaming some of the four priority areas as highlighted by the ERC. Specifically, the distribution of hygiene kits, adopted strict transparent criteria which prioritized women-headed households, persons with disabilities and the elderly – across all population cohorts (refugees, vulnerable Lebanese and migrants). This project added two other awareness raising components, where one directly contributed to tackling the gender-based violence through the prevention of sexual exploitation and abuse. The local NGO (Popular Aid for Relief and Development – PARD) which we partnered with, in addition to local community mobilizers were trained on Protection from Sexual Exploitation and Abuse (PSEA) principles and standards of conducts expected of humanitarian workers, including the UN, which were subsequently communicated with beneficiaries.

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
UN Habitat	20-RR-HAB-001	WATER SANITATION HYGIENE - WATER, SANITATION AND HYGIENE	49,996

2. OPERATIONAL PRIORITIZATION:

People Directly Reached:

CERF funding enabled life-saving assistance to 4,421 vulnerable individuals in Sabra and Daouk Ghawash neighbourhoods within Tarik el Jdideh in Beirut, affected by COVID-19 crisis, and further impacted by the economic crisis in Lebanon.

This allocated funding enabled the delivery of hygiene kits to 2,424 refugees living in the targeted neighbourhoods, who represent 55 percent of all assisted people.

UN-Habitat and PARD with the support from the local Community Mobilizers adopted a tracking system on the numbers of people directly targeted through CERF funding. Detailed information on family members was gathered during door-to-door awareness sessions and distribution of hygiene kits. The collected information was compared, validated, and confirmed to avoid any discrepancy and duplication. Consequently, targeted persons in more than one activity were counted only once.

Thus, the project reached 92 percent of targeted people under the life-saving component; nevertheless, 992 kits were provided instead of 500. As a result, the funding reached a lower number of people than planned but provided hygiene kits to a larger number of families (198%) which served them for a longer duration.

People Indirectly Reached:

[14] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

Through this grant, UN-Habitat developed a pamphlet as an awareness material on the adequate use of hygiene kits and proper protection practices and measures to be undertaken to prevent the potential spread of COVID-19. The pamphlets were distributed during the door-to-door visits, whereby an awareness session was provided to the targeted households. Consequently, the families who received the awareness sessions played a key role in spreading the knowledge to a larger community beyond the 992 targeted families. Moreover, the involvement of four local staff from PARD in addition to seven community mobilizers who were trained on different topics, has ensured a wider dissemination and sensitization on COVID-19 protective measures and gender related issues. Therefore, approximately 8,000 persons from Tarik el Jdide have indirectly benefited from the project's activities.

PART XI – PROJECT OVERVIEW: UNHabitat

Project Report 20-RR-HAB-001

1. Project Information

Agency:	UN Habitat	**Country:**	Lebanon
Sector/cluster:	Water Sanitation Hygiene - Water, Sanitation and Hygiene	**CERF project code:**	20-RR-HAB-001
Project title:	Providing life-saving COVID-19 protection gear to vulnerable urban communities in Lebanese cities, including refugees and migrants.		
Start date:	20/04/2020	**End date:**	19/01/2021
Project revisions:	No-cost extension ☐ Redeployment of funds ☐		Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 49,996**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 49,996**
Total CERF funds sub-granted to implementing partners:	**US$ 0**
Government Partners	US$ 0
International NGOs	US$ 0
National NGOs	US$ 0
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through this CERF grant, UN-Habitat in partnership with the Popular Aid for Relief and Development (PARD) equipped 992 vulnerable families living in different neighbourhoods within Tarik el Jdide area in Beirut with lifesaving personal hygiene protection kits. Each kit included basic necessities such as detergents, bleach, laundry powder, shampoo, soap bars, trash bags, surface cleaning cloths and a bucket and its lid. These kits allowed approximately 4,421 individuals to adopt proper hygiene practices with priority given to those considered as additionally vulnerable, including female-headed households, women, girls, the elderly, and people with disabilities.

Furthermore, in the midst of the pressing socio-economic challenges that Lebanon has been facing since October 2019, the provision of hygiene kits reduced the burden caused by the constant and dramatic increasing living costs and household-related expenditures for an average period of two months. The 992 families from the host and refugee communities were reached through a door-to-door campaign, to raise their awareness on the adequate use of the hygiene kit items to protect themselves from COVID-19.

Additionally, as a preparation of project launching, four members from PARD field team and seven community mobilizers from the two neighbourhoods, have received a training on the humanitarian code of conduct, the Prevention from Sexual Exploitation and abuse (PSEA) and the distribution protective measures.

The distribution of kits was achieved during June 2020, the starting period of the surge of COVID-19 cases in Lebanon

3. Changes and Amendments

The CERF grant amounting US$ 49,996 allowed UN-Habitat to procure 992 hygiene kits instead of 500, which were distributed to 992 families (4,421 people) in the targeted neighbourhoods, which resulted in a deviation of approximately 7.9 percent compared to target figures in the proposal. As a result, the project reached 92 percent of targeted people under the life-saving component but provided hygiene kits to a larger number of families (198%) which served them for a longer duration.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Water Sanitation Hygiene - Water, Sanitation and Hygiene									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	700	400	800	700	**2,600**	1,154	1,270			**2,424**
Returnees	0	0	0	0	**0**					
Internally displaced people	0	0	0	0	**0**					
Host communities	600	400	700	500	**2,200**	1007	990			**1,997**
Other affected people	0	0	0	0	**0**					
Total	**1,300**	**800**	**1,500**	**1,200**	**4,800**	2,161	2,260			**4,421**
People with disabilities (PwD) out of the total										
	50	25	75	50	**200**	268	282			**550**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

Through this grant, UN-Habitat developed a pamphlet as an awareness material on the adequate use of hygiene kits and proper protection practices and measures to be undertaken to prevent the potential spread of COVID-19. The pamphlets were distributed during the door-to-door visits, whereby an awareness session was provided to the targeted households. Consequently, the families who received the awareness sessions played a key role in spreading the knowledge to a larger community beyond the 992 targeted families. Moreover, the involvement of four local staff from PARD in addition to seven community mobilizers who were trained on different topics, has ensured a wider dissemination and sensitization on COVID-19 protective measures and gender related issues. Therefore, approximately 8,000 persons from Tarik el Jdide have indirectly benefited from the project's activities.

6. CERF Results Framework

Project objective	Through evidence-based mapping and data analysis, the objective of the project is to target some of the most vulnerable communities in urban settings in Lebanon, provide them with COVID-19 hygiene protection kits and accompanying awareness raising on rational use, in order to help them better protect themselves against the spread of COVID-19.
Output 1	An analysis and mapping of available neighbourhood profiling data about the vulnerable communities in the geographic scope of the project. Water Sanitation Hygiene - Water, Sanitation and Hygiene

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Water Sanitation Hygiene - Water, Sanitation and Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Vulnerable population groups in selected neighbourhoods are identified and used in targeted activities (number of neighbourhoods)	2	2	List of targeted families in the two neighbourhoods (click to check)
Indicator 1.2	Women, girls, the elderly and disabled persons are identified and specifically highlighted in the selected neighbourhoods (number of neighbourhoods)	2	2	List of targeted families in the two neighbourhoods (click to check)
Explanation of output and indicators variance:				

Activities	**Description**	**Implemented by**
Activity 1.1	Review of available neighbourhood profile data and identification of key locations and vulnerable populations to target	UN-Habitat
Activity 1.2	Report produced based on mapping and analysis clearly indicating key locations and vulnerable populations to target	UN-Habitat

Output 2	Provision of approximately 500 PPE family kits in identified and targeted vulnerable urban communities.

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☒
Sector/cluster	Water Sanitation Hygiene - Water, Sanitation and Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Most vulnerable families are identified and provided with PPE kits, particularly women, girls, the elderly and disabled persons	4,800	4,421	List of targeted families in the two neighbourhoods (Click to check)
Indicator 2.2	Vulnerable persons identified, use PPE kits when necessary	4,800	4,421	List of basic necessities included in the kit (Click to check)
Explanation of output and indicators variance:		The CERF grant amounting US$ 49,996 allowed UN-Habitat to procure 992 hygiene kits instead of 500, which were distributed to 992 families (4,421 people) in the targeted neighbourhoods, which resulted in a deviation of approximately 7.9 percent compared to target figures in the proposal.		

Activities	**Description**	**Implemented by**
Activity 2.1	Local implementing partners are identified by UN-Habitat and plan distribution to targeted families as per mapping and analysis, with particular focus on women, girls, the elderly and disabled persons	UN-Habitat and PARD
Activity 2.2	PPE equipment is procured	UN-Habitat
Activity 2.3	PPE equipment is distributed by implementing partner	PARD

Output 3	Targeted awareness raising on basic COVID-19 hygiene principles and rational use of the PPE kit and disposal			
Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☒
Sector/cluster	Water Sanitation Hygiene - Water, Sanitation and Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	Recipient vulnerable persons are equipped with the knowledge on how to rationally use the provided PPE kits, with particular focus on women, girls, elderly and disabled persons	4,800	4,421	List of targeted families in the two neighbourhoods (click to check)
Indicator 3.2	Recipient families correctly use and dispose of PPE kits	4,800	4,421	Awareness materials (click to check)
Explanation of output and indicators variance:		The CERF grant amounting US$ 49,996 allowed UN-Habitat to procure 992 hygiene instead of 500, which were distributed to 992 families (4,421 people) in the targeted neighbourhoods, which resulted in a deviation of approximately 7.9 percent compared to target figures in the proposal.		

Activities	**Description**	**Implemented by**
Activity 3.1	Awareness raising material is updated, designed and produced according to population targeted	UN-Habitat

Activity 3.2	UN-Habitat works with implementing partners and coordinate awareness raising and knowledge on how to use PPE kits at the time of distribution, with particular focus on women, girls, elderly and the disabled persons	UN-Habitat and PARD

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[15] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP) [16]:

UN-Habitat first identified an implementing partner (PARD) who has a long experience working in Sabra and adjacent neighbourhoods and has built upon a long-term relationship and trust with the targeted communities.

UN-Habitat and PARD worked together to make sure that proper operational steps are considered to ensure participation of affected people in decision making throughout the project design and implementation phases.

Therefore, a people centred approach was adopted through involving local community mobilizers (five men and two women) who were identified from the different neighbourhoods, with fair representation of host and refugees' communities. These mobilizers have played a key role in the identification of targeted families, the reach out mechanism, the door-to-door awareness, as well as the distribution of hygiene kits.

b. AAP Feedback and Complaint Mechanisms:

UN-Habitat with support from PARD has put in place a community-based complaints mechanism. Whereas the close coordination with representative local mobilizers has enabled us to receive feedback and complaints from the beneficiaries including the most marginalized and at-risk groups among the targeted communities. This active involvement ensured that the beneficiaries play an active role in the decision-making and monitoring processes, as well as the delivery of high-quality service.

Moreover, the close direct monitoring by UN-Habitat and PARD personnel during the door-to-door and distribution activities, represented an opportunity to both agencies to directly communicate with the beneficiaries and receive their feedback in order to take corrective actions when necessary.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

Through the support from PARD personnel and local mobilizers who were trained on PSEA principles and have signed the code of conduct, the pertaining knowledge and awareness were subsequently communicated with beneficiaries. Also, hotline numbers of NGO's who can deliver support for GBV and PSEA victims, were shared with the beneficiaries during the distribution of hygiene kits.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

[15] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[16] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

Women are often on the frontlines of any crisis. During COVID-19, they played and continue to play a central role in the protection of their families and communities. However, these women usually face challenges in accessing and benefitting from humanitarian assistance. Through this funding, the specific needs and challenges of women were adequately addressed. Specific focus was given to women and female-headed households. For instance, 35 out of 992 families supported with the CERF funding were female-headed households. In total, 49 percent of people reached were women and girls. Moreover, the kits included the essential hygiene supplies for women.

e. People with disabilities (PwD):

People with disabilities are often among the most vulnerable because they are frequently less visible. Through this funding, UN-Habitat largely focused on persons with disabilities in response to COVID-19 pandemic. For instance, 505 people including elderly were provided with lifesaving hygiene kits which enabled them to protect themselves from COVID-19. These people are considered at high risk of infection or severe illness because of their underlying medical conditions. Particularly, 268 girls and women with disabilities were reached.

f. Protection:

The project provided protection to the affected vulnerable population, contributing to meeting basic COVID-19 hygiene needs of Syrian and Palestinian refugee populations in the targeted areas, in addition to migrants and vulnerable Lebanese through the distribution of 992 hygiene kits, to enable them to protect themselves from the pandemic for a minimum of two months.

g. Education:

N/A

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	N/A

9. Visibility of CERF-funded Activities

Title	Weblink
Story: Hygiene kits reach most vulnerable urban populations in Beirut	https://unhabitat.org/hygiene-kits-reach-most-vulnerable-urban-populations-in-beirut
Story: Hygiene kits reach most vulnerable urban populations in Beirut	https://lebanon.un.org/en/100537-hygiene-kits-reach-most-vulnerable-urban-populations-beirut
Video: Critical hygiene kits reach most vulnerable urban populations in Beirut	https://youtu.be/YF6DCijl99o
Flickr Album	https://flic.kr/s/aHsmNQXvec

PART XII – AGENCY OVERVIEW: UNHCR

1. STRATEGIC PRIORITIZATION

Statement by the agency focal point:

With the support of CERF UNHCR was able to scale up response efforts for refugees and other persons of concern during the initial stages of the COVID-19 public health crisis in **Jordan, Iran, and Venezuela**. In Jordan, multi-purpose cash assistance was urgently needed to help vulnerable refugees meet their basic needs during the lockdowns, particularly in terms of accessing food, housing, and health items. Support from CERF made this possible by allowing UNHCR to quickly scale up its cash programme, helping also to mitigate against protection risks due to negative coping mechanisms. Although the healthcare system in Iran is of generally high standard, the scope and scale of the virus outbreak in Iran, combined with the effects of unilateral sanctions, resulted in critical shortages of essential medical supplies, especially Personal Protective Equipment (PPE). In the initial period of the pandemic, local markets were volatile and only stocked with generally low-quality medical items including masks and PPEs. With the support received from CERF, UNHCR was able to help address these shortages quickly, particularly for healthcare workers in refugees hosting areas, and thus contribute to basic protective measures against the spread of the virus amongst refugees and host communities in settlements and urban settings. In Venezuela, due to the influx of returnees in early 2020, and in order to cope with spread of COVID-19, WASH interventions, hygiene kits, and NFIs were urgently needed in prioritised communities and border regions, as well as the PASI (Punto de Asistencia Social Integral) temporary reception and quarantine centres. CERF funding allowed UNHCR to distribute Water tanks, hygiene kits, and NFIs, helping to ensure the health and safety of returnees during this critical period.

CERF's Added Value:

With the global spread of COVID-19 in 2020, the contribution from CERF allowed UNHCR to respond quickly to the most time critical needs of refugees in Jordan and Iran, as well as returnees in Venezuela. Interventions were complementary to the assistance provided by the Governments and humanitarian actors in each country. UNHCR was able to play a crucial role in the overall coordination of COVID-19 response efforts in those countries, helping to ensure that displaced populations were able to access health assistance, meet their basic needs, and mitigate against the spread of the virus among vulnerable populations. For instance, in Venezuela, with the influx of returnees in early 2020, the country was facing a dual emergency when the COVID-19 pandemic began. The CERF-funded hygiene kits, Non-food items, and water tanks helped UNHCR support the Government to quickly adapt the quarantine and reception centres in order to mitigate against contagion risks, and further enabled UNHCR to play a significant role in the context of the UN interagency response to returns, helping to optimize coordination, including for procurement, and ensuring complementarity with other forms of assistance to the influx of returnees. In Jordan, to respond to the additional needs for cash arising from the COVID-19 pandemic, the support from CERF helped UNHCR scale up its existing cash programme and expand the Common Cash Facility (CCF), a platform jointly managed and used by UN agencies and NGOs to deliver more than 90 per cent of the cash assistance in Jordan through the same financial service provider with lower overhead costs. The assistance supported by CERF was further coordinated through the a COVID-19 Emergency Response Taskforce in Jordan, co-chaired by UNHCR, UNICEF, IOM and Caritas. The taskforce helped develop the package of assistance for refugees, targeting criteria, joint communication messages, tenure of assistance and an exit strategy. To determine which refugees were at heightened risk due to reduced economic opportunities, the target population was jointly identified by the taskforce based on an assessment of home visit data and UNHCR registration data. In Iran, to ensure synergies were maximized and overlaps avoided in the procurement of PPE, UNHCR coordinated its activities through the Pro-Health Working Group led by WHO, with engagement of all UN and International agencies.

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

Yes ☒ Partially ☐ No ☐

Did CERF funds help respond to time-critical needs?

Yes ☒	Partially ☐	No ☐
Did CERF improve coordination amongst the humanitarian community?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help improve resource mobilization from other sources?		
Yes ☒	Partially ☐	No ☐

Considerations of the ERC's Underfunded Priority Areas[17]:

The assistance provided by UNHCR mainly contributed towards (4) other aspects of protection. The spread of COVID-19, lockdowns, and resulting economic decline have led some displaced populations to adopt adverse coping strategies and created conditions ripe for exploitation and abuse. Transactional sex, early marriage, gender-based violence, and trafficking in persons have been on the rise in displaced communities across the Globe. The contribution from CERF to enhance multi-purpose cash assistance in **Jordan** therefore helped UNHCR to mitigate against heightened protection risks among vulnerable refugees by enabling them to meet their basic needs for food, shelter, and health. The pandemic has also put additional pressure on Governments hosting refugees - the **Iranian** government for instance, has had difficulty maintaining its refugee inclusive health policies by providing the same level of health care to refugees as nationals. The support provided to the Ministry of Health for PPE, helped ease the burden on the government, better enabling refugees hosting sites to safely continue providing health services to those with a severe course of the disease, in turn protecting refugees right to access health assistance. Communal settings such a reception centres and sites, also put vulnerable populations at increased risk of COVID-19 infection, particularly if not properly adapted to the required public health measures. Due to the influx of returnees in **Venezuela**, there were heightened risks of spreading the COVID-19 infection with returnees being hosted in communal reception, quarantine centres and border regions. By enhancing the hygiene and public health measures through distribution of water tanks, hygiene kits, and other non-food items, the assistance from CERF enhanced the overall protection of the population from the spread of the virus, and enabled key protection activities to continue uninterrupted (e.g. information desks for individual counselling, identification and referrals of persons with specific needs, information sessions on protection-related issues, case management, legal assistance for birth certification and for women survivors of GBV, distribution of dignity kits, mental and psychosocial support services, and training of specialized personnel on child protection and GBV).

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
UNHCR	20-RR-HCR-017	Multi-Cluster - Multi-sector refugee assistance	4,623,018
UNHCR	20-RR-HCR-017	Water Sanitation Hygiene - Water, Sanitation and Hygiene	1,656,006
UNHCR	20-RR-HCR-017	Emergency Shelter and NFI - Shelter and Non-Food Items	345,001
UNHCR	20-RR-HCR-017	HEALTH – HEALTH	276,001

2. OPERATIONAL PRIORITIZATION:

People Directly Reached:

[17] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

In **Jordan**, the total number of beneficiaries were 11,115 families / 55,573 individuals. This has been calculated based on UNHCR bio metric registration data used for beneficiary targeting and verified through month end reconciliation reports from the bank. Assistance was provided through the common distribution platform called the Common Cash Facility (CCF), which is a public-private partnership between UNHCR, the Cairo Amman Bank, U Wallet, and the biometrics company IrisGuard. Refugees withdraw cash from cash points using iris scanning without the need for a card or PIN, which ensures that only refugees targeted for the assistance can access the funds, as the ATM's authenticate the beneficiaries by linking to UNHCR's secure biometric registration data through an encrypted network connection known as EyeCloud. At the end of each month UNHCR receives a reconciliation report from the bank detailing each beneficiary's account status. Refugees who do not withdraw funds will be contacted by the CCF humanitarian partner. If after various attempts they cannot be reached, their names will be taken off the list of beneficiaries and the funds will be used to assist families on the waiting list.

PPE was also distributed to 65 medical universities in **Iran**, through the Ministry of Health and Medical Education (MoHME) and UNHCR's Government counterpart, the Bureau for Aliens and Foreign Immigrants' Affairs (BAFIA). The items are estimated to have benefited 20,000 health care staff countrywide based on the distribution lists of the government, and through UNHCR monitoring using sample spot checks.

In **Venezuela**, the numbers of beneficiaries of UNHCR's CERF-funded interventions are based on autonomous field office/unit and implementing partner reporting collated by UNHCR's Information Management team. Care has been taken to avoid duplication of beneficiaries, while it is also unavoidable that some members of the targeted population benefitted from more than one type of intervention. To reduce duplications to a minimum, UNHCR IM applies a Recurrent Beneficiary Variable (yes/no) in its reporting. The 105,706 beneficiaries reported under the Shelter/NFI Sector were therefore calculated based on implementing partners and Field Offices and Unit reports. However, the figures are estimates because UNHCR was not authorised, nor able on account of COVID-19 restrictions, to distribute the kits directly to beneficiaries, rather distribution was carried out by military or civilian authorities managing the reception and quarantine centres. These numbers were provided by the local authorities in charge of the PASIs (i.e. the military commanders in Zulia, the Protectorate in Tachira, and the Paez Municipality in Apure). The number of WASH beneficiaries are calculated based on the population of the communities where the water tanks were installed.

People Indirectly Reached:

The cash assistance in **Jordan** has indirectly benefitted the broader host community, by contributing to the local economy through an injection of liquidity into the market. Further, by providing PPE to healthcare workers in **Iran**, this has also indirectly benefited thousands of refugees and host communities serviced by the 65 university hospitals in 31 provinces, by helping to limit and contain the impact of COVID-19. In **Venezuela**, medical personnel, other first responders, institutional counterparts, and implementing partners are among the people indirectly reached, as health, reception, and quarantine centres were provided with hygiene supplies and protective equipment.

PART XIII – PROJECT OVERVIEW: UNHCR

Project Report 20-RR-HCR-017

1. Project Information

Agency:	UNHCR	**Country:**	Global
Sector/cluster:	Multi-Cluster - Multi-sector refugee assistance Water Sanitation Hygiene - Water, Sanitation and Hygiene Emergency Shelter and NFI - Shelter and Non-Food Items Health - Health	**CERF project code:**	20-RR-HCR-017
Project title:	Urgent support to UNHCR preparedness and response to Covid-19 emergency in situations of forced displacement.		
Start date:	01/04/2020	**End date:**	31/12/2020
Project revisions:	No-cost extension ☐ Redeployment of funds ☐		Reprogramming ☐

Funding		
	Total requirement for agency's sector response to current emergency:	**US$ 255,200,000**
	Total funding received for agency's sector response to current emergency:	**US$ 103,500,000**
	Amount received from CERF:	**US$ 6,900,027**
	Total CERF funds sub-granted to implementing partners:	**US$ 0**
	Government Partners	US$ 0
	International NGOs	US$ 0
	National NGOs	US$ 0
	Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Overview

With the global spread of COVID-19 in 2020, from March to December 2020, the contribution from CERF allowed UNHCR to respond quickly to the most time critical needs of refugees in **Jordan and Iran**, as well as returnees in **Venezuela**, helping to ensure that displaced populations were able to access health assistance, meet their basic needs, and mitigate against the spread of the virus. Over 55,000 refugees received multi-purpose cash assistance in Jordan, 22,000 healthcare workers received PPE in Iran, and 14,000 returnees and 130,000 host community members in Venezuela benefitted from distribution of 42,360 NFI kits, 20,516 hygiene kits, and 88 water tanks.

Jordan

With the support of CERF, in Jordan UNHCR assisted 11,115 families / 55,573 individual refugees with one-time 200 USD multi-purpose cash assistance. The project targeted refugees living in urban settings to help them meet their basic needs for food, shelter, and health, as income sources have been destabilized because of the COVID-19 pandemic. The assistance thus helped mitigate the negative effects of COVID-19 and provided refugees with temporary means to survive the lockdown and its detrimental consequences.

Iran

In Iran, UNHCR provided PPE, including over 240,000 N95 respiratory masks and 6,406 protective equipment kits (e.g. goggles, face shields, face masks, gloves, gowns, coverall suits, surgical scrubs, aprons, gumboots, surgical head covers, and hoods) to assist 22,000 healthcare workers in 65 university hospitals in areas and sites where refugees are hosted. As Iran has had the highest share of reported COVID-19 infections and deaths in the region, the scale and scope of the outbreak in the country, combined with the effects of sanctions and border closures, severely affected the Government's ability to respond to the crisis. As a result, with CERF's support, UNHCR was able to help address critical PPE shortages in the country by undertaking international procurement and airlifting the items. This has in turned helped the Government maintain its refugee inclusive health policies, by ensuring health centres in refugee hosting areas received urgently needed PPE.

Venezuela

With the influx of returnees and the outbreak of COVID-19 in Venezuela, CERF support enabled UNHCR to assist over 144,000 Venezuelans, including returnees, through the distribution of 41,560 NFI kits, 20,516 hygiene kits, 800 community NFI kits, and 88 water tanks. The Community NFI kits included bleach, alcohol, disinfectant, gloves, and face masks, which were distributed to 42 health centres in prioritized communities. The water tanks were further installed in PASI reception and quarantine centres, hospitals, clinics, health centres, and emergency service centres. Hygiene kits, including alcohol, disinfectant gel, wet wipes, and other hygiene items were distributed to 26,000 vulnerable individuals, and standard NFI kits, including jerry-cans, plastic buckets, sleeping mats, and hygiene kits, benefited 105,706 individuals in the PASI reception and quarantine centres.

3. Changes and Amendments

There were no changes or amendments, the project was implemented as planned.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health - Health									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	8,098	8,910	1,621	1,621	**20,250**	12,600	13,860	2,520	2,520	**31,500**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	32,390	35,640	6,485	6,485	**81,000**	50,400	55,440	10,080	10,080	**126,000**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**40,488**	**44,550**	**8,106**	**8,106**	**101,250**	**63,000**	**69,300**	**12,600**	**12,600**	**157,500**
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**

Sector/cluster	Water Sanitation Hygiene - Water, Sanitation and Hygiene									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	0
Returnees	3,384	3,722	677	677	**8,460**	6,244	5,159	1,529	1,344	14,276
Internally displaced people	0	0	0	0	**0**	0	0	0	0	0
Host communities	5,077	5,585	1,015	1,015	**12,692**	10,821	8,942	2,650	2,330	24,743
Other affected people	0	0	0	0	**0**	0	0	0	0	0
Total	**8,461**	**9,307**	**1,692**	**1,692**	**21,152**	17,065	14,101	4,179	3,674	39,019
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

Sector/cluster	Multi-Cluster - Multi-sector refugee assistance									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	13,025	7,014	15,030	15,029	**50,098**	14,126	9,463	15,992	15,992	55,573
Returnees	0	0	0	0	**0**	0	0	0	0	0
Internally displaced people	0	0	0	0	**0**	0	0	0	0	0
Host communities	10,000	10,000	0	0	**20,000**	10,000	10,000	0	0	20,000
Other affected people	0	0	0	0	**0**	0	0	0	0	0
Total	**23,025**	**17,014**	**15,030**	**15,029**	**70,098**	24,126	19,463	15,992	15,992	75,573
People with disabilities (PwD) out of the total										
	456	245	526	526	**1,753**	**494**	**331**	**559**	**559**	**1,943**

Sector/cluster	Emergency Shelter and NFI - Shelter and Non-Food Items									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	1,440	1,560	0	0	**3,000**	46,231	38,201	11,320	9,954	105,706
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	2,160	2,340	0	0	**4,500**	0	0	0	0	0
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**3,600**	**3,900**	**0**	**0**	**7,500**[18]	**46,231**	**38,201**	**11,320**	**9,954**	**105,706**
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	611	505	150	132	1,398

[18] During the application phase, planning figures for emergency shelter and NFI accidentally were accidentally recorded in terms of number of households rather than number of people.

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

In Jordan, although the project indirectly benefitted the host community by supporting the local economy, there were not quantifiable indirect beneficiaries targeted.

By providing PPE to healthcare workers in Iran, this has also indirectly benefited thousands of refugees and host communities serviced by the 65 university hospitals in 31 provinces, by helping to limit and contain the impact of COVID-19.

In Venezuela, the assistance provided to the 42 health centres helped UNHCR indirectly reach over 101,000 returnees and host community members who accessed the health services through these centres.

6. CERF Results Framework.

Project objective	Provide urgent support to preparedness and response activities for the Covid-19 emergency to UNHCR's persons of concern.
Output 1	Protection and assistance are provided to Covid-19 affected refugees in Iran Multi-Cluster - Multi-sector refugee assistance

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Multi-Cluster - Multi-sector refugee assistance			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	# of protective health equipment procured	Estimated 20,000 healthcare workers	20,000	MoH and MoHME Reports
Explanation of output and indicators variance:				

Activities	**Description**	**Implemented by**
Activity 1.1	Procurement of protective health equipment	UNHCR

Output 2	Protection and assistance are provided to Covid-19 affected refugees in Jordan

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Multi-Cluster - Multi-sector refugee assistance			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	# of people receiving a one-off cash-assistance	50,098	55,573	Month end reports from the Bank
Indicator 2.2	Amount of cash transferred	2,223,081	2,223,081	Month end reports from the Bank
Explanation of output and indicators variance:		The family size of the beneficiaries was slightly higher than estimated in the proposal.		

Activities	**Description**	**Implemented by**
Activity 2.1	Provide a one-off cash assistance to vulnerable refugee families in Jordan (in urban areas; all nationalities).	UNHCR

Output 3	Protection and assistance are provided to Covid-19 affected people in Venezuela			
Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☐
Sector/cluster	Water Sanitation Hygiene - Water, Sanitation and Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	# of hygiene kits procured	Estimated 21,152	20,516	UNHCR (Supply PO)
Indicator 3.2	# of water tanks procured	Estimated 70	88	UNHCR (Supply PO)
Indicator 3.3	# of NFI kits procured for community health centers	Estimated 420	800	UNHCR (Supply PO)
Indicator 3.4	# of NFIs procured for vulnerable Venezuelans	Estimated 30,000	41,560	UNHCR (Supply PO)
Explanation of output and indicators variance:		Considering the size/volume of an 8,000 litres water tank, purchasing also small size/volume tanks (2,100 litres) increased the installation feasibility in places with limited space. The procurement costs of NFI Kits were lower than initially estimated which allowed UNHCR to increase the number of NFI kits for community health centers and for distribution to vulnerable Venezuelans		

Activities	**Description**	**Implemented by**
Activity 3.1	Procurement of hygiene kits	UNHCR
Activity 3.2	Procurement of water tanks	UNHCR
Activity 3.3	Procurement of NFIs for community health centres	UNHCR
Activity 3.4	Procurement of NFIs for vulnerable Venezuelans	UNHCR

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[19] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP)[20]:

UNHCR has a strong commitment to ensuring **Accountability to the Affected People**. In Jordan, Iran, and Venezuela, views of the affected population have sought throughout the design, implementation, and monitoring of the project. Project are designed based on the feedback of affected populations through focus group discussion, using an Age, Gender and Diversity approach (AGD) to identify the most pressing needs and priorities. Throughout implementation two-way communication with beneficiairies is actively sought, through established remote communication mechanisms, which were further strengthened during the course of the project in order to adapt to the COVID-19 pandemic. For instance in Jordan, multiple tools were used for communitication with beneficiaries, including the Helpline,

[19] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[20] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

remote focus group discussions, information sessions, remote surveys and meetings, targeted visits, phone counselling, e-mail, WhatsApp, Help website, social media, and community structures. In Iran, UNHCR offices across the country operate hotlines from Sunday to Thursday allowing for two-way communication with refugees. Offices also conducted outreach via phone to Refugee Focal Points and other community members with different profiles to obtain feedback. This information has informed the implementation and monitoring of the project.

b. AAP Feedback and Complaint Mechanisms:

UNHCR has established strong AAP feedback and complaints mechanisms in each of the country operations where the project has been implemented. Specific tools developed by UNHCR include and are not limited to UNHCR confidential complaint boxes at the registration centres, online pages for refugees illustrating how to report fraud, exploitation, or abuse, UNHCR Helplines, and a dedicated email address. Community structures/committees have also been utilized for receiving feedback from beneficiaries. These mechanisms contribute to transparency by creating multiple channels for people to register concerns, report misconduct, and the abuse of power by the organisation, staff, or partners. Such mechanisms provided invaluable sources of information instrumental for better project management and outcomes, which are followed-up by UNHCR's staff in the respective operations.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

UNHCR has put Standard Operating Procedures in place for **Prevention of Sexual Exploitation and Abuse (PSEA**), operationalising the four main referral pathways for all victims (safety/security, legal, medical, and psychosocial), and promotes the same with partners, including the Government. UNHCR staff and partners are also made aware of their duty of care to act on any concerns about sexual exploitation or abuse to ensure that the situation is addressed as a matter of priority. UNHCR ensures regular outreach to communities and awareness raising on PSEA as a preventive measure. Mechanisms are in place to report any type of misconduct (including PSEA allegations) to the appropriate office at UNHCR headquarters in Geneva. In Jordan, UNHCR also supports inter-agency efforts around PSEA, as lead of the PSEA Network and administrator of the Community Based Complaint referral mechanism (CBCRM). The PSEA Network works to increase community awareness and capacity on SEA in camps and urban areas.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

UNHCR applies **an Age, Gender and Diversity (AGD)** approach to all programming and projects, ensuring that activities are adapted to the specific needs of the populations we serve. The project's interventions were implemented also in complementarity to UNHCR's other protection interventions, such as community sensitization on SGBV and gender equality, advocacy for gender sensitive inclusion of refugee women and girls in health systems (e.g. maternal and child health, antenatal care and family planning in health posts), as well as the established community structures where women play a prominent role, and help to identify/prioritize the beneficiaries for distribution of NFIs and hygiene kits. In Jordan, for instance, the targeting criteria for cash assistance is determined by the Vulnerability Assessment Framework (VAF), which assesses the risk of exposure of refugee households to harm, primarily in relation to protection risks and other dimensions. For the selection of beneficiaries, 25% (i.e. 2,723) were female headed households. This helps to directly contribute to gender equality, because when women and girls have equitable access to and control over resources and are able to meaningfully participate in and influence decision making processes, they are rendered less vulnerable to sexual exploitation and negative coping strategies, such as child marriage or forced labour.

e. People with disabilities (PwD):

The intervention considered disability as part of a larger vulnerability-based beneficiary selection criteria, with over 1,900 Individuals and their families directly benefitting from the cash assistance in Jordan, and 1,397 receiving hygiene kits in Venezuela. Through the cash assistance, support from CERF has helped individuals with disabilities to meet their basic needs according to their own priorities, including facilitating access to health care. This was further implemented in complementarity with UNHCR's other protection interventions, particularly to help address the additional barriers faced by PwD to access healthcare due to the COVID-19 pandemic and resulting mobility restrictions. UNHCR worked with partners to follow up with PwD and the caregivers/support persons through various modalities including phone calls, video calls, and, when possible, in-person visits in line with MoH guidelines.

f. Protection:

Protection considerations underpin all interventions undertaken by UNHCR during all stages of the programme cycle. In so doing, efforts are made to ensure that individual rights are respected as part of programming and that potential protection risks are identified from the outset and mitigated. As part of its standard protection mainstreaming efforts, funding from CERF supported UNHCR to prioritize the safety and dignity of beneficiaries, and ensured meaningful access to health services, accountability measures, and promoted the participation and empowerment of vulnerably groups throughout the project. By enabling UNHCR to support the Governments of Jordan, Iran, and Venezuela in responding the unprecedented health and socio-economic emergency caused by COVID-19, the project supported UNHCR's broader advocacy efforts to maintain the protection space and rights for refugees and returnees.

g. Education:

N/A

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
Yes, CVA is a component of the CERF project	Yes, CVA is a component of the CERF project	55,573

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

CVA was not considered for Venezuela due to the hyperinflation affecting the economy, the constant devaluation of the national currency, the informal nature of the creeping dollarization process in the country and the extreme scarcity of cash.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
Multi-purpose cash assistance	11,115 families / 55,573 individuals	2,223,081	Unconditional	Unrestricted

9. Visibility of CERF-funded Activities

Guidance (to be deleted): Please list weblinks to publicly available social media posts (Twitter, Facebook, Instagram, etc.), videos and/or success stories, evaluations or other kind of reports on the agency's websites covering CERF-funded activities under this project.

Title	Weblink
Social Media	https://twitter.com/UNHCRJordan/status/1262283729344618496 https://twitter.com/UNHCRJordan/status/1259775450223689728 https://twitter.com/UNHCRJordan/status/1275681328684556289 https://twitter.com/UNHCRgov/status/1268480268937109505 https://twitter.com/IFreijsen/status/1252525867227656194?s=20

	https://twitter.com/IFreijsen/status/1267816746326482950 https://www.instagram.com/p/CA7SLYJAgDG/ https://www.instagram.com/p/CAqnqHsn8pd/ https://www.instagram.com/p/CAgOqr7HxmS/ https://www.instagram.com/p/CAYmK9Vnw-3/ https://www.instagram.com/p/CAVnK7NHWLs/ https://www.instagram.com/p/CANx05AHxNw/ https://twitter.com/ACNUR_Venezuela/status/1281652182073237504 https://www.instagram.com/p/CCeJTxtJNM5/ https://www.instagram.com/p/CCqygIqJqIo/ https://twitter.com/ACNUR_Venezuela/status/1283431083535749120 https://www.instagram.com/p/CCwS47zpcPZ/ https://twitter.com/ACNUR_Venezuela/status/1283431083535749120 https://www.instagram.com/p/CDmGV6kHBZv/ https://www.instagram.com/p/CDt0e-UnCLj/ https://www.instagram.com/p/CDzRbPfA-GE/ https://twitter.com/ACNUR_Venezuela/status/1293637228929982465 https://www.instagram.com/p/CD12lSlgOlf/ https://twitter.com/ACNUR_Venezuela/status/1294001010449448969 https://www.instagram.com/p/CECVoHFgeX5/ https://twitter.com/ACNUR_Venezuela/status/1295758426165977088 https://www.instagram.com/p/CEKCj1igC_y/ https://twitter.com/ACNUR_Venezuela/status/1296839197098151937 https://www.instagram.com/p/CEZm4yIAUDR/ https://twitter.com/ACNUR_Venezuela/status/1299027812851036161/photo/2 https://twitter.com/ACNUR_Venezuela/status/1300849675415756800 https://www.instagram.com/p/CEmjBlNnZpX/ https://www.instagram.com/p/CE11sJdnndC/ https://twitter.com/ACNUR_Venezuela/status/1303000676591710208 https://www.instagram.com/p/CFZzQfEHY3_/ https://twitter.com/ACNUR_Venezuela/status/1308062199781437444 https://twitter.com/ACNUR_Venezuela/status/1308813332896518147 https://www.instagram.com/p/CFfJA7bHB1k/ https://www.instagram.com/p/CJkOZKgHxqe/
Web stories	https://www.unhcr.org/jo/13189-unhcr-begins-distribution-of-emergency-cash-assistance-appeals-for-79-million.html https://cerf.un.org/news/story/sms-instant-relief-ibrahim-and-his-family-receive-much-needed-support
Signboards	Signboards in different locations
UNHCR reports	https://data2.unhcr.org/en/documents/details/84307 (this is an example of many reports acknowledging CERF's contribution)
Press Release	https://www.unhcr.org/ir/2020/05/07/unhcr-flies-additional-aid-items-to-iran-to-fight-the-coronavirus/

PART XIV – AGENCY OVERVIEW: UNICEF

1. STRATEGIC PRIORITIZATION

Statement by the agency focal point:

CERF enabled UNICEF to respond to critical needs of children and their families when the impact of COVID-19 and its associated mitigation measures were having significant negative impact on them. CERF ensured lifesaving health and nutrition services were sustained and bridged gaps in government provided services in 23 countries through provision of PPE, delivery of essential health and WASH supplies and services, and training of healthcare workers (in IPC and detection, referral, and management of COVID-19 cases) that benefitted over 3.7 million women and children. When schools closed due to COVID-19, CERF support was critical in contributing to national education systems developing and rolling out distance/home-based learning programmes, keeping over 30 million children learning in 5 countries. Restricted movements, physical distancing, and fear of the disease took a significant toll on mental health and wellbeing and thanks to CERF support, over 318,000 children, parents and primary caregivers were reached with mental health and psychosocial support during the first few months of the pandemic in 13 countries. CERF was one of the first funds received for the COVID-19 response by UNICEF teams in some countries, including Ecuador, Sudan, Somalia and Haiti, and these timely funds helped to kickstart UNICEF, government, and partner responses.

CERF's Added Value:

CERF was one of the first funds received by UNICEF in Somalia and kickstarted the COVID-19 response with procurement of health-related commodities (PPE and IPC supplies), ensuring continuity of health services. In Pakistan, CERF contributed to initial development of content and rollout of the national education response, helping to ensure continuity of learning for 1.27 million children directly, and contributing to the distance/home-based learning programmes which reached 8 million children with high, low, and no tech modalities. In Iran, CERF helped fill a critical gap in COVID-19 test kits, when cases were spiking at an alarming rate, used to identify positive cases for contract tracing – key in curbing the spread of the virus. In Haiti CERF supported the purchase of oxygen cylinders and concentrators, emergency health kits, equipment, medicines, and consumables that were distributed to 15 public hospitals to maintain healthcare services for approximately 10,000 people over an initial 3-month period during the peak of the COVID-19 crisis. Over 10,000 handwashing stations were also installed in Haiti in public spaces and private and public institutions (including schools) allowing more than 2 million people to wash their hands as a key COVID-19 prevention measure. In Peru, CERF enabled the design and start of UNICEF Peru's first cash transfer programme, aimed at 1,577 Venezuelan migrants to help them mitigate the economic hardships caused by COVID-19. CERF was also instrumental in supporting UNICEF teams in many countries to strengthen national coordination mechanisms which included the development and monitoring of sectoral COVID-19 response plans and roll out of programmes.

Did CERF funds lead to a fast delivery of assistance to people in need?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help respond to time-critical needs?		
Yes ☒	Partially ☐	No ☐
Did CERF improve coordination amongst the humanitarian community?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help improve resource mobilization from other sources?		
Yes ☐	Partially ☒	No ☐

Considerations of the ERC's Underfunded Priority Areas[21]:

In all UNICEF interventions supported by CERF gender was taken into consideration during the design, implementation and monitoring phases. The project outputs and outcomes targeted females and males equally, where appropriate, and where one gender required differential support, UNICEF's interventions met those needs where possible. As an example, in Afghanistan, the health and nutrition programme specifically targeted pregnant and lactating women who are the most vulnerable at community

level and supported them with access to and provision of gender-based specific services, such as antenatal care, postnatal care, family planning, and screening and GBV case referrals. In Burundi, female psychologists were preferentially recruited to encourage women and girl's participation in psychosocial support as women and girls often do not attend these services. In Turkey, the design of the COVID-19 hygiene kits as well as the information brochures included in the kits addressed the specific needs of women and girls. UNICEF interventions also took into consideration disabilities, working to ensure equity in programme targets, reach and impact for all. In Afghanistan, social workers received an orientation at the start of the child protection programme to ensure that children requiring assistance due to their disabilities were supported and activities were adapted and appropriate for them. Additionally, in Afghanistan, as part of the cash grant programme UNICEF worked with government social departments to actively target persons with disabilities through verification of existing lists of persons with disabilities collected by Government agencies. In Peru, the cash-based programme used a vulnerability scorecard where the existence of persons with disabilities or severe medical and mental health conditions were strong factors in selection criteria for entry into the programme. In Chad, people living with a disability, in particular women and girls, were given priority in the selection of beneficiaries for CERF supported programmes. In the refugee camps in Tanzania, COVID-19 prevention messages were tailored to people with special needs in of braille form, sign language posters and application videos and disseminated through peer education and service provision centres. Additionally, in Tanzania, four block latrines that provide special access for children with physical disabilities, ramps leading to latrines as well as handwashing stations using foot operated taps were implemented in schools in the refugee camps that had children with disabilities in attendance. Considerations for the protection of all beneficiaries was taken in all CERF supported interventions. As an example, in Afghanistan, mobile health and nutrition services were made safer via tents set up for consultations to provide privacy for confidential discussion and examinations of patients. In Myanmar, nutrition services sites were located in safer areas and services were provided during daylight to ensure beneficiaries could access the services and return to their homes before dark to lessen protection concerns. Education for children was a significant component of the CERF supported programmes in 6 countries where the development and roll out of national distance and homebased learning programmes helped to keep over 30 million children learning while schools were closed.

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount (US$)
UNICEF	20-RR-CEF-030	Health - Health	$4,380,000
UNICEF	20-RR-CEF-030	Water Sanitation Hygiene - Water, Sanitation and Hygiene	$3,285,000
UNICEF	20-RR-CEF-030	Protection - Child Protection	$1,642,500
UNICEF	20-RR-CEF-030	Education - Education	$1,642,500
UNICEF	20-RR-CEF-025	Health - Health	$2,700,000
UNICEF	20-RR-CEF-025	Education - Education	$1,250,000
UNICEF	20-RR-CEF-025	Protection – Child Protection	$1,050,000

2. OPERATIONAL PRIORITIZATION:

People Directly Reached:

Through CERF support over 51 million people were reached with messages on COVID-19 prevention and access to services, exceeding the target by 4%, however, Haiti reported their risk communication and community engagement results of 6.5 million people reached under the WASH sector, and if it were included under the health sector this result would have exceeded the target by 15%. This overachievement is attributed to the use of television, radio, social media and digital forums that reached large numbers of people.

Essential healthcare services in UNICEF and CERF supported facilities served 2.7 million children and women - exceeding the target by 19%. This was possible due to the wide variety of interventions undertaken covering large geographic areas (i.e. many health facilities) in 18 countries, the decreased commodity costs in some countries, and from co-funding of some interventions by additional donors.

Through CERF support, 4.9 million people in 14 countries were reached with critical WASH supplies including hygiene items and services, which exceeded the target by 55% mainly due to high numbers of people reached in Burundi with bars of soap and through the installation of 10,000 handwashing stations in Haiti that were installed in public locations, including schools, which have consistently large numbers of people utilizing them.

Over 7,000 healthcare workers in 7 countries were trained in IPC measures to reduce COVID-19 transmission in healthcare facilities, while 14,600 healthcare staff were trained in 9 countries on detecting, referring, and managing COVID-19 cases, exceeding the original targets by 85% and 72% respectfully. The needs increased significantly because COVID-19 cases increased widely through these countries. Once the trainings switched to online/remote modalities, many more people could be reached at no extra cost. The number of healthcare staff and community workers provided with PPE through CERF support was 28,000 in 11 countries, which exceeded the original target by 83% mainly due to the reduction in costs in PPE from the initial project planning stages.

Over 18 million children were provided with distance/online education programmes exceeding the original targets by 71%, mainly by TV, radio and digital lessons that were broadcast throughout countries reaching a significantly higher number of children than originally planned.

Over 230,000 people were reached with community based mental health and psychosocial support exceeding the original targets by 50% which can be attributed to some countries incorporating psychosocial and mental health support with COVID-19 awareness raising activities and through other donor co-funds, allowing for a significantly higher than planned number of people being reached.

People Indirectly Reached:

It is difficult to quanitfy the number of people who were or will be indirectly reached by CERF supported programmes. In many countries COVID-19 prevention messages and information campaigns reached many people indirectly (through passing of information between community members, friends and families). Wtihin the health sector, UNICEF's support to the national health system, through fund support, traning, mentoring, coordination and planning with national health authorities and teams, as well as through the training of health workers in IPC, detection and management of COVID-19 cases, through the provision of PPE for health staff, medical supplies, including drugs, and support for improved WASH facilities and supplies, have reached millions of people and will continue to support millions in the future. Within the WASH sector, the establishment of handwashing facilities, toilets, water storage tanks as well as the distribution of hygiene supplies and support for hygiene awareness, can be expected to benefit many more people than results reported in this report as some of these WASH facilities and knowledge will remain and benefit people for years to come.

PART XV – PROJECT OVERVIEW: UNICEF

Project Report 20-RR-CEF-030

1. Project Information						
Agency:	UNICEF			**Country:**	Global	
Sector/cluster:	Health - Health Water Sanitation and Hygiene Protection - Child Protection Education - Education			**CERF project code:**	20-RR-CEF-030	
Project title:	Preventing and Responding to the COVID-2019 Pandemic					
Start date:	01/04/2020			**End date:**	31/12/2020	
Project revisions:	No-cost extension	☐	Redeployment of funds	☐	Reprogramming	☒

Funding		
	Total requirement for agency's sector response to current emergency:	**US $1.93 Billion**
	Total funding received for agency's sector response to current emergency:	**US $1.62 Billion**
	Amount received from CERF:	**US $10.95 Million**
	Total CERF funds sub-granted to implementing partners:	**US$ 5,136,218**
	Government Partners	US$ 1,692,199
	International NGOs	US$ 2,319,758
	National NGOs	US$ 1,068,226
	Red Cross/Crescent Organisation	US$ 56,035

2. Project Results Summary/Overall Performance

Overview

Through this CERF grant, 2.7 million people were provided with continued access to essential health care services in 18 countries; protection services were enhanced with mental health and psychosocial support reaching 219,567 people (including 131,000 children) in 9 countries; risk communication and community engagement (RCCE) interventions reached 12.7 million people with critical mCOVID-19 prevention and access to service messages; 4.9 million people were reached in 14 countries with WASH supplies and services to mitigate the risks of COVID-19 transmission; approximately 12.2 million children were able to continue their education during closures through distance/homebased modalities; cash-based transfer and voucher programmes benefited over 40,000 people, including over 11,000 school children in 6 countries.

Afghanistan

CERF helped UNICEF and partners reach 221,450 people (including 138,151 children) with essential health, nutrition, and child protection services (including the disbursement of cash grants) as part of its COVID-19 response in seven provinces of Afghanistan (Kandahar, Helmand, Uruzgan, Zabul, Herat, Badghis and Ghor). In health and nutrition CERF supported the operations of 38 mobile health teams in the seven provinces providing 228 staff with PPE, training for 152 staff on proper screening, referral and infection prevention measures, and reaching 13,812 people with health and nutrition support, including 4,352 women with COVID-19 related nutrition counselling. CERF enabled UNICEF and partners to reach 193,340 community members, including IDPs, in Herat province on COVID-19 prevention using TV, radio, billboards and distribution of information, education and communication (IEC) materials. Amongst the population reached in Herat, 1,633 children were reached with community based mental health and psychosocial support (MHPSS) activities. Through the Child Helpline and house-to-house visits, 165 child protection cases were identified and referred to

appropriate services. UNICEF provided an unconditional, unrestricted cash transfer to 2,010 households who had children working in dangerous situations during the COVID-19 pandemic in Herat province, benefitting 14,070 people and financially supporting families. UNICEF used a cash plus approach, combining cash transfers with child protection case management and COVID-19 information sessions.

Bolivia
Through CERF, UNICEF and partners provided mental health and psychosocial support to 787 caregivers and 1,113 children (including 426 migrant and asylum-seeking children; 687 children from host communities, children living on the streets and victims of violence and sexual exploitation). The staff who provided psychosocial interventions were trained by UNICEF in psychological first aid, in identification of children of concern, and referral mechanisms. The intervention took place in 5 shelters for migrants and 3 host communities in 3 departments of the country (La Paz, Santa Cruz and Beni). Cash transfer assistance was provided by CERF to 840 people, including 250 Venezuelan migrant and asylum-seeking children and 42 children in vulnerable situations from host communities. The cash transfers were unconditional and unrestricted, and beneficiaries were targeted based on a number of criteria including difficulties in covering rent and food.

Brazil
The CERF grant helped ensure the uninterrupted provision of critical WASH services through the installation of 11 handwashing stations, water storage units and water trucking services, in both official shelters and in spontaneous settlements, benefiting over 9,200 Venezuelan migrants and refugees in Roraima State. The capacity of 30 community WASH monitors was strengthened through trainings and mentoring to conduct hygiene promotion activities, monitoring and basic maintenance of WASH facilities in these communities. CERF supported nutritional surveillance and screening of over 2,500 children under 5 and micronutrient supplementation for over 1,000 children aged 6 to 59 months. High risk groups living in shelters in Boa Vista were reached through mobile health and nutrition teams providing on average 1,800 weekly consultations in 2020. A total of 6,615 women and children were provided with essential healthcare services in UNICEF supported facilities while 5,756 people were reached with COVID-19 messages on prevention and access to essential services. To ensure the continuity and expanded coverage of education and psychosocial support, the CERF grant partially contributed to the purchase and distribution of 2,000 radio sets and solar chargers to families who tuned into 72 age-appropriate educational episodes, co-created with children and adolescents and narrated in Portuguese, Spanish and Warao. From this intervention 2,600 children had access to distance learning during pandemic school closures. CERF supported the Super Panas safe spaces programmes implemented by Pirilampos where 2,500 children and adolescents accessed a diversity of psychosocial support activities and protection interventions.

Burundi
CERF played an important role in supporting UNICEF's programmes in RCCE, WASH, health, nutrition, and child protection and covering the most immediate needs in the response to COVID-19. More than 3.59 million people in 6 of Burundi's 18 provinces benefited from COVID-19 protection and prevention messages, while 2.5 million were reached by Operation Blue Soap (the provision of soap during the pandemic when the market was not able to keep up with the demand). Through CERF support, 119,823 children were reached with messages on personal hygiene and improved sanitary practices. A total of 93,800 caregivers of children under 2 years old were reached with messages on the importance of breastfeeding, while 2,126 children 6-59 months were treated for SAM through the procurement of 1,928 cartons of RUTF. In addition, 445 health workers were trained on awareness raising about health and hygiene practices. Through CERF support, 70,766 caregivers and 107,000 children were reached with mental health and psychosocial support activities, while 4,750 children were provided with alternative care arrangements.

CAR
Through this CERF grant, 21,386 people (including 7,238 women; 3,570 girls and 3,360 boys) were reached with critical WASH supplies and services to prevent and control the spread of COVID-19. These were: installation and management of 30 public handwashing stations at strategic points (marketplaces, bus and taxi stations, stadiums in Koui, Bocaranga and Ngaundaye sub-prefectures, at the border with Cameroon); through the set up and management of three water emergency distribution systems in Bangui to mitigate acute water shortages during the pandemic. CERF supported the provision of PPE to 339 health workers in 14 health centres on the Bossembele-Yaloke-Bossemptele and Yaloke-Pama axes, while 234 health workers were trained on COVID-19 community-based surveillance and IPC, and 180 health care providers were trained in the detection, referral and appropriate management of COVID-19 cases. Five isolation and management centres for COVID-19 were supported with rehabilitation work and rapid COVID-19 tests, medicines and consumables in the Bouar-Ngaraboulaye and Berberati-Kenzo corridors (Nana Mambéré and Mambéré Kadéi prefectures). A total of 10,016 people (including 5,989 women and children) were provided with essential health care services through CERF support. Through CERF 12,832 individuals (5,954 females) were reached through awareness raising sessions and community dialogues on key child protection concerns, including GBV, care and protection for children without adequate parental

care and protection of children from recruitment into armed groups in the context of COVID-19. UNICEF and partners trained 316 (90 females) NGO and government staff as frontline child protection responders, including in psychological first aid, identification of child victims or at risk of violence, abuse and exploitation, and support service referrals.

Chad
With this CERF grant, UNICEF and partners raised awareness on good hygiene practices and preventive measures against COVID-19 reaching 2,530,000 people (1,315,600 girls and women). RCCE interventions targeted people in health facilities, public spaces, markets, places of worship, schools, vulnerable households and displacement sites in the provinces of N'Djamena, Ouaddai, Guera, Kanem, Lac, Logone Occidental, Logone Oriental, Tandjilé, and Mandoul. UNICEF's WASH interventions focused on ensuring strong IPC in health care facilities, publics spaces and IDP sites. CERF helped to build the capacity of 1,857 health workers, intermediaries and hygiene technicians on IPC in all 23 provinces in the country, while 34,200 people were reached with critical WASH supplies (including hygiene items) and services in displacements sites among which 4,200 benefitted from access to gender-separated latrines. In health facilities, UNICEF and partners provided 6,650 social workers, sanitation technicians and hygienists with PPE in the provinces of N'Djamena, Ouaddai, Lac, Logone Occidental, Logone Oriental, Tandjilé, Lac, Mandoul, Guera, and Kanem. While 112 health facilities were provided with handwashing, sanitation and maintenance equipment kits to prevent COVID-19 in the provinces of N'Djamena, Logone Oriental, Tandjile, Logone Occidental and Mandoul. Oxygen equipment (15 concentrators, 35 oxygen cylinders), PPE and emergency medicines enabled 1,000 COVID-19 patients to receive essential healthcare in UNICEF supported facilities, and 834 health staff were trained on surveillance and COVID-19 case management in districts of Kanem, Hadjer Lamis and Ouaddai provinces. In N'Djamena, UNICEF and the provincial delegation for social action (Délégation Provinciale de l'Action Sociale, DPAS) reached 12,291 children (570 girls) with hygiene items and messages covering COVID-19 protection and preventative measures. A total of 132 children were reached with mental health and psychosocial support services while 82 children were supported with alternative care arrangements thanks to CERF support.

Colombia
Through this grant, UNICEF and partners reached 88,655 people in La Guajira department with COVID-19 related messages on prevention and access to services. Access to water, sanitation, and the promotion of adequate hygiene practices to prevent the spread of COVID-19 were provided to 12,327 people in informal settlements in urban and peri-urban areas, while 7,652 people were provided with hygiene kits and 84 medical staff from Uribia´s main hospital were provided with PPE. A total of 1,106 children and 846 pregnant and breastfeeding women were supported with maternal, child health and nutrition services (including prenatal care, malnutrition screening, child growth and development monitoring, vaccination, psychological first aid interventions), with a special emphasis on girls and boys under 5 years old and adolescent mothers between 10 and 14 years of age. Through health-related support, including public health awareness raising and provision of essential health care services, a total of 4,111 people were reached through CERF support.

Ecuador
Through this grant UNICEF provided 60 oxygen concentrators to 24 hospitals, including a pediatric hospital, in towns with high percentages of indigenous populations as these people were the most disadvantaged by the crisis due to poverty, social exclusion and lack of access to health services. The provinces where the oxygen concentrators were sent were Chimborazo, Tungurahua, Bolivar, Loja and Azuay in the highlands; El Oro in the coast and Zamora Chinchipe, Napo, Orellana, Pastaza, Sucumbios and Morona Santiago in the Amazon region. Oxygen concentrators are one of the most essential pieces of equipment in the care of mild and moderate cases of COVID-19 and thanks to this intervention over 10,854 people (including 5,491 women and children) were provided with adequate oxygen therapy.

Haiti *(Haiti's results in this report cover two COVID-19 CERF grants as requested and approved by OCHA's CERF team)*
The CERF grants supported the purchase of 8,600 oxygen cylinders and 70 oxygen concentrators, emergency health kits, equipment, medicines and consumables for 15 public hospitals to maintain healthcare services for approximately 10,000 people over an initial 3-month period during the peak of the COVID-19 crisis. In addition, 117 health workers were trained on COVID-19 patient management, 95 health workers were trained in oxygen therapy, 11,000 health workers and community volunteers were trained on awareness raising about health and hygiene practices and 260,000 people were reached with sensitization on the importance of vaccination as a key barrier measure against COVID-19. A total of 2,807 health workers were provided with PPE and trained in IPC through CERF support. Through these interventions 295,990 people (including 168,358 women and children) were reached with essential health care services during the pandemic. Over 10,000 handwashing stations were installed in public spaces and private and public institutions (including 2,500 schools) allowing more than 2 million people to wash their hands as a key COVID-19 prevention measure. Through CERF support 2,646,294 children were reached with messages on personal hygiene and improved sanitary practices. Around 6.5 million people were reached with COVID-19 messages on prevention, access to services and hygiene promotion with the help of at least 10,000 community leaders, 1.2 million leaflets and posters and 12 audio and video spots.

Iran
Through this CERF grant UNICEF procured, shipped and delivered 32,160 COVID-19 test kits to the Ministry of Health and Medical Education to be used for COVID-19 testing among high-risk population groups. Mental health counsellors and social workers serving in social clinics (in Tehran, Markazi, Kohgiluyeh & Boyer Ahmad, West Azarbaijan, Ilam, Kermanshah, Khuzestan, Alborz and Fars) were trained to provide parenting counselling services to families and children reaching 1,500 children with mental health and psychosocial support during the pandemic. Coupled with the above-mentioned intervention, UNICEF supported procurement of a package consisting of toys (puzzles, educational and interactive games, etc) and hygiene items (soap, mask, disinfectant gel, hand and surface sanitizer) for 17,107 children in family-based foster care settings across the country. To support the health of children in challenging settings (i.e. children living on the street, working children, children with disabilities, etc), UNICEF in partnership with the Ministry of Cooperative, Labour and Social Welfare, procured and distributed hygiene items (including 689,700 face masks and bottles for repackaging of procured hand sanitizers) and brochures covering COVID-19 prevention measurements and the instructions for use of PPE items for 11,412 children.

Iraq
Through this CERF grant, UNICEF and its partners reached people with COVID-19 related interventions and services over a 6-month period in Ninewa, Anbar, Salah-al-Din, Kirkuk, Erbil, Duhok, Sulaymaniyah, Najaf, Karbala, Baghdad, Babil, Diyala, Wassit, Missan and Basra. Over 2.3 million people were reached through health-related messaging on prevention of COVID-19 and access to services, while 350 healthcare workers (including 143 women) and community volunteers were trained on health and hygiene practice awareness raising. Over 1.2 million people (including 990,998 women and girls) were reached with essential healthcare services, while 2,000 healthcare workers in 25 health facilities in IDP and refugee camps received PPE and have enhanced their capacity on IPC through trainings.

Libya
With this CERF grant, UNICEF provided oxygen concentrators and emergency health kits, which included items to help meet the immediate primary health care needs of people living in the municipalities of Alkhoms, Baniwalid, Ghat, Kabaw, Misrata, Sabha, Sorman, Tripoli, and Zwara over a 3-month period. With the use of these supplies, an estimated 109,000 individuals (including 78,236 women and children) were reached with primary health care services during the pandemic.

Mali
With CERF support, 94,637 people (including 74,861 women and children) were reached with essential care in health facilities in 6 regions (Mopti, Timbuktu, Gao, Kidal, Taoudeni and Menaka). This was achieved through capacity building of 4,986 health workers (1,504 women) on essential basic care and COVID-19 prevention, awareness raising about health and hygiene practices, and case management, the training of 642 health workers on IPC and the delivery of IPC and PPE materials (including face masks, the installation of handwashing devices and soap) to 25 health care facilities. A total of 194,462 (53,167 women, 44,145 boys and 42,558 girls) were reached with WASH interventions which included the provision of critical WASH supplies (hand washing devices and soap) to 2,189 IDPs in Mambiri camp (Kayes region) and to 13,491 people from the host communities in this same region. In addition, 178,782 people (47,761 women, 41,215 boys and 42,858 girls) were informed and sensitized on the risks and means of prevention of COVID-19 while 3,792 people were reached with emergency protection services including family alternative care and mental health and psychosocial assistance in Bamako district, Mopti and Kayes regions. UNICEF and partners provided alternative family care to 224 children (80 girls) affected by the COVID-19; delivered psychosocial support to 942 children (373 girls) and 315 primary caregivers (227 women); trained 387 UNICEF partners (90 women) on GBV risk mitigation and referral of survivors and sensitized 1,924 people (935 women) on GBV prevention and risks mitigation, referral pathways and access to response services. This enabled the affected population to overcome the psychosocial distress and rebuild their resilience during the pandemic.

Myanmar
With CERF funding, UNICEF in collaboration with partners worked to ensure continuity of life-saving health interventions reaching 144,273 women and children with essential health services (including management of newborn illnesses, severe pneumonia, diarrhea, SAM treatment for 1,742 children, IYCF counselling reaching 34,351 pregnant and lactating women, etc.) that were implemented in Ayeyarwardy, Magway, Sagaing, Kayin, Kachin, Shan North, Shan East and Chin. These services were supported through the provision of PPE for 1,464 health care staff (1,130 female), the procurement of 3,340 cartons of ready to use therapeutic food (RUTF), as well as through the training of 815 health care staff in detecting, referral and appropriate management of COVID-19 cases and the training of 1,492 health staff in IPC. Additionally, 4 hospitals were provided with 20 oxygen concentrators, 4 neopuff (self-inflating resuscitator for newborns), and 9 pulse oximeters with 4 back-up generators to ensure oxygen used for COVID-19 patients does not create a shortage of oxygen for the management of under-5 pneumonia cases. Approximately 700,000 people were reached with

COVID-19 prevention and public health related messaging. In addition, 21 hospitals were provided with improved WASH facilities through the installation of 32 hand washing facilities, 7 water storage tanks along with consumable hygiene items directly benefiting at least 51,182 people. CERF supported the National COVID-19 Call Centre (which answered an average 200 calls per day from the public with concerns and questions about COVID-19) with laptop computers, staff trainings, and staff travel support.

Niger
This CERF grant supported the development and dissemination of COVID-19 prevention messages and information through 23 community radio stations, social media and radio programmes reaching 127,546 people. A total of 12,755 children were reached with targeted messages on personal hygiene and improved health practices, while 6,587 health workers and community volunteers were trained to raise awareness of health and hygiene practices with their local communities. UNICEF reinforced WASH services and strengthened IPC measures in 9 health centers and 2 referral centers in Tahoua. This included 3 boreholes and 30 latrines rehabilitated, 9 new water storage tanks installed, 12 new blocks of latrines constructed, 9 handwashing devices installed and critical WASH supplies including 108 boxes of soap, 9 buckets of calcium hypochlorite and 27 waste bins were provided. These interventions benefited 39,910 people (including 8,549 women, 11,805 girls and 11,342 boys). In addition, CERF funds helped provide 46,785 people (including 44,775 women and children) with access to essential health services during the pandemic. These services were realized through the provision of PPE and training of 92 health staff (77 women) on IPC measures, the training of 157 health workers in epidemiological surveillance and COVID- case management and through the purchase and delivery of medicines and consumables (including antibiotics, ORS/Zn, kits, oxygen concentrators, thermometers) to 9 health centers. In addition, 9 triage centers were built in the health centers in Tahoua, while 8 triage centers were built in the region of Zinder (Dungass Health District) to detect COVID-19 cases early and prevent transmission within the health centers.

State of Palestine
This CERF grant allowed UNICEF to support the most urgent and critical health sector activities to respond to the COVID-19 pandemic through offshore procurement of urgent medical equipment. This mainly included ICU ventilators (built-in Turbin) to ensure delivery of critical and urgent health support for people with COVID-19. At least 54 people benefited from these ICU adult ventilators between October and December 2020. Some 4,560 suspected cases of COVID-19 benefited from the 456 (Xpert Xpress) testing kits procured for the Ministry of Health in the West Bank. CERF support also contributed to reaching 23,124 people with critical WASH supplies through using an innovative e-Voucher system whereby beneficiaries were provided with a card with credit allowing them to purchase prequalified items from approved storekeepers.

Peru
CERF funds enabled the design and start of UNICEF Peru's first cash transfer programme, aimed at helping Venezuelan migrant families mitigate the economic hardships caused by COVID-19. As a result, 400 vulnerable migrant families in two districts of Northern Lima received the first of six-monthly cash transfers of US$217. During the first cash transfer, covered by CERF funds, 1,577 people benefited (including 300 girls, 384 boys, 516 women) and were also provided with information on nutrition, COVID-19, violence prevention and support to access education, health care facilities, protection and migration services. Through this intervention 48 beneficiaries were referred to psychological support while 84 out-of-school children were enrolled in school.

Sudan
Through this CERF grant, UNICEF was able to procure PPE to support 3,315[22] healthcare providers to continue the provision of lifesaving health and nutrition services. In the facilities where UNICEF provided PPE, 485,631 children were reached with essential health care services during the pandemic.

Tanzania
With CERF support, UNICEF and partners reached 176,679 people with COVID-19 prevention messages and information on access to available services, while another 31,082 children were reached with targeted messages on personal hygiene and improved sanitary practices. During the pandemic, 17 healthcare facilities were supported with improved WASH facilities through the provision of handwashing devices with soap, while 194,084 refugees were provided with critical WASH supplies (including hygiene items) and improved WASH services to enhance IPC among the community. A total of 3,949 healthcare workers and community volunteers in the refugee community were trained on health and hygiene practice awareness raising. IPC training was provided to 180 healthcare facility staff and community health workers and 165 healthcare facility staff and community health workers were provided with PPE. With these interventions, 207,761 people (including 139,736 women and children) were able to receive ongoing and safe health related services during the pandemic. Through CERF support, 15,073 caregivers and 14,260 children (5,158 girls) were provided with community-based

[22] *This results is for CERF funds only; the midterm result reported for PPE included other donor funds combined with CERF.*

mental health and psychosocial support services in Mtendeli, Nduta and Nyarugusu refugee camps. Alternative care services were provided to 2,133 children (1,290 girls) in Mtendeli, Nduta and Nyarugusu refugee camps as part of the COVID-19 response.

Turkey
Through this CERF grant, UNICEF and partners supported national IPC efforts through the distribution of 5,050 family hygiene kits reaching 25,798 vulnerable refugees. CERF funding also helped to support the national Education Information Network distance learning platform, which included TV and digital lessons, that has enabled the learning of 12,286,458 students from K-12 grades, including over 768,000 refugee children, when schools were closed.

Ukraine
In Ukraine, CERF helped UNICEF and partners support 23,496 children (including 12,035 preschool-age children in non-government-controlled areas (NGCA) and 11,461 primary and secondary age children in the 0 to 5km zone along the Line of Contact in government-controlled areas). This was achieved by providing infection prevention and hygiene supplies and through the dissemination of information on key preventive measures to 169 schools. In the NGCA, CERF funds provided 3,100 people with critical WASH supplies (including hygiene items). CERF support helped provide 400 healthcare staff and community health workers with PPE and 100 front-line medical workers with Home Visitor Kits including essential medical equipment for screening and monitoring of people's health status. CERF funding enabled 380 frontline health workers to attend 30 training sessions on effective COVID-19 response and treatment management strategies. Medical and non-medical equipment was delivered to 21 health facilities in both Donetsk and Luhansk GCA, while awareness-raising and support activities reached 6,000 families with children under 3 and covered topics including immunization, breastfeeding, early childhood development and COVID-19 prevention measures. Through CERF funds 12,000 women and children were provided with essential health care services, while 621,880 people benefited from health services provided in the facilities where the interventions mentioned above were implemented. Through UNICEF's COVID-19 digital awareness-raising campaign on major social media platforms over 2.5 million people were reached with COVID-19 messages on prevention and access to services. CERF funded protection services reached 3,760 beneficiaries (1,267 boys, 1,344 girls, 1,022 women), including 214 children (101 boys, 113 girls) without parental care in Luhanska and Donetska NGCA. The beneficiaries of these interventions were the most vulnerable boys, girls and caregivers affected by the consequences of COVID-19 and military conflict in eastern Ukraine. UNICEF and partners carried out several activities within Community Protection Centres and mobile teams for children and their caregivers including psychosocial and mental health wellbeing (reaching 1,149 caregivers and 2,397 children), and awareness-raising on child protection issues and child protection case management. Fifty hygiene kits, including PPE, were distributed among the most vulnerable families during child protection service delivery.

Venezuela
Through CERF's contribution, UNICEF supported 102 health centres (including COVID-19 centres, maternal and paediatric control and reference centres, outpatient facilities, hospitals, regional health directorates). Oxygen concentrators for respiratory therapy for COVID-19 patients were distributed to 16 outpatient facilities and 65 hospitals in the border states where population density is high. Through procurement and distribution of essential medicines to health centres, provision of PPE to 12,552 (6,263 female) front line health workers, and training of 7,000 health workers on detecting, referral and management of COVID-19 cases, health services were able to continue, reaching 529,056 people (329,689 women and children), including 51,061 women with antenatal care services. In addition, 300 frontline health workers from Corposalud Táchira, 180 Táchira Civil Protection workers and 2,911 social workers from the Tachira regional government benefited from in-kind incentives, specifically food bags distributed for a period of two months, conditioned to attendance and compliance to duty schedules. UNICEF disseminated key COVID-19 prevention messages, including hygiene and COVID-19 IPC practices, through 52 community promoters and broadcasts on 21 radio stations in the states of Táchira and Amazonas. Promoters and broadcasts also disseminated family practice messages, which include handwashing, importance of education continuity, civil registration of children, and the importance of breastfeeding during COVID-19, among others. In support to community promoter's activities, UNICEF provided bicycles, mobile phones, power banks, some apparel items, and other supplies. In total 529,056 people (including 110,594 children) were reached with these messages.

3. Changes and Amendments

UNICEF teams faced challenges in gathering dissagragated results data from government partners, as many government services and systems were stretched beyond capacity. There were significant delays in supply deliveries with many international and domestic boarder closures, strict quarentine measures and movement restrictions imposed. Due to COVID-19 related movement restrictions, lockdowns and the closure of services, the movement of UNICEF and partner staff, as well as beneficiaries varied signficantly

throughout the pandemic. In some cases, results against some indicators were lower due to these contraints such as in Myanmar and Chad, however, in many countries interventions changed to remote modalities, leading to signficantly more beneficiaries than originally planned. As an example, with the use of television, radio, social media and digital forums for the disimination of awareness and information campaigns over 12 million people were reached through CERF support, a significantly higher number than originally targeted.

Under the WASH programme significant overachievement can be attributed to a few factors: Burundi reached 2.5 million people as these people were provided with bars of soap through a national campaign supported by the government which reached many more people than originally planned; Haiti reported 2 million people reached as 10,000 handwashing stations were installed in public locations including 2,500 schools and the consistent use of these facilities throughout the pandemic led to this large result; Local procurement of some supplies and the reduction of costs in PPE from the initial planning stages of the project contributed to the overachievement in health and WASH results as well.

Under the health programme the overachievement of results can be attributed to the wide variety of interventions undertaken covering large geographic areas (i.e. many health facilities) in the 18 countries that implemented health programmes. The price of commodities during the planning and implementing stages of the project decreased, leaving additional funds which UNICEF was able to use to procure more items, allowing for more people to be reached than originally planned, such as was the case in the Ukraine.

Under the education programme the significant overachievement of the target is attributed to Turkey's result of over 12 million children reached due to UNICEF's support to the national education distance learning platform which included support for the development and roll out of TV, radio and digital lessons that was broadcasted throughout the country reaching a significantly higher number of children than originally planned.

In child protection, the overachievement of results is attributed to Burundi's results for children reached with psychosocial and mental health support as the team incorporated this activity with COVID-19 awareness raising activities, allowing a significantly higher than planned number of people to be reached by this intervention.

Some countries faced unforeseen challenges, such as in Iraq, where some IDP camps that were originally targeted for COVID-19 response were closed abruptly by the government. In Niger, the security situation deteriorated in 2020, and Government imposed armed escorts were required for all movements outside of the urban areas. This heavily limited UNICEF's access to intervention sites for supervision and monitoring purposes, however, UNICEF's team strengthened collaboration with implementing partners to ensure quality services continued.

In Iran, the government originally requested UNICEF to procure oxygen concentrators for the treatment of COVID-19 in hospitals, which UNICEF included in the CERF proposal. However, the government changed their request during the year asking UNICEF to procure COVID-19 test kits instead, which UNICEF did to meet the new needs of the national COVID-19 response.

In Bolivia, the cash transfer programme prioritized the migrant population after it became evident that these people were not included in the national social protection services.

In Ecuador, the estimated price of each oxygen concentrator during the initial CERF proposal was $2,500, and due to changes in market availability, later in the year the purchase price per unit was set at $987. This allowed the procurement of 60 oxygen concentrators as well as other critical medical supplies for frontline health care workers such as nitrile and examination gloves, in addition to what was included in the original CERF proposal.

In Colombia administrative and internal hospital challenges limited implementation in Uribia and as a result, UNICEF changed the location of planned activities to the rural area of Vallendupar, department of Cesar, bordering La Guajira. Vallendupar has a similar profile to the originally municipality with a large indigenous population and extremely poor communities. The same maternal and child services as those originally planned for Uribia were implemented in Vallendupar.

In Mali, WASH activities were initially planned for the Bamako district, Mopti, Timbuktu, and Kayes regions, but were eventually implemented only in the Kayes region, as Kayes was the first region with confirmed COVID-19 cases after Bamako, thus there was an urgent need to direct WASH interventions and scale up services and support in this region.

In Venezuela, a reprogramming of funds was requested to procure essential medicines to reduce under five child mortality by ensuring appropriate maternal, neonatal and child healthcare in hospitals and primary health facilities. UNICEF also procured 58 oxygen concentrators, instead of the 20 originally planned, to increase the effectiveness of COVID-19 treatment. UNICEF submitted a change in incentive modalities, from 190 cash incentives of $50,00 for seven months; to 3,391 in-kind incentives (food bags) for two months targeting 300 frontline health workers from Corposalud Táchira, 180 Táchira Civil Protection workers and 2,911 social workers from the Táchira regional government, to mitigate the low income and the migration of key personnel of different areas in health centres and regional institutions.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Education - Education									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	337,722	349,006	**686,728**	N/A	N/A	1,300	1,300	**2,600**
Returnees	0	0	0	0	**0**	N/A	N/A	0	0	**0**
Internally displaced people	0	0	0	0	**0**	N/A	N/A	0	0	**0**
Host communities	0	0	9,000	9,500	**18,500**	N/A	N/A	6,031,244	6,278,710	**12,309,954**
Other affected people	0	0	0	0	**0**	N/A	N/A	0	0	**0**
Total	**0**	**0**	**346,722**	**358,506**	**705,228**	**N/A**	**N/A**	**6,032,544**	**6,280,010**	**12,312,554**
People with disabilities (PwD) out of the total										
	0	0	36,700	34,800	**71,500**	N/A	N/A	253	219	**472**

Sector/cluster	Health - Health									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	122,456	120,358	28,517	29,093	**300,424**	110,624	92,950	55,523	54,815	**311,598**
Returnees	160,231	153,108	133,501	131,707	**578,547**	145,952	128,333	104,826	113,784	**492,895**
Internally displaced people	335,685	343,047	255,854	264,333	**1,198,919**	258,263	262,692	222,409	245,079	**988,443**
Host communities	577,812	483,720	276,960	285,015	**1,623,507**	428,126	694,116	358,418	364,899	**1,843,762**
Other affected people	2,377,688	1,562,802	1,105,108	909,591	**5,955,189**	674,096	630,026	1,091,594	432,617	**2,828,333**
Total	**3,573,872**	**2,663,035**	**1,799,940**	**1,619,739**	**9,656,586**	**1,619,359**	**1,810,433**	**1,832,770**	**1,211,194**	**6,473,756***
People with disabilities (PwD) out of the total										

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

	181,020	80,709	128,619	100,797	**491,145**	**50,764**	**63,71**	**8,058**	**8,194**	**130,735**

**Haiti reported 6.5 million people reached with key messages on COVID-19 prevention under WASH results as the majority of these messages and activities focused on WASH, this can explain the difference in the overall targets and results for Health.*

Sector/cluster	Water Sanitation Hygiene - Water, Sanitation and Hygiene									
	Planned					**Reached**				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	21,154	20,076	24,787	23,983	**90,000**	74,540	70,481	100,237	96,603	**342,077**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	7,360	7,090	7,760	7,790	**30,000**	8,550	7,928	9,284	8,928	**34,690**
Host communities	10,040	7,220	8,510	8,350	**34,120**	37,671	37,700	34,768	33,955	**144,094**
Other affected people	690,065	662,222	368,348	356,675	**2,077,310**	3,564,580	3,391,748	1,090,785	1,053,800	**9,100,913**
Total	**728,619**	**696,608**	**409,405**	**396,798**	**2,231,430**	**3,685,341**	**3,507,857**	**1,235,074**	**1,193,286**	**9,621,774****
People with disabilities (PwD) out of the total										
	101,001	97,052	52,036	50,015	**300,104**	673,827	643,443	183,173	176,294	**1,676,737**

***As mentioned above Haiti reported 6.5 million people reached with WASH which is attributed to the people reached with key messages on COVID-19 prevention as the majority of these messages and activities were focused on WASH.*

Sector/cluster	Protection - Child Protection									
	Planned					**Reached**				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	6,480	7,010	5,594	5,935	**25,019**	10,367	6,357	7,422	11,471	**35,617**
Returnees	29,900	39,980k	5,720	3,800	**79,400**	1,623	1,636	2.235	2.374	**7.868**
Internally displaced people	2,927	2,927	2,700	3,305	**11,859**	15,543	20,950	37,696	33,297	**107,486**
Host communities	8,080	9,980	19,722	20,293	**58,075**	46,307	48,381	65,396	82,389	**242,473**
Other affected people	1,910	1,790	33,539	36,818	**74,057**	10,883	8,294	32,492	30,221	**81,890**
Total	**49,297**	**61,687**	**67,275**	**70,151**	**248,410**	**84,723**	**85,618**	**145,241**	**159,752**	**475,334**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

People with disabilities (PwD) out of the total										
	583	592	4,365	4,375	**9,915**	1,575	1,197	1,521	906	**5,199**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

GUIDANCE (delete when completed): Please quantify and briefly describe the people who will benefit indirectly from project activities, for example from awareness/information campaigns, expansion of service delivery capacity, etc. If the project has multiple sectors, differentiate between people indirectly targeted in each sector.

As covered in the Operationation section above, it is difficult to quanitfy the number of people who were or will be indirectly reached by CERF supported programmes. In many countries COVID-19 prevention messages and information campaigns reached many people indirectly (through passing of information between community members, friends and families). Wtihin the health sector, UNICEF's support to the national health system, through fund support, traning, mentoring, coordination and planning with national health authorities and teams, as well as through the training of health workers in IPC, detection and management of COVID-19 cases, through the provision of PPE for health staff, medical supplies, including drugs, and support for improved WASH facilities and supplies, have reached millions of people and will continue to support millions in the future. Within the WASH sector, the establishment of handwashing facilities, toilets, water storage tanks as well as the distribution of hygiene supplies and support for hygiene awareness, can be expected to benefit many more people than results reported in this report as some of these WASH facilities and knowledge will remain and benefit people for years to come.

6. CERF Results Framework

Project objective	Reduce human-to-human transmission in affected countries and mitigate the impact of the pandemic on the most vulnerable

Output 1	Strengthened risk communication and community engagement (RCCE) Health - Health			
Was the planned output changed through a reprogramming after the application stage?		Yes ☐	No ☒	
Sector/cluster	Health - Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	# of people reached on COVID-19 through messaging on prevention and access to services	8,235,398	**Total - 12,776,459** Brazil - 5,756 Burundi - 3,593,288 Venezuela - 529,056 Chad - 2,530,000 Colombia - 88,655 Iraq - 2,331,626 Myanmar - 715,071 Niger - 127,546 Ukraine - 2,500,000 Tanzania - 176,679 Mali – 178,782	Implementing partners and government Ministry regular reports, Kobo.
Indicator 1.2	Number of children reached with targeted messages on personal hygiene and improved sanitary practices	505,135	**Total – 2,920,548** Burundi - 119,823 Venezuela - 110,594 Niger - 12,755 Tanzania - 31,082 Haiti - 2,646,294	Implementing partners and government Ministry regular reports.
Indicator 1.3	Number of healthcare workers and community volunteers trained on awareness raising about health and hygiene practices among the local populations.	12,107	**Total – 27,317** Burundi - 445 Iraq – 350 Niger - 6,587 Tanzania - 3,949 Mali - 4,986 Haiti – 11,000	Implementing partners regular reports covering attendance of trainings and topics covered during trainings.

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Explanation of output and indicators variance:		**Indicator 1.1** – Eleven countries reported on this indicator. The difference between the target and results for this indicator is attributed to the use of television, radio, social media and digital forums for the disimination of awareness and information campaigns that were able to reach significantly more people than origianlly targeted in the planning of the activity. In addition, Haiti's results of 6.5 million people reached with RCCE interventions are not included in this result, as the Haiti reported these results under the WASH sector as the majority of messages and activities focused on WASH in Haiti. **Indicator 1.2** – Five countries reported on this indicator. The difference between the target and results for this indicator is attributed to the use of television, radio, social media and digital forums that were able to reach significantly more people than origianlly targeted in the planning of the activity. **Indicator 1.3** – Six countries reported on this indicator. The difference between the target and results can be attributed to a change in some countries from planned face-to-face trainings to online/remote modalities which could reach more people at a time. In addition, in Mali, UNICEF combined this training with other interventions funded by other donors, meaning many more health workers and community volunteers were trained than originally planned.
Activities	**Description**	**Implemented by**
Activity 1.1	Coordinate with authorities to track and respond to misinformation and ensure pregnant women, children and their families know how to prevent COVID-19 and seek assistance	Brazil - ADRA. Colombia - Fuerza Mujeres Wayuu Iraq – Directorate of Health, NGOs, media channels Myanmar - Ministry of Health and Sports and the RCCE Working Group. Niger - Health facilities, Community Health Workers, Local Associations and NGOs. Tanzania - Norwegian Refugee Council Mali - Ministry of Public Health and regional health directorates of Bamako, Kayes, Mopti, Gao and Tombouctou. Haiti - State partners MoPH, DINEPA, MoE, IBESR and DGPC.
Activity 1.2	Conduct community level outreach to reduce stigma and increase social support and access to basic needs for affected people and their families;	Burundi - World Vision International Venezuela - National NGO FINAMPYME Community Promoters. Colombia - Fuerza Mujeres Wayuu Iraq – Health care workers and community volunteers Myanmar - Ministry of Health and Sports, Village Administrators and Basic Health Staff in the villages. Haiti - Some 50 NGOs (international and local) as well as the national and local government agencies of MoPH, DINEPA, MoE, IBESR and DGPC. Niger - Community Surveillance Committees, Community Health Workers and NGOs. Tanzania - Norwegian Refugee Council Mali - Ministry of Public Health and regional health directorates of Bamako, Kayes, Mopti, Gao and Tombouctou.
Activity 1.3	Develop and broadcast messaging and information on COVID-19 through social media, radio broadcasts, and other channels including targeted messaging for key stakeholders and at-risk groups based on community risk perceptions (including children, parents/care givers, pregnant women, health providers etc);	Venezuela - Enlace Radial - Radio network Alliance between FINAMPYME and La Nación Newspaper. Chad - UNICEF, Union des Radios Privées du Tchad (URPT), Scouts and Guides Movement of Chad and World Vision. Iraq - Media channels and the private sector. Myanmar - Ministry of Health and Sports, UNICEF and health staff in rural areas. Niger - 23 Community Radios, Hirondelle Foundation, Bloggers, Ministry of Health, chatbot WhatsApp (www.coronavirus.ne) Ukraine – Postmen LLC (vedor)

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		Tanzania - Norwegian Refugee Council Haiti - NGOs and government departments - MoPH, DINEPA, MoE, IBESR, DGPC.
Activity 1.4	Work with key influencers, community groups, women and youth groups, health workers and community volunteers to build their capacity for awareness raising and promoting healthy practices through participatory interventions;	Burundi - World Vision International Venezuela - National NGO FINAMPYME community promoters. Iraq - NGOs, private sector, health care workers and volunteers Niger – Ministry of Health - Commission Higher Council of Communication (CSC/COVID). Tanzania - Norwegian Refugee Council Mali - Ministry of Public Health and regional health directorates Bamako, Kayes, Mopti, Gao and Tombouctou. Haiti - Key influencers like Jeanjean Roosvelt, BIC Tizon Dife and others helped UNICEF build and convey key messages on good behaviour practices mainly through songs. Chad - Union des Radios Privées du Tchad URPT, Scouts and Guides movement of Chad and World Vision.
Activity 1.5	Launch handwashing campaigns in ECD centres, schools, health facilities and public spaces to improve preventive practices among children, at-risk groups, and the general public;	Burundi - World Vision International Tanzania - Norwegian Refugee Council Haiti – NGOs and government departments - MoPH, DINEPA, MoE, IBESR, DGPC.
Activity 1.6	Conduct targeted outreach to urban poor and other potentially high-risk communities including refugees, migrants and host communities, on utilization of existing social protection systems, to ensure delivery of accurate information on prevention assistance.	Burundi - World Vision International Haiti - NGOs and government departments MoPH, DINEPA, MoE, IBESR, DGPC. Venezuela - National NGO, FINAMPYME Community Promoters Niger - ACTN, Islamic council Tanzania - Norwegian Refugee Council Mali - Ministry of Public Health and regional health directorates of Bamako, Kayes, Mopti, Gao and Tombouctou

Output 2	Provision of critical water, sanitation, and hygiene (WASH) supplies and improving Infection Prevention and Control (IPC)			
Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☒
Sector/cluster	Water Sanitation Hygiene - Water, Sanitation and Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Number of people reached with critical WASH supplies (including hygiene items) and services	2,242,510	**Total - 4,936,802** Brazil - 9,274 Burundi - 2,500,000 CAR - 21,386 Chad - 34,200 Colombia – 7652 Myanmar – 51,182 Niger - 39,910 Turkey - 25,798 Ukraine - 3,100 Tanzania - 194,084 Palestine - 23,124 Mali - 15,680 Iran – 11,412	Implementing Partner reports, Kobo, U-reports, field monitoring by UNICEF staff, field monitoring surveys by 3rd parties, national health data base information (Niger), government reports, distribution forms received from the soap producer (Savonor) in Burundi.

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			Haiti – 2,000,000	
Indicator 2.2	Number of healthcare facility staff and community health workers trained in Infection Prevention and Control (IPC)	1,142	**Total – 7,286** CAR - 234 Chad - 1,857 Myanmar - 1,492 Niger – 92 Tanzania – 180 Mali – 624 Haiti - 2,807	Implementing partner reports, Ministry of Health and National Solidarity (Chad), ALIMA NGO project reports (Chad), Chadian Red Cross project reports, training report including attendance records.
Indicator 2.3	Number of healthcare facilities staff and community health workers provided with Personal Protective Equipment (PPE)	4,962	**Total – 28,068** CAR - 339 Chad - 6,650 Colombia - 84 staff Myanmar - 1,464 Niger – 92 Ukraine – 400 Tanzania – 165 Sudan - 3,315 Mali – 200 Haiti - 2,807 Venezuela – 12,552	Ministry of Health and National Solidarity (Chad), ALIMA NGO project reports (Chad), hospital and government supply delivery and receiving forms, UNICEF staff field visit and monitoring reports.
Indicator 2.4	Number of healthcare facilities with improved access to safe water and basic sanitation (Niger)	9	9	Technical and final reports from contractors, UNICEF field visit and monitoring reports, verification from health care staff.
Indicator 2.5	Number of healthcare facilities provided with handwashing devices with soap and hygiene kits for safely waste management items (Niger)	9	9	Technical and final reports from contractors, UNICEF field visit and monitoring reports, verification from health care staff.
Indicator 2.6	Number of handwashing stations installed (Haiti)	New Indicator for Haiti	10,000	Technical and final reports from contractors, UNICEF field visits and monitoring reports, verification from principals/teachers.
Indicator 2.7	Number of schools with improved access to safe water and basic sanitation (Haiti)	New Indicator for Haiti	1,420	Technical reports from contractors, UNICEF field visits and monitoring reports, verification from principals/teachers.
Indicator 2.8	Delivery of COVID-19 Family Hygiene Kits to refugee and migrant children and their care givers (Turkey).	Moved this indicator from activity section	5,050 family hygiene kits distributed – benefiting 25,795 refugees	Distribution (technical) reports from suppliers and partners, UNICEF - post-distribution monitoring reports
Explanation of output and indicators variance:		**Indicator 2.1** – Fourteen countries reported on this indicator. The significant overachievement in this intervention can be attributed to Burundi's reported		

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	result of 2.5 million people reached as these people were provided with bars of soap through a national campaign supported by the government which reached many more people than originally planned for. In addition, Haiti reported 2 million people reached as 10,000 handwashing stations were installed in public locations including 2,500 schools and the consistent use of these facilities throughout the pandemic led to this large result. Chad combined CERF with other donor funds to reach 34,500 beneficiaries which was higher than initial planning figures. **Indicator 2.2 –** Seven countries reported on this indicator. Some of the overachievement in this result was due to trainings moving to online/remote modalities meaning more health workers could join at no extra cost. In addition, in some countries including CAR, additional staff were included in the trainings that originally were not planned for based on the overwhelming need. **Indicator 2.3** – Eleven countries reported on this indicator. Local procurement of some supplies and the reduction of costs in PPE from the initial planning stages of the project contributed to the overachievement in this result.

Activities	Description	Implemented by
Activity 2.1	Support implementation and monitoring of infection prevention and control enhancements in schools, health facilities, markets, and other public spaces and workplaces including Ministries and Departments	Chad - Ministry of Health and National Solidarity - in all 23 provinces of the country. NGO implementing partners: Chadian Red Cross (Ouaddai); Help Chad (Ouaddai); ALIMA (N'Djamena); World Vision (Logone Oriental, Logone Occidental, Tandjile, Mayo Kebbi Est, Mayo Kebbi Ouest, Mandoul); ACF (Lac, Kanem, Hadjer Lamis). Municipalities of N'Djamena and Abeche. Myanmar – RCPCH. Niger - Regional Directorate of Public Health and Tahoua municipality Health District. Tanzania – NRC Mali - NGO ADG and Health Districts in Kayes Iran – UNICEF with the Ministries Haiti – Some 50 NGOs (international and local) as well as government departments of MoPH, DINEPA, MoE, IBESR, DGPC, both at national and decentralized levels.
Activity 2.2	Provide supplies including PPE (gowns, gloves, masks, etc.) to health facilities to ensure the prevention and treatment of COVID-19	Niger - Regional Directorate of Public Health and Tahoua municipality Health District. Ukraine – UNICEF, Donbass Development Centre (DDC) Tanzania – NRC Sudan - State ministries of health. Mali - National NGO ADG and Health Districts in Kayes. Haiti - 50 Implementing partners including Solidarités International, ACTED, ACF, CRNL. Chad - Ministry of Health and National Solidarity - in all 23 provinces of the country. NGO implementing partners: Chadian Red Cross (Ouaddai); World Vision (Logone Oriental, Logone Occidental); ALIMA (N'Djamena). Colombia – ZOA. Myanmar – RCPCH and Health Poverty Action (HPA).
Activity 2.3	Support IPC in health facilities including WASH services and supplies, ensure IPC protocols in place, and training of health workers on WASH and IPC behaviors	CAR – CONCERN Chad - Ministry of Health and National Solidarity - in all 23 provinces of the country. NGO implementing partners

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		ALIMA (N'Djamena); World Vision (Logone Oriental, Logone Occidental, Tandjile, Mayo Kebbi Est, Mayo Kebbi Ouest, Mandoul). Myanmar - RCPCH Health care providers Niger - Regional Directorate of Water and Sanitation, Regional Directorate of Public Health and Tahoua municipality Health District. Tanzania – NRC Mali - Health Districts and Directorates of Water and NGO ADG in Kayes. Haiti - ACTED, SI, CRNL, ACF, among other NGOs.
Activity 2.4	Support IPC in communities by ensuring access to WASH services for households living in affected areas, at vulnerable collective sites, and in public spaces	Brazil - ADRA Burundi - Savonor CAR - Agir en Centrafrique (AEC), General Directorate of Hydraulic Resources (DGRH). Colombia - ZOA Chad - Chadian Red Cross: Ouaddai NGO implementing partners: Help Chad (Ouaddai); ALIMA (N'Djamena); World Vision (Logone Oriental, Logone Occidental, Tandjile, Mayo Kebbi Est, Mayo Kebbi Ouest, Mandoul); ACF (Lac, Kanem, Hadjer Lamis) Municipalities in N'Djamena and Abeche. Tanzania – NRC Mali - NGO ADG and Health Districts in Kayes Haiti - Some 50 NGOs (international and local) and government departments of MoPH, DINEPA, MoE, IBESR, DGPC, both at national and decentralized levels
Activity 2.5	Implement guidelines for safe school operations during COVID-19 outbreak (e.g. promotion of hand and respiratory hygiene, screening and referral of suspected cases, as appropriate), and education about COVID-19 prevention	Tanzania – NRC Mali - ADG. Haiti – Ministry of Education and NGOs
Activity 2.6	Launch handwashing campaigns in facility and community level, to improve preventive practices among children, at-risk groups, and the general public.	CAR - Agir en Centrafrique (AEC) Colombia - ZOA Tanzania – NRC Mali - National NGO ADG and Health Districts in Kayes Haiti - Some 50 NGOs (international and local) and government departments of MoPH, DINEPA, MoE, IBESR, DGPC, both at national and decentralized levels
Activity 2.7	Delivery of COVID-19 Family Hygiene Kits to refugee and migrant children and their care givers (Turkey).	The Association for Solidarity with Asylum Seekers and Migrants (ASAM) – UNICEF NGO partner. UNICEF Turkey partnered also with five other NGO and Government partners on delivery of kits, using other available funding sources, in addition to CERF.

Output 3	Continued access to essential health care and nutrition services for women, children and vulnerable communities, including COVID-19 case management			
Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☒
Sector/cluster	Health – Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**

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Indicator 3.1	Number of children and women receiving essential healthcare in UNICEF supported facilities	2,258,011	**Total – 2,748,103** Afghanistan - 13,812 Brazil - 6,615 Venezuela - 329,689 Chad - 500 Colombia – 1952 Iraq - 990,998 Libya – 109,000 Myanmar – 144,273 Niger – 44,775 Ukraine - 12,000 Sudan - 485,631 Palestine - 54 Mali - 74,861 Haiti – 168,358 CAR - 5989 Ecuador – 5491 Tanzania - 139,736 Burundi - 700,000	Implementing partner reports, Health Management Information Systems, Ministry of Health reports, hospital in-patient and outpatient records, lists of supplies procured and delivered from companies and hospitals, UNICEF staff field monitoring reports.
Indicator 3.2	Number of healthcare providers trained in detecting, referral and appropriate management of COVID-19 cases	4,189	**Total – 14,621** Afghanistan - 152 Venezuela – 7,000 CAR - 180 Ukraine - 380 Chad – 834 Niger – 157 Mali - 4,986 Haiti – 117 Myanmar - 815	Hospital, district health and project training and attendance reports, implementing partner training reports, UNICEF field monitoring and reports.
Indicator 3.3	Number of women who receive nutrition counselling services through integrated mobile teams (Afghanistan)	4,200	4,352	Implementing partner reports, UNICEF field monitoring and reports.
Indicator 3.4	Number of facilities supported with rapid COVID-19 tests, drugs and consumables (CAR)	5	5	NGO Report Lutheran World Federation reports, UNICEF field monitoring and reports.
Indicator 3.5	Number of children under 3 reached with adequate health supervision on immunization, breastfeeding and early childhood development (Ukraine)	2,450	6,000	Reports and data collected from health authorities.
Indicator 3.6	Number of HFs in the camps received PPE (Iraq)	25	25	Ministry and Directorates of Health, UNICEF field monitoring and reports, health facility and company delivery reports, NGO partners working in the camps.
Indicator 3.7	Number of healthcare personnel receiving cash incentives to ensure provision of essential services. (Venezuela) (Indicator change –	190	3,391	Attendance and incentive distribution lists from health care facilities.

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	Number of essential workers reached with in-kind incentive food bags to ensure provision of essential services)			
Indicator 3.8	# of caregivers of children (0-23 months) reached with messages on breastfeeding in the context of COVID-19 (Burundi)	100,000	93,800	Ministry of Health regular activity report
Indicator 3.9	# of children 6-59 months admitted for treatment of severe acute malnutrition (Burundi)	15,250	2,126	Health care facility reports of admissions and treatment of SAM cases and DHIS2.
Indicator 3.10	Number of community-based networks who enable real time alerting of patients presenting COVID-19 symptoms (Niger)	14	2	ACTN, Islamic Council
Indicator 3.11	Percent of patients presenting COVID19 symptoms referred and managed through community and health system (Niger)	80%	72%	The Tahoua Health District Activity update and report.
Indicator 3.12	Number of health facilities receiving oxygen concentrators for COVID-19 case management (Ecuador)	20	24	Reports from the Ministry of Health and UNICEF field monitoring and reports.
Indicator 3.13	Number of people who benefit from oxygen concentrators (Ecuador)	7,236	10,854	Reports from health facilities.
Indicator 3.14	Number of people provided with case management supplies (Iran) (Indicator change - Number of people tested for COVID-19 through CERF funded COVID-19 tests)	4,800 people for 6 months	32,160	Ministry of Health reports
Indicator 3.15	Number of pregnant, lactating women who receive IYCF support messages in the context of COVID-19 (Myanmar)	25,000	34,351	Health facility, NGO partner reports and UNICEF team field monitoring and reports.
Indicator 3.16	Number of children with Severe Acute Malnutrition (SAM) who receive treatment in the context of COVID-19 (Myanmar)	3,000	1,742	Government NIS report and UNICEF team field monitoring and reports.
Explanation of output and indicators variance:		**Indicator 3.1** – Eighteen countries reported results on this indicator with specific results per country listed in the country narratives in the overview section of this report. The health excel table shows numbers of people who have benefited in some way through CERF supported health interventions, including provision of PPE and IPC training for health workers, etc. Therefore, the excel totals are larger than what is reported as results under this indicator in most countries. The overachievement in this result can be attributed to an underestimation in the planning phase of the project, as well as the wide variety of interventions undertaken covering large geographic areas (i.e. many health facilities) in the 18 countries. In Iraq mobile health teams were able to reach many more people with healthcare services than initially planned for, while in the Ukraine the price of commodities during the planning		

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	and implementing stages of the project decreased, leaving additional funds which UNICEF used to procure more items for medical workers, including awareness-raising materials. This allowed to reach out more families and children than originally planned. In Myanmar CERF resources were combined with other donor support allowing for additional beneficiaries to be reached during programme implementation. **Indicator 3.2** – Nine countries reported results on this indicator with specific results per country listed in the country narratives in the overview section of this report. The overachievement of this result can be attributed to the overwhelming need to train additional health care staff, who were included as extra participants where possible, and that some training of healthcare staff was conducted remotely meaning more staff could be reached at one time. As an example, in Venezuela the team planned to reach 1,000 health workers with this training, however, using remote modalities, the team reached 7,000 health workers with trainings through CERF support. **Indicator 3.5** – As mentioned in 3.1 above, prices of commodities decreased between the planning and implementation phase of the project, meaning additional supplies and support could be provided reaching more beneficiaries than originally planned for. **Indicator 3.7 -** Incentive programmes in Venezuela were originally designed as a cash incentive programme for 190 health workers for a period of seven months. Yet, as agreed and authorized by the local health authority (Corposalud Táchira) incentives were modified into in-kind donations of food bags to health and other workers of diverse areas of responsibilities, reaching 3,391 persons, for two months. **Indicator 3.9** – The SAM treatment target was overestimated during the planning stages of the project as the country team predicted that there would be approximately 15,000 additional SAM cases in 2020 due to the COVID-19 impact, however, there were only 2,126 additional SAM cases reported in the country in 2020. This could be attributed to support for the continuity of essential health and nutrition services in some locations throughout the pandemic and/or a decline in the number of people accessing some health services due to fear of contracting COVID-19 and movement restrictions during the pandemic. **Indicator 3.10** – As part of the COVID-19 response, large community efforts brought together multiple community networks (women and youth groups, professionals, etc.) to enable real time alerting of patients presenting COVID-19 symptoms. These efforts were led by two main organizations: The Association of Traditional Chiefs (ACTN) and the Islamic Council through their national networks. These two main organizational networks led to the creation of several community sub-networks that supported the COVID–19 response, however, because there are two main networks leading the response, these were listed in the results table above. **Indicator 3.13 –** This result number is an estimation based on infection rates and hospitalizations needing oxygen support for COVID-19 treatment in the locations where oxygen concentrators were supplied. **Indicator 3.14** – This indicator was changed. In Iran, the government originally requested UNICEF to procure oxygen concentrators for COVID-19

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	hospitals, which UNICEF included in the original CERF proposal. However, the government changed their request during the year asking UNICE instead procure COVID-19 test kits. Therefore, UNICEF changed this intervention to meet the new needs of the national COVID-19 response. **Indicator 3.15** – Additional pregnant and lactating women were reached with IYCF counselling as this intervention was integrated with some RCCE and multiple micronutrient supplementation interventions in communities allowing additional people to be reached than originally planned. **Indicator 3.16** - Due to increased COVID-19 movement restrictions for beneficiaries, quarantine requirements for frontline workers, suspension of domestic flights, and fear among the population in going in public to reach services during the pandemic, the number of children reached with SAM treatment was not able to be fully achieved. Community health volunteers were also not able to conduct regular house to house nutrition screening and referral of children with SAM.

Activities	Description	Implemented by
Activity 3.1	Ensure that case management is adapted to children and pregnant women and supports implementation of breastfeeding recommendations and nutrition support to patients.	Afghanistan - UNICEF-supported government Mobile Health & Nutrition Teams. Brazil – ADRA Chad – UNICEF and the Ministry of Public Health and National Solidarity Myanmar – MoHS staff provided health services while health partner HPA (Health Poverty Action) provided community sensitization and counselling. Burundi - Ministry of Health, World Vision, WR. Venezuela – Ministry of Health through the network of outpatient clinics and hospitals, with technical support of PAHO and UNICEF. Niger - Health District of Tahoua Sudan - The Sudanese Federal Ministry of Health Haiti – Ministry of Health (DSF, UCPNANU, UCNPV)
Activity 3.2	Support Ministries of Health to utilize community-based networks to assist with prevention measures and surveillance and referral, and to build the capacity of health workers to detect and manage COVID-19.	Burundi - Ministry of health Venezuela – Ministry of Health through the network of outpatient clinics and hospitals, with technical support of PAHO and UNICEF. Haiti – Ministry of Health (DPSPE, DELR) CAR - Ministry of Health and Lutheran World Federation Myanmar - Health Poverty Action (HPA) and Community Partnership International (CPI) in collaboration with local community out-reach workers. Niger - Health District of Tahoua Mali - Ministry of Public Health (MoH) and regional directorates of (DRS) of Bamako, Kayes, Mopti, Gao and Tombouctou.
Activity 3.3	Build the capacity of health care providers and ensure continued access to life-saving care and support such as the clinical management of endemic and epidemic diseases, GBV management, and mental health and psychosocial support (MHPSS).	Afghanistan - UNICEF-supported government Mobile Health & Nutrition Teams (MHNTs) Venezuela – Ministry of Health through the network of outpatient clinics and hospitals, with technical support of PAHO and UNICEF. Haiti – Ministry of health, local NGOs Foundation BEBE, LIGHT, CSE, SOJER, PROFAMIL.

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		CAR – Ministry of Health and NGOs Lutheran World Federation, Beatitudes and Médecins d'Afrique. Chad – UNICEF health team. Iraq – Ministry and Directorates of Health, NGOs Myanmar - Implemented by RCPCH and HPA Ukraine – UNICEF health team. Mali - Ministry of Public Health (MoH) and regional directorates (DRS) of Bamako, Kayes, Mopti, Gao and Tombouctou.
Activity 3.4	Provide case management supplies (oxygen concentrators, medicines) to health facilities to ensure the prevention and treatment of COVID-19	Venezuela – Ministry of Health, PAHO and UNICEF Haiti – Ministry of Health. CAR: UNICEF and Ministry of Health. Chad - Ministry of Public Health and National Solidarity and UNICEF. Ecuador - Ministry of Health and UNICEF. Iraq - UNICEF (through UNICEF supply division and local procurement). Libya – UNICEF and Ministry of Health Myanmar - RCPCH. Ukraine – UNICEF Mali - Ministry of Public Health (MoH) and regional directions (DRS) of Bamako, Kayes, Mopti, Gao and Tombouctou. Iran – UNICEF and Ministry of Health
Activity 3.5	Procure key health and nutrition commodities (e.g. vaccines, ORS, Ready to Use Therapeutic Foods etc.) at district and health facility levels to sustain services in the event of disruptions to international and national supply chains	Afghanistan – UNICEF and Ministry of Health Burundi - Ministry of Health Venezuela – Ministry of Health, PAHO and UNICEF. Libya - UNICEF and Ministry of Health Myanmar - UNICEF and MoHS Mali - Ministry of Health and UNICEF. Haiti – Ministry of Health, NGOs AVSI and ACF
Activity 3.6	Provide care in maternal-child health and nutrition, through mobile health teams for primary health care (prenatal care, malnutrition screening, child growth and development, vaccination, Psychological first aid interventions), with special emphasis on girls and boys under 5 years old and adolescent mothers between 10 and 14 years of age (Colombia)	IPS Dusakawi
Activity 3.7	Provide IYCF counselling on appropriate feeding (breastfeeding, good complementary feeding practices and nutritional care for diseases) to caregivers of boys and girls 0-60 months (Colombia).	IPS Dusakawi
Activity 3.8	Ensure that home-visiting model and telemedicine system are adapted and introduced at local and regional levels at primary health care settings, process is well documented and ready for further scaling up (Ukraine)	Government Public Healthcare facilities.
Activity 3.9	Procurement of Home Visiting Kit (for medical nurses) and Home Care Kit (for vulnerable families) to monitor and report the health status for decision making (Ukraine)	Government health authorities.
Activity 3.10	Procurement of medical supplies; 9 Adult ICU Ventilators with Trolley. UNICEF will coordinate	Ministry of Health

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	procurement and distribution of ventilators with key health cluster partners in particular with WHO, to ensure synergies, complementarity and avoid duplication (State of Palestine)	
Activity 3.11	Provision of cash incentives for healthcare personnel to reduce their desertion from hospitals and primary healthcare facilities (Venezuela) Change in indicator: Number of essential workers reached with in-kind incentive food bags to ensure provision of essential services	Construyendo Futuros (NNGO)

Output 4	Access to continuous education services			
Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒				
Sector/cluster	Education - Education			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 4.1	Number of children supported with distance/home-based learning	686,728	**Total – 12,289,058** Brazil – 2,600 Turkey – 12,286,458	Implementing partner bi-weekly reports including documenting radio set distribution in Brazil. Official statistics and reports from the Ministry of Education. UNICEF field monitoring and reports.
Indicator 4.2	Number of schools implementing safe school protocols (COVID-19 prevention and control) (Ukraine)	168	169	Ministry of Education and school updates/lists, UNICEF field monitoring reports.
Indicator 4.3	Number of boys and girls enrolled in schools implementing safe school protocols (COVID-19 prevention and control) (Ukraine)	18,500	23,491	Ministry of Education and school updates/lists, UNICEF Field monitoring reports.
Explanation of output and indicators variance:		**Indicator 4.1** – Two countries reported results on this indicator. Brazil reported 2,600 children reached through the provision of 2,000 laptops funded by CERF, while Turkey reported 12,286,458 students reached, including 768,000 refugee children. The overachievement is related to Turkey's support to the national education distance learning platform which included support for the development and roll out of TV, radio and digital lessons that was broadcasted throughout the country reaching a significantly higher number of children than originally planned. **Indicator 4.3** – The actual number of children enrolled in schools that were implementing safe school protocols turned out to be higher than initially predicted during the planning stage of the project. At the time of planning this intervention the average number of children per education facility was 110 while the actual number in 2020 turned out to be 139 which was verified by distribution lists and monitoring visits to selected schools.		
Activities	**Description**		**Implemented by**	

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Activity 4.1	Support Ministries of Education and other education actors in the production of pre-primary, primary and secondary education lessons to be broadcast on media (radio/tv) and other distance learning platforms as required (Turkey)	Ministry of Education and UNICEF.
Activity 4.2	Provide teaching and learning materials to families to enable them to support home study in short term school closures	Brazil – Pirilampos
Activity 4.3	Support the Ministries of Education and Health to develop and implement guidelines for safe school operations during COVID-19 outbreak (e.g. promotion of hand and respiratory hygiene, screening and referral of suspected cases, as appropriate), and education about COVID-19 prevention	Ukraine - Donbass Development Center (DDC) and Triangle génération humanitaire (TGH)

Output 5	Enhanced protection services for populations			
Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☐
Sector/cluster	Protection - Child Protection			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 5.1	Number of children provided with community based mental health and psychosocial support	57,890	**Total – 131,477** Bolivia - 1,113 Afghanistan - 1,633 Brazil – 2,500 Burundi 107,000 Chad – 132 Ukraine - 2,397 Tanzania - 14,260 Mali – 942 Iran – 1,500	Implementing partner reports, case management reports from social worker departments, UNICEF field monitoring and reports, Kobo forms. In Chad the Ministry of Women and Child Protection.
Indicator 5.2	Number of parents and primary caregivers provided with community based mental health and psychosocial support	16,660	**Total – 88,090** Bolivia - 787 Burundi 70,766 Ukraine - 1,149 Tanzania - 15,073 Mali - 315	Implementing partner reports, case management reports from social worker departments, UNICEF field monitoring and reports.
Indicator 5.3	Number of children without parental or family care provided with appropriate alternative care arrangements	8,350	**Total – 7,403** Burundi - 4,750 Chad – 82 Mali - 224 Ukraine - 214 Tanzania - 2,133	Implementing partner reports, case management reports from social worker departments, UNICEF field monitoring and reports. In Chad the Ministry of Women and Child Protection.
Indicator 5.4	Number of persons reached with awareness raising messages on	120,560	193,340	Partner progress reports, health mobile team visit

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	COVID-19 prevention and risk mitigation (Afghanistan)			reports, UNICEF field monitoring and reports.
Indicator 5.5	Number of households reached with one-off unconditional, unrestricted cash transfers (est. 7 members per household) (Afghanistan)	2,000	2,010	Payment lists, monitoring reports of UNICEF and IP staff.
Indicator 5.6	Number of people reached with messages on Covid-19 related child protection risks (CAR)	11,900	12,832	Partner reports. Mali - Monthly monitoring sheet and progress reports. UNICEF Mali also contributed to this indicator with CERF project through training and awareness of community child protection actors on COVID-19 and related child protection risks
Indicator 5.7	Number of people trained on covid-19 impact and psychological first aid (CAR)	300	316	Partner reports.
Indicator 5.8	Number of persons benefitting from cash transfer-based interventions (Peru)	1,419 (330 families)	1,577 (400 families)	Internal reports (implementing partner reports)
Indicator 5.9	Number of persons benefitting from cash transfer-based interventions (Bolivia)	500	840	Bolivia - Monitoring tool from UNICEF
Indicator 5.10	Number of children in alternative care provided with PSS and hygiene packages (Iran)	17,107	17,107	SWO reports
Explanation of output and indicators variance:		**Indicator 5.1** – Nine country offices reported results for this indicator. This result was significantly higher than planned largely based on Burundi's result for this indicator which was 107,000 children reached. Burundi incorporated psychosocial and mental health support with COVID-19 awareness raising activities allowing for a significantly higher than planned number of people to be reached with this intervention. In addition, Tanzania implementing partner Plan International combined funds from CERF with other donors for this intervention, allowing additional children to be reached. **Indicator 5.2** – Five country offices reported results for this indicator, with Burundi's result for this indicator being 70,766. As explained in 5.1 above, Burundi incorporated psychosocial and mental health support with COVID-19 awareness raising activities allowing for a significantly higher than planned number of people to be reached with this intervention. In Tanzania implementing partner Plan International combined funds from CERF with other donors for this intervention, allowing additional people to be reached. In the Ukraine some beneficiaries were reached through remote/on-line modalities allowing for additional people to benefit from this intervention. **Indicator 5.3** – In Burundi, the initial planned/expected number of children that would require temporary alternative care arrangements during national COVID-19 prevention measures (including isolation of positive cases) was higher than what happened in reality in 2020. The Burundi government opted		

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	for children to remain with their families even if there was a family member with a positive COVID-19 case, leading fewer children requiring temporary care. **Indicator 5.4** – The lower result is attributed to a lower-than-expected number of people tuning into TV stations where some awareness raising messages on COVID-19 prevention and risk mitigation were shared with the public. **Indicator 5.5** - The slight over-reach of the indicator can be explained through small favourable changes in exchange rates which enabled the project to reach additional households. **Indicator 5.8** - CERF funds were combined with a small amount of funds from other donors to allow additional people to be reached with this cash-support programme. In addition, the number of people targeted during the planning of the project was based on the country national survey on the Venezuelan population from 2018, and in reality, family composition was much different among households that were targeted for this support. **Indicator 5.9** – There was a small adjustment made in the cash transfer programme whereby migrant populations became a priority to receive this support, and the number of beneficiaries per household in reality was higher than what was originally planned.

Activities	Description	Implemented by
Activity 5.1	Ensure that children affected by COVID-19 have access to adequate alternative care arrangements as well as deliver protection services for children left without a care provider, due to the hospitalization or death of the parent or care provider	Burundi - Plateforme des intervenants en Psychosocial et en Santé Mentale (PPSM) Chad - Delegation de l'Action Sociale (Ministry of Women and Early Childhood Protection Ukraine - NGO SOS Children Villages Luhansk and NGO Variant. Tanzania - Plan International. Mali - Samu Social and COOPI
Activity 5.2	Provide mental health and psychosocial support, counselling and rehabilitation support to children and families impacted by COVID-19	Afghanistan - War Child UK Brazil - Pirilampos Burundi - Plateforme des intervenants en Psychosocial et en Santé Mentale (PPSM) Chad - Delegation de l'Action Sociale (Ministry of Women and Early Childhood Protection) Ukraine - NGO SOS Children Villages Luhansk and NGO Variant Tanzania - Plan International. Mali - COOPI and DRPFEF Iran – Ministry of Health and Medical Education, and State Welfare organization Bolivia - Fundacion Munasim, Fundacion Scalabrini
Activity 5.3	Support the development of referral pathways to other organizations and agencies for specialized MHPSS services and other basic needs	Bolivia - UNICEF Burundi - Plateforme des intervenants en Psychosocial et en Santé Mentale (PPSM) Ukraine - NGO SOS Children Villages Luhansk and NGO Variant Tanzania - Plan International. Mali - COOPI and DRPFEF/DRDSES

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Activity 5.4	Train and supervise local staff in basic psychosocial support, including psychological first aid.	Burundi - Plateforme des intervenants en Psychosocial et en Santé Mentale (PPSM) CAR – AFEB (Association des Femmes Evangéliques de Bossangoa) and the Ministry for the Promotion of Women, Families and Child Protection Chad - UNICEF in collaboration with Delegation de l'Action Sociale (Ministry of Women and Child Protection) across their centres in N'Djamena Ukraine - NGO SOS Children Villages Luhansk and NGO Variant Tanzania - Plan International. Mali - COOPI and DRDSES
Activity 5.5	Strengthen/establish and raise awareness of local and national protection services, safe and trusted response and referral mechanisms for GBV	Burundi - Plateforme des intervenants en Psychosocial et en Santé Mentale (PPSM) Chad - Delegation de l'Action Sociale (Ministry of Women and Early Childhood Protection across their centres in N'Djamena Ukraine - NGO SOS Children Villages Luhansk and NGO Variant Tanzania - Plan International. Mali - COOPI and DRDSES
Activity 5.6	Provide children and their caregivers with key awareness raising messages on COVID-19 prevention and risk mitigation (Afghanistan)	War Child UK
Activity 5.7	Provide one-off unconditional, unrestricted cash transfers to targeted returnee, IDP and host community households with children affected by COVID-19 (Afghanistan)	UNICEF, with support from the Herat Department of Labour and Social Affairs (DoLSA) and HELP Germany
Activity 5.8	Develop and disseminate child protection messages through community level outreach activities and other channels to raise awareness on Covid-19 child protection related concerns (CAR)	AFEB and the Ministry for the Promotion of Women, Families and Child Protection
Activity 5.9	Establish and strengthen capacity of community-based child protection networks and mechanisms to address child protection concerns (CAR)	AFEB and the Ministry for the Promotion of Women, Families and Child Protection
Activity 5.10	Provide a humanitarian cash transfer to 400 migrant families with children, adolescents, pregnant and lactating women to cover basic needs and provide caregivers orientation to prevent VAC (Peru)	HIAS Implementing Partner
Activity 5.11	Provide humanitarian cash transfers to vulnerable populations, including migrants from Venezuela and host communities to mitigate the impact of the COVID19 (Bolivia)	UNICEF and Fundacion Munasim, Fundacion Scalabrini
Activity 5.12	Procurement and distribution of a package containing toys (games, puzzles, educational and interactive games, etc.) and hygiene items (soap and disinfectant gel) to children in family-based foster care settings to support their emotional wellbeing and reduce the negative mental health consequences of the outbreak and promote hygiene practices to prevent transmission of the virus (Iran)	State Welfare Organization

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Activity 5.13	Strengthen/establish and raise awareness of separated/ unaccompanied children living and working in the streets of N'Djamena, their families and communities on how to protect themselves from COVID-19 (Chad)	UNICEF in collaboration with Delegation de l'Action Sociale (Ministry of Women and Child Protection) across their centres in N'Djamena
Activity 5.14	Provide mental health and psychosocial support/parenting to children in family based foster care settings (Iran)	Ministry of Health and Medical Education, and State Welfare Organization

Output 6	Assessment of the social impacts of the epidemic on communities, with a focus on women and children for improved and better targeted mitigation response			
Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒				
Sector/cluster	Health - Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 6.1	# and % of UNICEF COs undertaking COVID-19 responses reporting on key results on a regular basis (Iraq)	One report per week	One report per week	Ministry and Directorates of Health, NGOs and UNICEF situation reports and updates.
Indicator 6.2	% of UNICEF COs undertaking COVID responses that participate in assessments of social impacts, including interagency assessments (Mali)	Mali UNICEF team included in interagency assessments of social impacts of COVID-19	Yes	Interagency and UNICEF assessment and regular COVID-19 situation reports.
Explanation of output and indicators variance:				

Activities	**Description**	**Implemented by**
Activity 6.1	Monitor and conduct epidemiologic analysis together with WHO, on COVID-19 infection among children and pregnant women – including susceptibility to COVID-19 infection, clinical features (including disease severity and mortality, any associated complications such as miscarriages, preterm deliveries, growth restriction in the uterus, etc.)	Iraq – Ministry and Directorates of Health, UNICEF and WHO Mali –Health District of Mopti.
Activity 6.2	Collect and analyze social sciences data and outbreak impact on children and pregnant women, including on local care seeking patterns targeting specific at-risk/vulnerable populations as appropriate (e.g. market workers, health care providers in public, private, traditional practices, pharmacies, community health workers, etc.).	Iraq – Ministry and Directorates of Health, UNICEF, WHO and John Hopkins University. Mali - Health District of Mopti.
Activity 6.3	Within the national coordination structure, establish a mechanism to share relevant findings and key recommendations to inform the multi-sectoral response and supporting the Government to implement a system to monitor behavioral change related to the outbreak.	Iraq – Ministry and Directorates of Health, UNICEF and WHO. Mali - Health District of Mopti

7. Effective Programming

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CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[23] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.

a. Accountability to Affected People (AAP) [24]: 150 words

All UNICEF's CERF supported projects took beneficiaries needs and interests into consideration during the design, implementation, and monitoring of interventions and in the majority, they were involved in the design, implementation, and monitoring of the programmes. For example, in Afghanistan beneficiaries were represented during the design of the health, nutrition and children protection programmes by Health Shuras, Community Health Workers and key community members who provided inputs to identify the most vulnerable people and to identify project site locations. In Tanzania, community and health information teams as well as community leaders in the refugee camps were consulted on the programme design and targeting, while field surveys, field visits and focus group discussions were held with various groups of beneficiaries, including refugees, youth, children, women and men to get feedback that was used to inform the response. In Turkey, rapid needs assessments were conducted by UNICEF and partners that involved beneficiaries who provided input on the composition of the COVID-19 family hygiene kits that were to be for household distribution. In Bolivia, beneficiaries of the cash transfer programme were consulted through calls by a company contracted by UNICEF to carry out third-party monitoring of the project. In Mali, beneficiaries were consulted through meetings and workshops where community member representatives including community child-protection teams attended to help identify the critical needs, appropriate interventions and targeting of the child protection response. In Peru, the complementary component of the cash intervention (education, health, child protection information and services) stemmed and evolved from consultation and feedback from the targeted population.

b. AAP Feedback and Complaint Mechanisms: 150 words

In all CERF supported programmes, beneficiaries were provided with ways to give feedback, suggest changes and express their opinions and additional needs to UNICEF and implementing partners through various means including direct contact between beneficiaries, implementing partners and UNICEF staff during programme roll out and monitoring visits where individual and focused group discussions were held. Examples from specific countries include: in Afghanistan communities shared their feedback on implementation of the project through the humanitarian helpline Awaaz (https://awaazaf.org/) and complaint/suggestion boxes installed at project sites. In Bolivia, a third-party company was hired to assess the impact and receive feedback from beneficiaries on the cash transfer programme. In Brazil, 30 WASH monitors in Roraima held monthly "roda de conversa" with community members to document critical concerns, complaints and recommendations on the project. In the State of Palestine, UNICEF led and supported the establishment of community feedback mechanisms through the roll out of the RCCE KAP survey which assessed beneficiaries' experiences, practices and satisfaction with interventions received. These findings influenced general messaging and tools used to reach targeted populations. In Burundi UNICEF's implementing partner World Vision International set up 40 feedback and rumor management committees on COVID-19 across 5 provinces which has helped inform on the needs and gaps in the messaging response to COVID-19, while U-Report was utilized with beneficiaries to ask questions and receive feedback. In Peru, monthly questionnaires were sent out to beneficiaries through WhatsApp groups; flyers were distributed to beneficiaries encouraging their feedback by providing an email address and suggestions on type of feedback (questions, complaints, suggestions) to send in. In Colombia implementing partners conducted calls to beneficiaries to get feedback and reply to concerns. In Myanmar UNICEF used the U-reporting system as well as group discussions via virtual modalities. Outreach workers expressed their opinions/ideas which helped to adjust the program for more effective implementation. For example, mother MUAC screening approach was used during COVID-19 pandemic as it was difficult even for volunteers to go outside for house-to-house nutrition screening and referral. Therefore, UNICEF provided MUAC tapes to care givers and asked CVs to orient caregivers on steps/techniques for MUAC screening. In this way, caregivers/mother could themselves do screening of their children and volunteers just had to monitor to ensure correct measurement.

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[23] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[24] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

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c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]: 150 words

All UNICEF staff (through trainings) and partners (through programme agreement documents) have been informed on UNICEF's PSEA and child safeguarding policies and guidance and the majority of UNICEF staff and implementing partners have been trained on PSEA. Each country has a PSEA system established to handle SEA related complaints. As an example, in the Sate of Palestine, a PSEA Task Team is established which UNICEF is a part of that has an obligation to refer survivors for appropriate assistance, including supporting child survivors during investigations, and to cooperate during the investigation process. In Afghanistan a mechanism has been established to report and address PSEA allegations through UNICEF-supported partners, with the support of community health Shuras and workers. In Mali, UNICEF has a PSEA focal point on staff who receives all SEA complaints and works with partners to ensure survivors are referred to specialized services and follows up on the complaint made to ensure appropriate actions are taken with the concern individual(s). In Tanzania, SEA related complaints are sent to UNICEF's PSEA focal person who escalates the case to UNICEF's Representative, regional office and eventually UNICEF headquarters, while following up locally to ensure the survivor is referred to appropriate services and that the case is managed appropriately to protect others. In CAR there is an inter-agency PSEA taskforce chaired by the Humanitarian Coordinator and all NGO partners are members of this taskforce. With UNICEF technical support, all NGO partners developed their own action plans for prevention and response to SEA, including with the establishment of community-based complaints mechanisms and referral systems.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence: 150 words

UNICEF teams are well aware that crises exacerbate existing gender inequalities, that women, men, girls and boys may face different risks, and the impacts of the crises can be felt differently between the genders. In all UNICEF interventions supported by CERF gender sensitivity was taken into consideration during the design, the implementation and monitoring phases of the project. The project outputs and outcomes targeted women, men, girls and boys equally, where appropriate, and where one gender required differential support, UNICEF's interventions met those needs where possible. As an example, in Afghanistan, the health and nutrition programme specifically targeted pregnant and lactating women who are the most vulnerable at community level and supported them with access to and provision of gender-based specific services, such as antenatal care, postnatal care, family planning, and screening and referral of GBV cases. In Peru the programme specifically targeted households with pregnant or lactating women and children and adolescents, and tailored messages for every age group and gender, considering gender dynamics within the household. For example, communication materials depict male and female characters in a balanced manner without discriminating for gender roles, promote active fatherhood and men's participation in household roles, and use gender-inclusive language. In Bolivia, the cash transfer program included targets of women, 139 of whom were single mothers and heads of household. In Burundi, the nutrition services delivery was centred around women and mothers as actors and beneficiaries of the program. As women are primary care givers in response to the COVID crisis, the project supported the promotion of Mother MUAC[25] which empowered mother to monitor their children's nutrition status. Mothers of under-five are now able to monitor nutrition status with a simple measurement of the child's mid arm circumference of children of malnutrition. In addition, preference was given to recruit female psychologists to encourage women and girl's participation in psychosocial support in Burundi as women and girls often do not attend these services. In Turkey, the design of the COVID-19 hygiene kits as well as the information brochures included in the kits addressed the specific needs of women and girls.

e. People with disabilities (PwD): 150 words

In Afghanistan, social workers received an orientation at the start of the child protection programme to ensure that children requiring assistance due to their disabilities were supported and activities were adapted and appropriate for them. As part of the cash grant programme UNICEF worked with government social departments to actively target persons with disabilities through verification of existing lists of persons with disabilities collected by Government agencies. In Peru, the cash-based programme used a vulnerability scorecard to prioritise beneficiary families, where the existence of persons with disabilities or severe medical and mental health conditions were strong factors in selection criteria for entry into the programme. In Bolivia, psychosocial support interventions were adapted to the needs of children with disabilities through the support of a clinical psychologist hired by UNICEF who specialized in disability. In Brazil, UNICEF's implementing partner Pirilampos for the education and child protection programmes under this grant has a dedicated team of therapists who besides ensuring full accessibility to the range of non-formal education and psycho-social support activities, offer dedicated sessions for children and adolescents with disabilities, including ergotherapy and sign language classes. In Chad, people living with a disability, in particular women and girls with disabilities, were given priority in the selection of beneficiaries for CERF supported programmes. In Tanzania in the refugee camps COVID-19 prevention messages were tailored to people with special needs in form of braille dots, sign language posters and application videos and disseminated through peer education and service

[25] community screening approach which empowers mothers, caregivers and other family members to screen their own children for acute malnutrition using color-coded MUAC tapes.

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provision centres. Additionally, in Tanzania, four block latrines that provide special access for children with physical disabilities, ramps leading to latrines as well as handwashing stations using foot operated taps were implemented in schools in the refugee camps that had children with disabilities in attendance. In Turkey, the education CERF project took into account the specific needs of girls and boys living with disabilities through developing adapted learning and teaching materials and capacity development of educational professionals that specifically targeted children with disabilities, ensuring their full participation in education process.

f. Protection: 150 words

Considerations for the protection of all beneficiaries was taken in all CERF supported UNICEF interventions in this grant. As an example, in Afghanistan, mobile health and nutrition services were made safer via tents set up for consultations to provide privacy for confidential discussion and examinations of patients. As part of the cash transfer programme in Afghanistan UNICEF worked closely with social workers to ensure children at risk were identified and referred to social services. In Bolivia the design of the psychosocial interventions and the cash transfers took into account the security of the spaces where interventions were to take place to ensure protection for the beneficiaries. In Venezuela, UNICEF and partners placed special emphasis on risk perception and prevention of stigmatization associated with COVID-19. In Myanmar nutrition services sites were identified in safer areas and services were provided in day light time ensuring that beneficiaries can access the services and return to their home before dark to mitigate protection related concerns.

g. Education: 150 words

In the Ukraine the project directly contributed to ensuring continuation of education in areas affected by both the armed conflict and the pandemic through supporting the conflict-affected schools in implementation of COVID-19 safe school operation guidelines. In Bolivia, based on project monitoring carried out by partners, 47% of the families benefiting from cash transfers spent 7% of the amount they received on their children's education. In Turkey, the continuity of education and learning for children, including refugee and migrant children, has been one of the centrepieces of this project. By providing financial and technical support to the Ministry of National Education in Turkey to expand the capacity and reach of its national distance learning platform throughout the period of 'lockdowns' and temporary suspension of face-to-face learning. In Peru, the programme included an education component as part of the scorecard, through which out-of-school children were identified and referred to the local education directorate to be enrolled in school while Informative materials were also provided to the families on availability of education services and how to access them. Moreover, at least 5% of the cash transfer received by families was put towards children's school supplies.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
Yes, CVA is a component of the CERF project	Yes, CVA is a component of the CERF project	Afghanistan: 14,070 people (2,010 households) Bolivia: 840 people Venezuela – Food bags for 3,391 essential workers. Ukraine - 50 schools with 11,461 children enrolled Palestine: 23,124 people Peru: 1,577 people (400 families)

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

In Afghanistan, UNICEF provided an unconditional, unrestricted cash transfer to 2,010 households who had children working in dangerous situations during the COVID-19 pandemic in Herat province, providing financial support to 14,070 people. UNICEF used a cash plus approach, combining cash transfers with child protection case management and COVID-19 information sessions.

In Bolivia, the cash transfers targeted and reached 840 vulnerable people to help them mitigate the impacts of COVID-19. The cash transfers were unconditional and unrestricted and ranged in amounts of between $57.91 and $202.69 per person, depending on the selection criteria and type of vulnerabilities identified. Based on monitoring conducted, among the needs covered by the beneficiaries

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with these funds, 38% of the money was spent on food, 31% on rent, 12% on healthcare, 7% on education, 4% for family needs (furniture, kitchen utensils, cleaning materials, etc.), 3% for children's needs (diapers, clothing, toys, etc), 2% for entrepreneurship, 1% for utilities and 1% for other expenses.

In Peru, the cash-based intervention provided monetary assistance to 400 vulnerable migrant families to cover their basic, time-critical needs during the pandemic. The CERF-funded design and implementation of the programme was successful in the initial transfers of cash, and thanks to additional donor support, the programme was extended from 330 to 400 beneficiary families (from 1,419 to 1,577 people) and was provided over a 6-month timeframe instead of 1.5 months. On average, most of the money was used for rent and food, followed by health and then hygiene and entrepreneurship. The number of people who were reached through this support was higher than originally planned, as many households included grandparents and other family members not initially considered. Moreover, the target for children was initially calculated using information from the National Survey on Venezuelan Population from 2018, yet family composition was different among the households targeted.

In the State of Palestine, UNICEF with WFP and the Ministry of Social Development targeted the most vulnerable communities using an innovative e-Voucher system to provide residents with hygienic items, previously distributed as a 'hygiene kit'- a package of items helping a child or a family to look after personal hygiene. Typically, the kit contains cleaning agents such as soap, menstrual pads, toilet paper, laundry detergent, Sodium Hypochlorite 5% and other such items. In the case of e-Voucher, the beneficiaries were given a card with credit worth approximately 139 ILS per family. The families were then able to buy prequalified items from approved storekeepers.

In the Ukraine, cash transfers were used to support schools in implementation of the guidelines for safe school operations during the pandemic to ensure the safe continuation of education. Schools were provided with e-vouchers to procure needed infection prevention and hygiene supplies. The intervention ensured a sufficient level of flexibility that allowed school administrations to timely address needs for specific supplies that were not provided by authorities or other humanitarian actors. In total 50 schools were provided with an e-voucher worth $400 benefiting 11,461 children enrolled in these schools.

In Venezuela, 3,391 people (1,692 women) were provided with an in-kind food bag (worth $21 each) incentive for two months. The beneficiaries were 300 frontline health workers from Corposalud Táchira, 180 Táchira Civil Protection workers and 2,911 social workers from the Táchira regional government. The aim of this interventions was to incentivise these essential workers to remain working in their areas of expertise, including health centres during the pandemic to maintain the continuity of critical services for the population.

Parameters of the used CVA modality:				
Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
Afghanistan: Activity 5.7 Provide one-off unconditional, unrestricted cash transfers to targeted returnee, IDP and host community households with children affected by COVID-19	14,070 people (2,010 households)	$109,993	Unconditional	Unrestricted
Bolivia: Activity 5.11 Provide humanitarian cash transfers to vulnerable populations, including migrants from Venezuela and host communities to mitigate the impact of the COVID-19	840 people	$67,820	Unconditional	Unrestricted
Venezuela: Activity 3.11 Change in indicator: Number of essential workers reached with in-kind incentive food	3,391 people (1,692 women)	$142,422	Conditional	Restricted

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bags to ensure provision of essential services				
Ukraine: Activity 4.3 Support the Ministries of Education and Health to develop and implement guidelines for safe school operations during COVID-19 outbreak and education about COVID-19 prevention	50 schools	$20,000	Conditional	Restricted
State of Palestine - Indicator 2.1 Number of people reached with critical WASH supplies (including hygiene items) and services	23,124 people	$160,000	Conditional	Restricted
Peru: Activity 5.10 Provide a humanitarian cash transfer to 400 migrant families with children, adolescents, pregnant and lactating women to cover basic needs and provide caregivers orientation to prevent VAC	1,577 people (400 families)	CERF supported $83,288 of this project. Combined with other donors this project utilized $499,726 over a 6-month period.	Unconditional	Unrestricted

9. Visibility of CERF-funded Activities

See Annex 1 attached – UNICEF CERF Report Visibility

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Project Report 20-RR-CEF-025

10. Project Information

Agency:	UNICEF	**Country:**	Global
Sector/cluster:	Health - Health Education - Education Protection - Child Protection	**CERF project code:**	20-RR-CEF-025
Project title:	Preventing and Responding to the COVID-2019 Outbreak		
Start date:	01/03/2020	**End date:**	31/08/2020
Project revisions:	No-cost extension ☐ Redeployment of funds ☐		Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	US $1.93 Billion
Total funding received for agency's sector response to current emergency:	US $1.62 Billion
Amount received from CERF:	US $5 Million
Total CERF funds sub-granted to implementing partners:	US$ 2,440,129
Government Partners	US$ 868,561
International NGOs	US$ 604,696
National NGOs	US$ 799,350
Red Cross/Crescent Organisation	US$ 167,522

11. Project Results Summary/Overall Performance

Overview

Within this project, UNICEF and partners worked to reduce the transmission in COVID-19, to mitigate the impact of COVID-19 on communities and to provide support for the continuation of essential services. This was achieved through strengthening RCCE interventions in 6 countries, reaching over 35.8 million people with COVID-19 related messages on prevention and access to services. CERF support to national education systems in 3 countries helped to develop and roll out distance/home based learning programmes reaching 6.5 million children, while child protection services were supported to continue in 4 countries, providing 99,308 people with mental health and psychosocial support during the pandemic.

Burkina Faso

With CERF funds, UNICEF contributed to the implementation of the national RCCE COVID-19 response through the provision of 150 megaphones, 30 mobile video projector kits and through the printing of over 20,000 posters and leaflets and a booklet for children to support sensitization and dissemination of COVID-19 related prevention and awareness messages in communities. RCCE interventions were rolled out through radio and TV programmes, door-to-door visits and educational talks in marketplaces, churches, mosques, schools and transport stations. Over 5,500 people (1,500 women), including community volunteers, community-based health workers, journalists and radios animators, members of socio-professional associations, and administrative frontline workers, were trained and mobilized to carry out the RCCE activities in Boucle du Mouhoun, Centre-Nord, Sahel and Hauts-Bassins regions, and the poor and most at risk areas of the capital city Ouagadougou. The activities actively engaged almost 1,651,000 people, including 793,300 women, and included COVID-19 prevention measures and hygiene promotion activities including proper handwashing. Combined with TV, radio programmes and social media, a total of 5 million people were reached through RCCE interventions supported by this CERF grant. CERF enabled UNICEF and partners to provide protection services in the municipalities of Barsalogho, Pissila, Kaya, Pensa, and Namisiguima (Centre-Nord region), Dori, Djibo and Gorom-Gorom (Sahel region) and Yatenga and Loroun (Nord region). Using a mobile approach, child protection services were implemented with families and communities reaching 17,593 children with mental

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health and community-based psychosocial support services to strengthen their resilience and wellbeing in the context of COVID-19. Social services and civil registration departments, such as alternative care centres, prisons and child friendly spaces were provided with handwashing kits (buckets and barrels, masks, soaps), while 119 UNICEF staff and partners completed their training of trainers on GBV risk mitigation and referrals for survivors.

Djibouti
Through this CERF grant UNICEF contributed to improving the availability of WASH services for preventing the transmission of COVID-19 by setting up 60 handwashing stations equipped with soap and hydro-alcoholic hand-sanitizing solutions in publics areas in Djibouti city. UNICEF supported the rehabilitation of 1 rural water point and set up WASH services coupled with hygiene promotion in government quarantine sites for migrants and travellers, reaching more than 600 migrants on a monthly basis. A total of 7,601 vulnerable households were provided with hygiene kits during door-to-door COVID-19 prevention and hygiene promotion activities. Through RCCE interventions, 10,680 youth were engaged in face-to-face interactions with the facilitation of 410 peer adolescents who were trained to pass on COVID-19 related prevention messages. This was coupled with a Facebook live gathering of 17,000 youth that covered COVID-19 prevention measures. In addition, 170 community members from 34 community management committees in Djibouti and the five regions were trained on COVID-9 key messaging and later performed door-to-door visits reaching 2,500 households (approximately 12,500 people), while 30 journalists were trained on behaviour change, preventing the spread of rumours and social listening during the pandemic. In addition, 513 street children were provided with child protection services through a child centre managed by the local faith-based partner Caritas.

Haiti *(Results were combined for these two CERF reports and Haiti all Haiti results were reported in the previous report).*

Lebanon
Thanks to CERF support, quality prevention and response services continued to be provided to the most vulnerable girls, boys, women and caregivers across Lebanon. The programme reached 111 children with case management and specialized services, 154 girls and women with safe space activities, 365 children with community-based psychosocial support, and 418 caregivers with parenting programmes, which included how to support children during COVID-19. Through co-funding from CERF, 6,500 PSS kits were procured to support children, young people and their families who had limited access to psychosocial support and safe spaces to help them cope with stressors caused by COVID-19 and its related impacts. UNICEF and partners trained youth groups on interpersonal communication skills to address stigma and worked with them to design local action plans for community outreach and social cohesion interventions. UNICEF also partnered with Community-based Organizations and local influencers to conduct door-to-door visits, phone, online outreach, and community activities that reached a total of 10,040 individuals. The youth digital platform U-report was also leveraged to support a mental health campaign for youth to listen to and address their concerns during the COVID-19 period.

Pakistan
To facilitate continuity of learning, UNICEF worked with the national education departments in developing provincial guidelines for safe school re-openings and provided technical and funding support through CERF for remote learning programmes reaching 1.27 million students directly and 8 million students indirectly during the pandemic. COVID-19 stigma prevention messages were broadcasted through TV, radio and social media, reaching 14 million people while 11.4 million people were reached with COVID-19 preventive messages through social mobilizers, local radio stations, mosque announcements, banners, IEC materials displayed at public spaces, flyers, posters, animated videos, social media videos and Facebook posts. As part of the RCCE activities, frontline workers and communities were provided with soap (62,500 bars) and sanitizers (4,483 bottles). UNICEF also contributed to the national helpline call center with human resource support to engage in collecting community feedback and answered more than 10,000 calls per day during the pandemic. Through CERF support, MHPSS was provided to 21,350 people (1,254 girls, 1,380 boys, 9,698 women), along with the training of 1,330 (682 women and 648 men) social service professionals on PSS and stigma prevention in all provinces.

Somalia
Through CERF support essential services were able to continue in the seven regions of Bay, Gedo, Hiran, Banadir, Galgadud, Lower Shabelle and Lower Juba. A total of 341,551 women and children were directly reached with services in 23 health care facilities, including 50,560 pregnant women who received their first antenatal care (ANC) visit and 16,809 who had their fourth ANC visit. Capacity building of 498 health workers (273 women) was conducted on the continuation of essential health services, triage, referral and home-based care in the context of COVID-19, while handwashing stations were established in all 23 health facilities mentioned above, and triage stations were set up outside of 21 of these health facilities. Furthermore, this contribution supported the development, pre-testing, printing and distribution of information education and communication materials that supported RCCE interventions nationwide. A total of 6,091 television and 9,386 radio spots were aired with 8,284,251 people reached with key messages on COVID-19 prevention and access to services. In partnership with the Ministry of Education and Higher Education of Puntland State of Somalia (MoEHE), UNICEF supported the adoption of the Learning Passport, a digital learning platform developed by UNICEF, Microsoft, and

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University of Cambridge that was one of the first ones to roll out the tool in the African continent. UNICEF also supported the MoEHE to record and uploaded over 2,300 audio-visual lessons, of which 1,300 targeted primary school learners. Most of these lessons incorporated sign language in the development and recordings to address the challenges faced by children with hearing impairments. A total of 24,468 Grade 8 and 12 learners (41% girls) had access to alternative distance learning during the school closure period, which lasted from March to September 2020. CERF support enabled the MoEHE to lay the ground for safe school re-opening in September 2020 through the development of the school re-opening plan, development of materials covering COVID-19 preventative measures and the roll out of community awareness-raising campaigns on COVID-19 and safe schools re-opening that was broadcasted on local TVs and radios, reaching 119,561 children. In partnership with the Ministry of Women and Human Rights (MoWHR) and INTERSOS, the child protection programme reached children in Puntland, Somaliland and the South-Central region (CSR). UNICEF and its partners provided family tracing and reunification support to 4,200 unaccompanied and separated children (UASC) and reached 60,000 people with MHPSS services delivered through distance counselling, social media and hotlines. A total of 600 social workers (330 women and 270 men) from the Federal States and the South Central Zone were trained on child protection issues, which included training on identification, documentation, tracing and reunification, alternative care, prevention of family separation and psychological first aid.

Uzbekistan
With CERF funds, Uzbekistan supported the Ministry of Preschool Education (MOPSE) and Ministry of Public Education (MOPE) to prepare national education sector response plans and to design and implement national distance learning programmes. In combination with other donor support, MOPE produced 4,492 video lessons covering grades 1 to 11 which were broadcasted nationally. Estimates show that 5,265,810 children regularly accessed these distance learning programmes throughout the pandemic. UNICEF also procured and distributed 37,000 N95 masks to 4 of the most affected city and regions of the country benefiting 7,700 lab technicians. In addition, 2,854 children and youth living in 31 state-run residential care and specialized educational correctional institutes (closed institutions) were provided with hygiene and sanitary items to protect them from COVID-19 transmission. Due to COVID-19 related lockdowns and limited access for family members and relatives to children living in these institutions, UNICEF and partners provided psychosocial support as well as recreational and sports equipment to these children. RCCE activities were implemented through social media forums reaching 7,735,366 people with messages on the symptoms of COVID-19, encouragement to visit health facilities, COVID-19 preventative measures, strengthening coping skills and resilience of families, awareness of care and learning opportunities for children, recreational and pedagogical activities to do from home; parents' and children's mental health and psychosocial wellbeing; and prevention of violence against children.

12. Changes and Amendments

In Somalia, the fluctuation in supply prices and rapid depletion of supplies on the global market (such as surgical masks and gloves), had an impact and affected procurement costs during the initial days of the response. For example, PPE ordered on 23 March 2020 were only delivered to Somalia by air in late May 2020. The situation was exacerbated by challenges faced by in-country logistics with disrupted road transport and delays in approval for tax exemptions from the government. While the funds dedicated to the education sector had initially been envisioned to also support social mobilization and capacity building activities, in consultation with the Ministry of Education and Higher Education, UNICEF decided to focus its support entirely on the recording of the distance learning lessons as other partners within the education sector committed to implementing the other priority activities identified by the COVID-19 Response Plan for Education. This way, education partners and activities ended up complementing each other and not duplicating.

In Pakistan PSS activities were originally intended to reach people only in quarantine and isolation centers and people returning home from these centers. However, during implementation, PSS activities expanded to reach the general public as well due to new cases of violence against children that were arising as a consequence of family COVID-19 confinement measures. UNICEF further developed a comprehensive SOP for the protection of women and children in quarantine facilities, which included information and referral to MHPSS services; these SOPs were adopted by the Government of Balochistan.

In Lebanon, one call center was established based on the proposal, however the contracting process was delayed and would not have been covered within the grant duration. As such, a re-programming of funds was requested to shift the remaining funds under the call center to fund a contract with the University of Balamand for capacity building and the development of a training manual for RCCE interventions.

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13. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Education - Education									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	639	748	**1,387**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	20,800	31,200	**52,000**	0	0	4,839	4,128	**8,967**
Host communities	0	0	31,200	46,800	**78,000**	0	0	58,931	50,276	**109,207**
Other affected people	235,519	250,991	3,061,345	3,239,555	**6,787,410**	339,718	918,097	2,586,246	2,692,469	**6,536,530**
Total	**235,519**	**250,991**	**3,113,345**	**3,317,555**	**6,917,410**	**339,718**	**918,097**	**2,649,944**	**2,748,332**	**6,656,091**
People with disabilities (PwD) out of the total										
	0	**0**	**5,200**	**7,800**	**13,000**	**0**	**0**	**639**	**748**	**1,387**

Sector/cluster	Health - Health									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	21,863	21,287	4,407	3,903	51,460	0	0	0	0	**0**
Returnees	0	0	0	0	0	0	0	0	0	**0**
Internally displaced people	4,063	1,627	5,543	5,228	16,461	27,251	0	24,652	26,066	**77,969**
Host communities	456,671	360,382	313,757	318,803	1,449,613	101,976	0	81,725	79,881	**263,582**
Other affected people	5,604,104	6,498,458	1,238,872	1,289,607	14,631,041	6,433,489	6,544,490	1,674,824	1,763,797	**19,817,564**
Total	**6,086,701**	**6,881,754**	**1,562,579**	**1,617,541**	**16,148,575**	**6,562,716**	**6,544,490**	**1,781,201**	**1,869,744**	**20,159,115***
People with disabilities (PwD) out of the total										

	5,383	**5,295**	**3,066**	**2,951**	**16,695**	**0**	**0**	**0**	**0**	**0**

**3 countries (Burkina Faso, Pakistan and Lebanon) reported RCCE messages on COVID-19 prevention as overall health results which were overachieved against targets in most countries due to the use of TV's, radios, social media and other modalities.*

Sector/cluster	Protection - Child Protection									
	Planned					**Reached**				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	1,674	892	2,053	2,053	6,672	401	63	84	83	**631**
Returnees	1,283	730	2,348	2,348	6,709	0	0	0	0	**0**
Internally displaced people	3,608	2,500	7,126	7,126	20,360	535	627	2,580	2,740	**6,482**
Host communities	2,879	2,307	5,348	5,348	15,882	4,997	5,668	32,110	33,551	**76,326**
Other affected people	272,340	290,110	170,663	180,436	913,549	4,298,635	5,610,824	2,317,912	2,317,912	**14,388,677**
Total	**281,784**	**296,539**	**187,538**	**197,311**	**963,172**	**4,304,568**	**5,617,182**	**2,352,686**	**2,354,286**	**14,628,772***
People with disabilities (PwD) out of the total										
	523	310	1,617	1,617	**4,067**	5	0	11	17	**33**

**The high results are attributed to Pakistan results of over 14 million people reached with stigma prevention messages under the child protection section.*

14. People Indirectly Targeted by the Project

As mentioned in the report above, it is difficult to quanitfy the number of people who were (or will be) indirectly reached by CERF supported programmes. However, for this grant, in Pakistan, approximately 8 million children indirectly benefited from CERF support to the government's national distance/home based education programme during lockdowns when schools were closed. In addition, PSS interventions supported by CERF in Pakistan likely supported an additional 160,000 children based on each person who has received direct support likely has shared the information with one other person either in their family or community. RCCE interventions in Pakistan can be estimated to have indirectly benefited an additional 25 million people.

15. CERF Results Framework

Project objective	Reduce human-to-human transmission in COVID-19 affected countries and mitigate impact of the outbreak in all countries

Output 1	Strengthen and/or amplify risk communication and community engagement (RCCE)
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Health - Health

Indicators	Description	Target	Achieved	Source of verification
Indicator 1.1	Number of people reached on COVID-19 through messaging on prevention and access to services	41,293,363	**Total – 35,860,761** Pakistan - 11,400,000 Somalia - 8,284,251 Uzbekistan - 7,735,366 Burkina Faso - 5,000,000 Djibouti – 40,180 Lebanon – 3,400,964	IP reports Uzbekistan - Social media channels of UNICEF Uzbekistan, KoronavirusInfo Telegram channel, Telegram channel of the General Prosecutor's Office
Indicator 1.2	Number of pregnant and lactating women and caregivers engaged and reached with specific behaviour focused information on COVID-19	122,966	**Total – 226,944** 76,944 – Somalia Burkina Faso - 150,000	IP reports
Indicator 1.3	Number of health professionals and community health workers trained on screening, triage infection prevention and emergency referral of suspected cases (Somalia)	270	498 (273 female)	Partners monthly report and training reports
Indicator 1.4	Number of vulnerable children (street children) accessing the COVID preventive measures (handwashing with soap, restriction of movements) in Djibouti city (Djibouti)	200	513	IP report
Indicator 1.5	Number of hand washing stations installed in public areas, markets, bus stations, bus stops and sites occupied by floating populations (out-of-the camps migrants and refugees) (Djibouti)	300	60	IP reports, company contract reports, UNICEF field visits, school and public administrators.
Indicator 1.6	Number of migrants and land travellers accessing WASH services	36,000	8,900	IP reports.

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	in the quarantine site in Ali Sabieh region (Djibouti)			
Indicator 1.7	Number of healthcare facility staff and community health workers trained on Infection Prevention and Control (focusing only on Community Health Workers] (Haiti)	250	250	IP reports.
Indicator 1.8	# or percentage of personnel (staff and volunteers) across all sectors responding to COVID-19 emergency who are trained on prevention and protection (Lebanon)	1,000 50% female, 50% male	10,671	ActivityInfo
Indicator 1.9	Number of healthcare facilities staff and community health workers provided with life-saving personal protective equipment (Uzbekistan)	7,700	7,700	Service for Sanitary and Epidemiological welfare and public health
Indicator 1.10	Number of people sharing their concerns and asking questions/clarifications for available support services to address their needs through feedback mechanisms (Pakistan)	121,000	311,922	IP reports
Explanation of output and indicators variance:		**Indicator 1.1** – Six countries reported on this indicator. The results reported are people directly reached with these interventions. **Indicator 1.2** – Two countries reported on this indicator, Burkina Faso with a result of 150,000 and Somalia with a result of 76,944. In Burkina Faso the targets were estimated for the Centre Nord region but during implementation activities were conducted in the Boucle de Mouhoun and the Sahel regions where there were additional needs, therefore the result is larger than the original target. **Indicator 1.3** – There were a larger number of health professionals and community health workers in need of this training, and with some training held remotely, additional people were able to be reached. **Indicator 1.4** – Due to the significant fear of COVID-19, many more street children sought the services from UNICEF's partner Caritas with 513 children registered in the centre during the first 3 months of the pandemic. **Indicator 1.5** – The cost for setting up handwashing stations significantly increased after work started in schools where multiple handwashing stations were required to meet children's WASH needs. UNICEF did reach the target of 300 for this indicator, but it was done in combination with other donor funds, therefore CERF funds alone can be attributed to supporting 60 handwash stations. **Indicator 1.6** - The initial expected numbers of migrants and land travellers to the transit center in the camp went down significantly than originally planned due to local and international travel bans and movement restrictions imposed by the government during the COVID-19 lock down.		

		Indicator 1.10 – This result was achieved through UNICEF's support to the national helpline call center that collected community feedback and answered more than 10,000 calls per day regarding COVID-19 concerns, information and availability of support services.
Activities	**Description**	**Implemented by**
Activity 1.1	Coordinate with authorities to track and respond to misinformation and ensure pregnant women, children and their families know how to prevent COVID-19 and seek assistance.	Pakistan – National government helpline center, civil society organizations, key influencers, such as religious leaders, health workers and frontline workers. Somalia Ministry of Health (MOH) Djibouti: UNICEF paired up with the MoH and WHO to track misinformation through the social medias and provide appropriate response to ensure that pregnant women, children and their families receive the correct information on how to prevent COVID-19 and seek assistance.
Activity 1.2	Conduct community level outreach to reduce stigma and increase social support and access to basic needs for affected people and their families.	Somalia Social mobilizers and SOMNET Pakistan – Provincial government departments and civil society partners, namely: Punjab: Social Welfare Department Sindh: Social Welfare Department, Health Department and DevCon (CSO) Khyber Pakhtunkhwa: Social Welfare Department, Interflow Communication Consultant (CSO) Balochistan: Health Department and DANESH (CSO) Djibouti: The RCCE interventions involved community-based organizations (Djiboutian National Womens Association, local NGOs, local Muslim authorities…) to better inform the population and reduce stigma linked to COVID-19
Activity 1.3	Develop and broadcast messaging and information on COVID-19 through social media, radio broadcasts, and other channels including targeted messaging for key stakeholders and at-risk groups based on community risk perceptions (including children, parents/care givers, pregnant women, health providers etc).	Pakistan Broadcasting Corporation. Somalia UNICEF Communication for Development Unit. Uzbekistan, UNICEF, National Association of Electronic Mass Media, KoronavirusInfo Telegram channel. Djibouti, UNICEF and social media forums, TV, radio broadcasts and community-based channels. Lebanon - UNICEF Communication for Development Unit; RCCE Task Force
Activity 1.4	Work with key influencers, community groups, women and youth groups, health workers and community volunteers to build their capacity for awareness raising and promoting healthy practices through participatory interventions.	Pakistan – Government helpline call centre, civil society organizations, key community influencers such as religious leaders, health workers and frontline workers. Somalia – Civil Society Organizations, media community, key influencers such as religious leaders, essential health workers and frontline workers. Lebanon – civil society organizations, key influences, frontline workers, implementing partners. Burkina Faso - civil society, mobilised community volunteers, key influencers such as traditional leaders and healers and religious leaders, women association leaders and youth association leaders including u-reporters; we also worked with medical students for community outreach activities.

Activity 1.5	Launch multi-sectoral handwashing campaigns in ECD centres, schools, health facilities and public spaces to improve preventive practices among children, at-risk groups, and the general public.	Djibouti: UNICEF and the Ministry of Education, the Japanese Embassy in Djibouti launched the national handwashing with soap campaign in schools during the setup of the handwashing in schools' initiatives. Burkina Faso: worked with religious organisations to support activities in mosques, churches and schools to promote handwashing and distribute handwashing kits.,
Activity 1.6	Conduct targeted outreach to urban poor and other potentially high-risk communities, including utilization of existing social protection systems, to ensure delivery of accurate information on prevention assistance.	Pakistan - Punjab Social Welfare Department and PAHCHAN (CSO). Sindh: Social Welfare Department and DevCon (CSO). Pakistan DANESH (CSO) for outreach with key messages on MHPSS and stigma prevention targeting high risk urban populations in Lahore, Gujranwala, Karachi and Quetta. Djibouti – UNICEF, local faith-based organization working with street children. Burkina Faso: worked in peri urban areas, and interventions in insecure regions; some interventions targeted people with disabilities – door to door activities, group discussions and community outreach activities by u reporters
Activity 1.7	Train and supervise front line community health workers and health professionals in COVID-19 prevention and case management, including case detection and home-based care (Somalia)	Somalia - AYUUB Organization, Burhakaba Town Section Committee (BTSC), International Committee for Development of People (CISP), Deeg-roor Medical Organization (DMO), Human Development Concern (HDC), Himilo Relief and Development Association (HIRDA), Mercy-USA, Relief International (RI), Skills Active Forward International (SAF-UK), SOS Children's Villages International (SOS), Somaliland Youth Development Association (SOYDA), WARDI Relief (WARDI), Wamo Relief and Rehabilitation Services (WRRS).
Activity 1.8	Provide WASH services in public space identified at risk in affected areas as such markets, bus station and stop, homeless residential area, migrants' temporary shelters, shelters for street children, mosque and vulnerable community setting (Djibouti)	Djiboutian National Women Association, Caritas (local faith-based organization), Ministry of Health, Ministry of Education, National Office for Migrants & refugees, CRD (local NGO).
Activity 1.9	Develop and disseminate contextualised operational guidance and job aids for COVID-19 awareness, case management and continuity of essential health services. (Somalia)	UNICEF developed visual materials on COVID-19 for the health facilities and availed in the Somali language. UNICEF provided technical support to the Government in developing case management SOP (with WHO as lead). UNICEF developed training materials on continuity of essential services, IPC, and community health workers training materials on basic COVID-19 home care, both in English and Somalia languages.
Activity 1.10	Support community health workers and community volunteers to build their capacity on infection prevention and control at community level (Haiti)	ACTED, SI, CRNL, AC.
Activity 1.11	Procurement of 37,000 N95 mask for health providers (Uzbekistan)	UNICEF procured N95 masks directly to the Government, Ministry of Health.

Output 2	Ensure continued access to education			
Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☒
Sector/cluster	Education - Education			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	# of students accessing schools practicing "safe school" operations	3,130,000	**Total – 5,970,461** Somalia - 119,561 Uzbekistan - 5,850,900	Puntland EMIS Education Statistics Yearbook 2019-2020 Uzbekistan - Ministry of Public Education and State Statistical Committee
Indicator 2.2	# of children supported with distance/home-based learning	4,580,000	**Total – 6,561,578** Pakistan - 1.27 million directly (8 million indirectly) Somalia – 25,768 Uzbekistan – 5,265,810	Pakistan - Gallup Survey Uzbekistan - L2CU survey, UNICEF Rapid Assessment. Somalia - Puntland school rapid assessment report and Puntland EMIS Education Statistics Yearbook 2019-2020.
Indicator 2.3	Number of teachers, school management committee members and other education personnel reached with prevention information, trained on psychosocial support and safe reopening of schools (Pakistan)	486,510	1.2 million educational personnel, 14,707 parents, 20,040 children and youth.	IP and Youth Perception Report
Explanation of output and indicators variance:		**Indicator 2.1 –** Two countries (Somalia and Uzbekistan) reported on this indicator. The overachievement of the target is attributed to Uzbekistan's overachievement due to UNICEF's support to the development, roll out and continued monitoring of the national education sector's COVID-19 response plan which included the development, dissemination of supplies and support to all schools nationwide to practice 'safe school' operations. **Indicator 2.2.** – Three countries reported on this indicator. Utilising online and remote modalities UNICEF was able to reach a higher number of children through national distance learning programmes than original estimated. **Indicator 2.3** – This result is broken down as follows: 545 teachers (307 women) reached with trainings on safe school reopening of schools and MHPSS support; 14,707 parents and 10,040 children (4,746 girls) reached with messages encouraging continuity of learning; 1.2 million school management committee members, teachers and education personnel reached with COVID-19 prevention messages; 10,000 youth between the ages of 14 and 29 reached through youth perception survey tool on COVID-19 (developed in collaboration with subject specialists from UNICEF, UNDP, UNFPA and Viamo). The overreach of the target can be attributed to		

	remote/online modalities and the significant reach of COVID-19 preventative messages with education personnel.	
Activities	**Description**	**Implemented by**
Activity 2.1	Support Ministries of Education and other education actors in the production of pre-primary and primary education lessons to be broadcast on media (radio/tv) and other distance learning platforms as required	Pakistan - Federal Ministry of Education Somalia - MoEHE of Puntland State of Somalia Uzbekistan -Ministry of Public Education
Activity 2.2	Support the Ministries of Education and Health to develop and implement guidelines for safe school operations during COVID-19 outbreak (e.g. promotion of hand and respiratory hygiene, screening and referral of suspected cases, as appropriate), and education about COVID-19 prevention	Pakistan – Ministry education departments Somalia - MoEHE of Puntland State of Somalia Uzbekistan - Ministry of Health, Ministry of Public Education, and Ministry of Pre-school Education

Output 3	Ensure continued access to protection services			
Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☒
Sector/cluster	Protection - Child Protection			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	Number of children without parental care provided with appropriate alternative childcare arrangements	3,900	**Total – 4,639** Somalia - 4,200 Burkina Faso – 21 Lebanon - 418	Monthly reports from partners.
Indicator 3.2	# of people provided with community based mental health and psychosocial support	58,411	**Total – 99,308** Pakistan - 21,350 Somalia - 60,000 Burkina Faso - 17,593 Lebanon – 365	IP and Field Offices Reports
Indicator 3.3	# of trained social workers, CP staff/ community volunteers/ committees on alternatives care systems	500	Somalia – 600	Monthly partner reports
Indicator 3.4	Number of boys and girls assisted through child protection case management and specialized services (Lebanon)	90	111	IP and UNICEF Field officer reports.
Indicator 3.5	Number of UNICEF personnel and partners that have completed training on GBV risk mitigation and referrals for survivors, including for sexual exploitation and abuse (Lebanon)	100	120	Training attendance forms.
Indicator 3.6	Number of women and girls accessing mobile and safe spaces (Lebanon)	500	154	IP reports, UNICEF field officer reports.
Indicator 3.7	Number of people reached with stigma prevention messages (Pakistan)	900,000	14,385,310	IP reports, UNICEF Field Offices Reports, UNICEF

				and Partner's Social Media Pages
Explanation of output and indicators variance:		**Indicator 3.1** – Three countries reported on this indicator. In Somalia the result was 4,200 children reached as there were more cases of children exposed to risks of abuse, violence and exploitation during COVID-19 than originally thought. **Indicator 3.2** – Four countries reported on this indicator. The overachievement of this indicator results is attributed to the use of multimedia, social media, online counselling, and use of hotline to provide people with MHPSS. **Indicator 3.3** – Somalia reported on this indicator. The overachievement can be attributed to the use of remote and online modalities to conduct some of these trainings meaning more people were able to be reached using the same amount of funds. **Indicator 3.6 –** Persistent and strict national COVID-19 lockdowns and movement restrictions impacted women and children's access to safe spaces throughout 2020. **Indicator 3.7** – This result is significantly higher than the target due to the use of remote/online modalities to deliver stigma prevention messages which were also included in other COVID-19 related prevention messaging broadcasts.		
Activities	**Description**	**Implemented by**		
Activity 3.1	Ensure that children affected by COVID-19 have access to adequate alternative care arrangements as well as deliver protection services for children left without a care provider, due to the hospitalization or death of the parent or care provider	Somalia - INTERSOS and UNICEF Burkina Faso - Social Service Departments of the Ministry of Women, National Solidarity, Family and Humanitarian Action (MWNSFHA) and implementing partners. Lebanon – L'Union Pour La Protection De Lenfan Au Liban (UPEL), Himaya, TDH Lausanne and IRC.		
Activity 3.2	Provide mental health and psychosocial support, counselling and rehabilitation support to children and families impacted by COVID-19	Pakistan - Punjab: Social Welfare Department, Punjab, Sindh: Department of Social Welfare, Department of Health, DevCon. Khyber Pakhtunkhwa: Department of Health. Balochistan: Department of Health, DANESH Somalia - INTERSOS, MOWHR and UNICEF Lebanon - UPEL, Himaya, TDH Lausanne and IRC		
Activity 3.3	Support the development of referral pathways to other organizations and agencies for specialized MHPSS services and other basic needs	Somalia - INTERSOS, MOWHR and UNICEF Burkina Faso - Social Service Departments of the Ministry of Women, National Solidarity, Family and Humanitarian Action (MWNSFHA) and implementing partners Lebanon - UPEL, Himaya, TDH Lausanne and IRC		
Activity 3.4	Train and supervise local staff in basic psychosocial support, including psychological first aid.	Somalia - INTERSOS, MOWHR and UNICEF		
Activity 3.5	Ensure that migrants' children and street children have access to adequate alternative care arrangements as well as protection services for keeping them out of the risk of COVID-19 transmission (Djibouti)	ONARS, Caritas, UNFD		
Activity 3.6	Provision of case management and referral to and provision of specialized services (Lebanon)	L'Union Pour La Protection De Lenfan Au Liban (UPEL), Himaya, TDH Lausanne and IRC		

Activity 3.7	Capacity building for frontline staff on GBV core concepts and safe referrals, including PSEA core principles, particularly to those engaged with direct COVID-19 response. (Lebanon)	This activity ended up being covered by another grant and was not conducted using CERF funds.
Activity 3.8	Provide women, girls with access to safe spaces package (Lebanon)	International Rescue Committee, Himaya
Activity 3.9	Psychosocial Support and care: For the majority of crisis-affected people, including children, meeting their basic needs and a supportive family and community environment will be sufficient for their recovery. However, if people demonstrate exacerbated distress and signs of mental health concerns or adverse reactions, they would be referred to specialized mental health and psychosocial support (MHPSS). (Pakistan)	Pakistan - Punjab Social Welfare Department. Sindh: Department of Social Welfare, Department of Health, DevCon. Khyber Pakhtunkhwa: Department of Health. Balochistan: Department of Social Welfare, DANESH
Activity 3.10	Stigma Prevention: Service provision will prioritize prevention of stigma, labelling and discrimination of people who are perceived to be infected or affected by the novel coronavirus. (Pakistan)	Punjab: Social Welfare Department. Sindh: Department of Social Welfare, Department of Health, DevCon. Khyber Pakhtunkhwa: Social Welfare Department, Interflow Communication. Balochistan: Department of Health, DANESH
Activity 3.11	Ensure provision of health, hygiene and psychosocial supplies for children in residential care institutions including closed facilities (Uzbekistan)	Ministry of Public Education

Output 4	Assess the social impacts of the epidemic on communities, with a focus on women and children for improved and better targeted mitigation response			
Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒				
Sector/cluster				
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 4.1	# of UNICEF COs undertaking COVID responses reporting on key results on a regular basis	Somalia, Uzbekistan	Uzbekistan - Joint UN-WHO Sitreps produced weekly with UNICEF inputs and monthly UNICEF reports produced. Somalia – Monthly UNICEF situation reports produced, and inputs regularly provided to other UN reports.	UNICEF and UN situation reports.
Indicator 4.2	# of UNICEF COs undertaking COVID responses that participate in assessments of social impacts, including interagency assessments	Somalia, Djibouti	Yes	Interagency, Ministry of Education and Higher Education (MoEHE) and UNICEF assessment reports
Explanation of output and indicators variance:				

Activities	Description	Implemented by
Activity 4.1	Monitor and conduct epidemiologic analysis together with WHO, on COVID-19 infection among children and pregnant women – including susceptibility to COVID-19 infection, clinical features (including disease severity and mortality, any associated complications such as miscarriages, preterm deliveries, growth restriction in the uterus, etc.)	UNICEF and Ministries of Health.
Activity 4.2	Collect and analyse social sciences data and outbreak impact on children and pregnant women, including on local care seeking patterns targeting specific at-risk/vulnerable populations as appropriate (e.g. market workers, health care providers in public, private, traditional practices, pharmacies, community health workers, etc.).	Somalia – UNICEF worked with WHO in conducting an analysis of the data on healthcare workers affected by COVID-19.
Activity 4.3	Within the national coordination structure, establish a mechanism to share relevant findings and key recommendations to inform the multi-sectoral response and supporting the Government to implement a system to monitor behavioral change related to the outbreak.	Somalia – UNICEF led the RCCE coordination pillar and facilitated an informed discussion forum to exchange ideas and updates. UNICEF continues to frequently attend all the relevant coordination forums for information sharing on COVID-19.

16. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[26] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.

a. Accountability to Affected People (AAP)[27]:

In Djibouti, beneficiaries were involved in the design of the programme whereby meetings were held with beneficiary representatives to review programme plans, specific actions, targets and timeframes of programme implementation. This dialogue was facilitated to some extent through existing NGO networks as well as parent associations in schools. Key beneficiaries consulted on the programme included travellers, migrants, community workers and schoolteachers. In Somalia, the Ministry of Education and Higher Education led the process of recording the distance learning lessons and included 240 local teachers in the process. These teachers were trained and given the responsibility to develop the educational content of the lesson's and participate in the recordings. Students were also given a chance to provide feedback on the recordings throughout the process, allowing adjustments to be made as required. In Pakistan, a youth perception survey was conducted reaching 10,000 youth before the design of the programme, helping UNICEF and partners gain a better understanding of new challenges faced, gaps in support provided and ongoing needs and interests youth had during the pandemic. In Lebanon, focus group discussions with several community based groups, including women, youth, religious leaders and municipality representatives, were conducted from March to May 2020 to inform the design of the key messages and key social mobilization interventions at national and community level.

b. AAP Feedback and Complaint Mechanisms:

[26] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[27] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

Multiple feedback and complaint mechanisms were either established or had already been established and were used by beneficiaries during programme implementation. Efforts were made to ensure that complaint mechanisms were confidential, easily accessible, appropriate, and robust enough to deal with (communicate, receive, process, respond to and learn from) complaints about breaches in policy and beneficiary dissatisfaction. As an example, in Pakistan, there was consistent collaboration and communication with established school management committees in the planning, roll out and monitoring of the education activities during the response. In Pakistan CERF funds supported the national COVID-19 call centre that received feedback, questions and other inputs from beneficiaries, while provincial helplines for child protection and health related concerns were also used to collect feedback from beneficiaries. In Somalia beneficiaries provided feedback through established hotlines, PSEA focal points, ballot boxes, and complaints desks that were set up alongside programmes. In Uzbekistan, the U-Report was used to receive feedback from beneficiaries, while rapid assessments engaged families/communities, including young people, school children and their parents, which helped inform the response during the pandemic.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

As mentioned in the previous report, all UNICEF staff and partners have been informed on UNICEF's PSEA and child safeguarding policies and guidance and the majority of UNICEF staff and implementing partners have been trained on PSEA. Each country has a PSEA system established to handle SEA related complaints. As an example, in Pakistan there are child helplines available across the country for recording and referring SEA related complaints to partners for case management follow up and informing UNICEF and partners. In Somalia UNICEF conducted a PSEA needs assessment for all IPs delivering UNICEF health services and provided scores on the risk levels based on core standards of PSEA, identifying with partners areas that need improvement. In Lebanon, in 2020, UNICEF invested heavily in advancing the PSEA measures within local implementing partners through trainings, coaching and mentoring of 30 local partners and through PSEA capacity assessments for 51 local partners. In Lebanon, incidents of SEA are recorded through the Significant Incident Reports (SIR) that are password protected and shared only with very limited number of concerned management staff; SEA survivors are supported through the pre-existing SGBV referral pathway and they have access to quality / age appropriate GBV case management services, with referral the relevant specialized health / psychosocial/ legal and safety services. These services are designed to promote SEA survivors' physical and psychosocial healing and recovery, to protect them from further violence, and to facilitate access to justice where available. If a SEA incident is reported, UNICEF follows with implementing partners conducting the oversight on the case management/risk mitigation activities put in place and provide needed support if deemed appropriate.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

In Djibouti latrines constructed took into consideration the different protection needs of women and girls in the design and location of where these were implemented. In Pakistan UNICEF and partners worked to reach the most vulnerable people, especially in regions where girls confront extreme education inequity due to economic barriers, lack of facilities and social and cultural norms. The programme made efforts to ensure gender equality through the use of gender disaggregated targets for each indicator and monitoring the interventions to ensure equal opportunities were provided to both genders. Also in Pakistan, awareness and advocacy materials were developed to raise awareness among communities regarding prevention of violence against children and gender-based violence, while females were recruited to support the programme roll out to improve participation amoung women and girls. In Somalia, while only 14 per cent of all primary school teachers in Puntland are women, for the recording of the distance learning lessons, UNICEF and the MoEHE gave priority to female teachers and engaged 44 female teachers in the recording of the videos (18 per cent of all teachers involved). While still short of gender parity, UNICEF and the MoEHE put effort into increasing female teachers' opportunities within the activity. In Somalia, psychosocial support activities were developed based on age, children's level of development, the needs of women and girls and the cultural sensitivities around gender during the project design and implementation. In Burkina Faso, UNICEF and partners Plan International and CERESSE engaged women associations in poor and high-risk areas of the capital city, Ouagadougou, to deliver interpersonal communication activities targeting women in mosques, churches, marketplaces and households. In Uzbekistan RCCE activities focused on parents' role in supporting distance learning of children, with an emphasis on supporting girls to continue to learn.

e. People with disabilities (PwD):

In Somalia, the delivery of child protection services considered the special needs of people living with disabilities ensuring protection messages and activities were tailored to meet their needs with 28 children living with disabilities (physical impairment) being reached in MHPSS programmes and benefitting from distance counselling and focused psychosocial support through house-to-house visits from trained social workers. Additionally, in Somalia, 1,387 children with disabilities benefitted from distance learning lessons that were adapted to these children's special needs. UNICEF and the MoEHE plan to continue improving the accessibility features in education

programmes in the future through captioning for children with hearing impairment. In Uzbekistan UNICEF worked with partners to ensure sign language interpretation was included for all TV educational lessons after schools closed in the country. In Lebanon, all UNICEF child protection tools and guidance to partners promote disability inclusion and services are inclusive with activities and spaces for programme implementation adapted to include and meet the needs of children with disabilities.

f. Protection:

In Somalia the project used the Humanitarian Needs Overview (HNO) to focus on communities with a high protection severity, targeting people with the highest need for protection and health services. As an example, the child protection interventions focused on internally displaced people living in communities affected by armed insurgency and natural disasters, taking into consideration the holistic nature of their needs and existing dynamics with the host communities. In Pakistan due to the risks involved with face-to-face and physical interactions most interventions were planned and implemented virtually, including counselling sessions and COVID-19 prevention and awareness raising activities, while stigma prevention was included in the dissemination of key messages. In Uzbekistan, COVID-19 related lockdowns prevented children and youth living in state-run residential care from regular contact with family members and relatives. This increased the vulnerabilities of these children and youth in relation to their health and mental wellbeing. Targeted PSS support for these children as well as the provision of health, hygienic and sanitary items helped contribute to their protection from the virus spread and to strengthen their abilities to cope with lockdown related stress and anxiety.

g. Education:

In Pakistan, Somali and Uzbekistan, CERF funding helped UNICEF and partners support the government's national distance education programmes, which kept millions of children learning throughout the pandemic when schools were closed due to national COVID-19 lockdown measures to contain the spread of the pandemic. *(More specific details on CERF's support in education in these countries can be found in the information included in the above sections).*

17. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	N/A	N/A

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

The nature of the programmatic interventions meant that it was not appropriate to use cash and vouchers for the response.

18. Visibility of CERF-funded Activities

See Annex 1 attached for list of UNICEF visibility for this CERF grant.

PART XVI – AGENCY OVERVIEW: WFP

1. STRATEGIC PRIORITIZATION

Statement by the agency focal point:

When COVID-19 began to spread around the world in early 2020, global supply chains and transport markets were severely impacted. The CERF funds enabled WFP to ensure both humanitarian workers and vital health supplies could continue to reach the places where they were most needed. WFP leveraged its extensive supply chain network and expertise, built up over decades of emergency response, to fill gaps created by a reduction in commercial capacity, setting up passenger and cargo movement services to destinations around the world.

These services, known as WFP Common Services, were set up to keep health and humanitarian workers and COVID-19 response items and other humanitarian cargo flowing to areas that needed them most, allowed the humanitarian community to respond to the massive needs triggered by the pandemic, delivering assistance and/or passengers to 162 countries – 82 percent of the world – and at one point even becoming the largest airline operating globally at the time.

CERF funds were critical to enable the humanitarian and health response, ensuring the critical movement of personnel and COVID-19 cargo despite supply chain disruptions caused by the pandemic.

CERF's Added Value:

The global nature of the pandemic as well as its consequences on humanitarian contexts and operations required unprecedented levels of coordination among stakeholders, at all geographical levels, while staff on the frontlines required access to adequate healthcare in order to "stay and deliver".

In particular, WFP, working closely with WHO, the UN system, the NGO community and governments, activated its logistics capacity and expertise to step in and provide critical services where commercial capacity was not available. Thanks to the CERF contribution WFP established a comprehensive platform of services, the Common Services, to enable humanitarian and health partners - including UN agencies, international and national NGOs and civil societies - to deliver support to the most vulnerable populations, as well as ensuring a duty of care to all frontline staff.

Through the Common Services, WFP acted as of service provider for humanitarian and health partners, delivering services to enable partners to reach their goals and implement their activities. Continuous coordination was ensured with partners to monitor demands, needs and constraints, and ensure that the plan was and continued to be fit for purpose.

WFP designed and built the Common Services to be flexible, ensuring that WFP and the entire humanitarian community could respond as quickly as possible to minimize the impact of the pandemic. This built-in flexibility allowed for strategic adjustments to be made according to the most up-to-date epidemiological and operational information, thus ensuring a successful operation. Financial requirements were adjusted accordingly, and services were carefully costed to remain in line with available and expected funding.

Did CERF funds lead to a fast delivery of assistance to people in need?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help respond to time-critical needs?		
Yes ☒	Partially ☐	No ☐
Did CERF improve coordination amongst the humanitarian community?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help improve resource mobilization from other sources?		
Yes ☐	Partially ☒	No ☐

Considerations of the ERC's Underfunded Priority Areas[28]:

Not applicable given that this was a common services project.

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
WFP	20-RR-WFP-023	Logistics - Common Logistics	20,000,000
WFP	20-RR-WFP-025	Logistics - Common Logistics	20,000,000

2. OPERATIONAL PRIORITIZATION:

People Directly Reached:

Although the WFP Common Services do not reach beneficiaries directly, the CERF funds allowed WFP to act as service provider for humanitarian and health partners, delivering services to enable partners to reach their goals and implement their activities. Continuous coordination was ensured with partners to monitor demands, needs and constraints, and ensure that the plan was and continued to be fit for purpose.

WFP facilitated access to crucial cargo delivery services for 48 organisations, thus allowing them to reach affected populations targeted by their programmes. Between the start of operations on 1 May 2020 until 31 March 2021, WFP transported 29,070 passengers to 68 destinations on behalf of 436 organizations, to allow humanitarian and health personnel to reach the frontlines of the response where no viable commercial options exist. Destinations were defined in line with partial or full suspension of commercial services in countries or regions, with regional passenger services established as needed, as well as a long-haul connection between Rome and Accra (Ghana) to link the continents at a time when no other options were available.

People Indirectly Reached:.

As countries clamped down on international arrivals in a bid to prevent the arrival of new infections, commercial air carriers saw many of their fleets grounded and critical airlinks were severed across the globe, severely impacting the ability of humanitarian and health partners to respond in an effective and efficient manner.

WFP worked country by country to open these networks, laying the groundwork for governments, regions and commercial airlines to re-establish connections in line with health and safety requirements.

According to OCHA, WFP efforts to sustain corridors and cargo/passenger movement was significant in alleviating access challenges. In April 2020, 90% of respondents to an OCHA survey flagged restrictions on movement as major access constraint – by early August this was down to 38%."

[28] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

PART XVII – PROJECT OVERVIEW: WFP

Project Report 20-RR-WFP-023

1. Project Information

Agency:	WFP	**Country:**	Global
Sector/cluster:	Logistics - Common Logistics	**CERF project code:**	20-RR-WFP-023
Project title:	Global service provision in support of humanitarian/health partners and governments response to the COVID-19 pandemic		
Start date:	25/03/2020	**End date:**	24/12/2020
Project revisions:	No-cost extension ☒	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 350,000,000**
Total funding received for agency's sector response to current emergency:.	**US$ 278,029,458.95**
Amount received from CERF:	**US$ 20,000,000**
Total CERF funds sub-granted to implementing partners:	**US$ [0]**
Government Partners	US$ [0]
International NGOs	US$ [0]
National NGOs	US$ [0]
Red Cross/Crescent Organisation	US$ [0]

2. Project Results Summary/Overall Performance

Through this CERF grant, WFP delivered assistance and/or passengers to 162 countries – 82 percent of the world – and at one point even becoming the largest airline operating globally at the time.
WFP established a network of eight global humanitarian response hubs to facilitate the movement of this critical cargo on a free-to-user basis on behalf of all humanitarian organizations. Since the start of operations on 30 April 2020 until 31 March 2021, WFP transported 131,579 m3 of essential COVID-19 items through this free-to-user mechanism to 162 countries on behalf of 48 humanitarian organizations.
Between the start of operations on 1 May 2020 until 31 March 2021, WFP transported 29,070 passengers to 68 destinations on behalf of 436 organizations.
Since its activation on 22 May, WFP has also played a key role in the UN medevac cell, used its access to a global network of contracted air ambulances. As of 31 March 2021, a total of 206 medevacs have been carried out under this mechanism, 129 of these by WFP and 77 by UNDOS. WFP embedded four staff in the Strategic Air Operations Centre (SAOC), based at SAOC/DOS in Brindisi. WFP also constructed two treatment centres, one in Accra and one in Addis Ababa, while a third field hospital has been prepositioned in Ghana to be immediately available for use should there be a need.
These WFP Common Services were critical to enable the humanitarian and health response, ensuring the critical movement of personnel and COVID-19 cargo despite supply chain disruptions caused by the pandemic.

3. Changes and Amendments

Following a peak in April and May, airfreight rates and capacity stabilized in July 2020 as restrictions in certain regions and countries were partially lifted. By August 2020, airfreight rates further re-adjusted to pre-COVID-19 levels, as a number of commercial carriers slowly resumed passenger and cargo operations. In addition, demand forecasting based on the epidemiological model towards the beginning of the response initially foresaw a response pipeline consisting of high volumes of personal protective equipment, biomedical items and diagnostics. However, quantities predicted did not materialize, for lack of supplies as well as lack of funding to acquire the supplies, and the global response began transitioning towards therapeutics much sooner than expected.
These market improvements, coupled with extensive consultation with partners on pipeline estimates and remaining available funding, provided the basis for WFP and partners to phase down the free-to-user cargo services while ensuring a flexible approach and continued support to partners within the framework of the COVID-19 Supply Chain System. Cargo movement requests were accepted until 31 October 2020, and deliveries to transport the booked cargo continued until 31 March 2021.
In line with its mission to fill gaps in commercial transport markets rather than replace commercial capacity, WFP stood down its own passenger services where safe and reliable commercial services resume. As a result, as of 31 March 2021 were discontinued to 62 locations. The service continues beyond this date to and from destinations based on needs and available funding. Based on current availability of commercial options, remaining travel restrictions and the continued spread of the pandemic, WFP foresees that the requirement for some limited passenger services will continue throughout 2021, especially for hard-to-reach areas, with implementation contingent on funding availability, commercial gaps and partner demand. WFP continues its close monitoring of the commercial sector and stands ready to reinstate flights to and from discontinued locations if there is a need and subject to available funding.
Medevac services are guided by the Medevac Task Force, which therefore holds the role to inform and advise on the timeframe of this service.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Logistics - Common Logistics									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

Although the WFP Common Services do not reach beneficiaries directly, the CERF funds allowed WFP to act as of service provider for humanitarian and health partners, delivering services to enable partners to reach their goals and implement their activities.
WFP facilitated access to crucial cargo delivery services for 48 organisations, thus allowing them to reach affected populations targeted by their programmes. Between the start of operations on 1 May 2020 until 31 March 2021, WFP transported 29,070 passengers to 68 destinations on behalf of 436 organizations, to allow humanitarian and health personnel to reach the frontlines of the response where no viable commercial options exist. Destinations were defined in line with partial or full suspension of commercial services in countries or regions, with regional passenger services established as needed, as well as a long-haul connection between Rome and Accra (Ghana) to link the continents at a time when no other options were available.
WFP worked country by country to open critical airlinks, laying the groundwork for governments, regions and commercial airlines to re-establish connections in line with health and safety requirements.
According to OCHA, WFP efforts to sustain corridors and cargo/passenger movement was significant in alleviating access challenges. "In April 2020, 90% of respondents to an OCHA survey flagged restrictions on movement as major access constraint – by early August this was down to 38%."

6. CERF Results Framework

Project objective	Provide global services to enable the uninterrupted health and humanitarian response;
Output 1	logistics services provided (including establishment of staging hubs, delivery of cargo through air and sea).

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☐

Sector/cluster	Logistics - Common Logistics			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of staging hubs established / operated	3	[4]	[WFP]
Indicator 1.2	Number of air cargo flights completed	10	[1,550]	[WFP Aviation]
Indicator 1.3	Percentage of logistics services' requests fulfilled	90%	[97.6%]	[Emergency Service Marketplace -WFP]

Explanation of output and indicators variance:	WFP when implementing the Common Services considered the global, flexible and partners' demand-driven nature of the response, adjusting the plan so that it could be fit for purpose. WFP leveraged on an existing network of hubs and set up four new logistics hubs (Guangzhou in China, Liege in Belgium, Johannesburg in South Africa, Addis Ababa in Ethiopia), for a total of eight operating hubs worldwide for cargo consolidation and shipment. From there, WFP established air links to deliver essential COVID-19 items and other cargo of behalf of partner organization, which submitted their cargo movement request via an online platform, the Emergency Service Marketplace.

Activities	**Description**	**Implemented by**
Activity 1.1	Contracting of supply chain services	[WFP]
Activity 1.2	Chartering aircrafts	[WFP]
Activity 1.3	Cargo consolidation and prioritization	[consolidation- WFP; prioritization- (EDG)]

Output 2	Air passenger transport provided

Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☐
Sector/cluster	Logistics - Common Logistics			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Percentage of request of passenger movement fulfilled.	90%	96.6%	WFP/Humanitarian Hub
Indicator 2.2	Customer satisfaction rate	85%	85%	Passenger feedback survey
Indicator 2.3	Number of air passenger flights completed	15	1,550	WFP
Explanation of output and indicators variance:		WFP carried out a Passenger Needs Assessment Survey during the planning phase to quantify the demand, and analyzed partners' stated needs, overlaying them with the availability of commercial air services in close coordination with the Civil Aviation Authorities. Services were provided in accordance with these needs. Daily assessments were also conducted of active/suspended commercial flights. Destinations and were defined in line with partial or full suspension of commercial services in countries or regions WFP continuously observed and reported on the gradual reopening of countries' airspace and adapted the Global Passenger flight schedule to the changing commercial Aviation situation.		

Activities	**Description**	**Implemented by**
Activity 2.1	Contracting of aircraft	[WFP]
Activity 2.2	Deployment of Aviation staff	[WFP]
Activity 2.3	Provision of scheduled air services	[WFP]

Output 3	Services provided to health and humanitarian partners, including establishment and equipping treatment centres			
Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☐
Sector/cluster	Logistics - Common Logistics			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	Number of treatment centres packages provided	3	3	WFP
Indicator 3.2	Number of treatment centres set up	3	2	WFP
Explanation of output and indicators variance:		To address the needs of patients with severe cases of COVID-19 that require hospital care not available at their location, the UN Medevac cell, co-lead by WFP, set up dedicated treatment hubs in which patients who are medically evacuated can receive the level of care deemed clinically necessary. These locations were identified based on a careful assessment of the prevailing epidemiological situation, the UN's footprint, and an assessment of local healthcare capacity by United Nations Medical Directors (UNMD), including Member State consent to host such services. On 4 June 2020 WFP finished construction of a 68-bed field hospital in Accra which has been handed over to WHO to manage. WFP also completed construction of a 92-bed COVID-19 field hospital in Addis Ababa that was handed over to the Ethiopian Ministry of Health for COVID-19 treatment of the local population. To ensure advanced preparedness, a third field hospital		

	was prepositioned in UNHRD Ghana to be immediately available for use should there be a need.

Activities	Description	Implemented by
Activity 3.1	Contracting of manpower and services for the set up of the treatment centres	[WFP]
Activity 3.2	Procurement and contracting of treatment centre packages & equipment	[WFP]

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[29] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP) [30]: .

Although the Common Services do not reach directly affected populations and individuals, they enable humanitarian and health partners, allowing a smooth delivery of services to enable partners to reach their goals and implement their activities.
Cargo delivery services were facilitated for 48 organisations in 162 countries, while 29,070 passengers were transported to 68 destinations on behalf of 436 organizations, to allow humanitarian and health personnel to reach the frontlines of the response where no viable commercial options exist. 129 MEDEVAC services were carried out to ensure the wellbeing of health and humanitarian personnel and to minimise the burden on host country healthcare systems.

b. AAP Feedback and Complaint Mechanisms:.

Two user feedback surveys were run in parallel at the end of October 2020: one for cargo and one for passenger services, with a total of 482 respondents. 55% of these belonged to NGOs, 19% to UN agencies.
The results were extremely positive with 93% of respondents either very satisfied or satisfied with the air passenger service and 78% of respondents either very satisfied or satisfied with the cargo services, with 56% of users stating that the services had been critical to their ability to access hard-to-reach destinations. Results of the survey are available here.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

As the WFP Common Services do not target nor assist affected people directly, mechanisms for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints were not established. All WFP staff continue to complete courses on prevention of fraud, corruption and sexual exploitation and abuse (PSEA). PSEA and gender-based violence (GBV) prevention clauses are included in staff contracts per WFP standards. Employees are expected to comply with WFP internal codes of conduct. PSEA and anti-GBV clauses and guidelines continue to be included in awards for cooperating partners and service providers, including definition of terms, penalties for failure to comply and hotline information for reporting concerns.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

WFP's Common Services were designed for and provided to humanitarian and health organizations, irrespective of age and gender, and they did not target directly affected population, PSEA and gender-based violence (GBV) prevention clauses are included in staff contracts per WFP standards. Employees are expected to comply with WFP internal codes of conduct. PSEA and anti-GBV clauses and

[29] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[30] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

guidelines continue to be included in awards for cooperating partners and service providers, including definition of terms, penalties for failure to comply and hotline information for reporting concerns.

e. People with disabilities (PwD):

Just like previous points, this section does not apply to this project as it dealt with provision of logistics services, not programmatic activities directly targeting beneficiaries.

f. Protection:

Just like previous points, this section does not apply to this project as it dealt with provision of logistics services, not programmatic activities directly targeting beneficiaries.

g. Education:

Just like previous points, this section does not apply to this project as it dealt with provision of logistics services, not programmatic activities directly targeting beneficiaries.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	[0]

9. Visibility of CERF-funded Activities

Title	Weblink
Cargo for COVID	https://medium.com/world-food-programme-insight/cargo-for-covid-8eda55826443
When air travel is restricted how do humanitarian workers get to where they are needed most?	https://medium.com/world-food-programme-insight/when-air-travel-is-restricted-how-do-humanitarian-workers-get-to-where-they-are-needed-most-872d645c5254
WFP flights between Europe and Africa prove critical during pandemic	https://medium.com/world-food-programme-insight/wfp-flights-between-europe-and-africa-prove-critical-during-pandemic-f021a01dd57b
Marking 100 days of the Addis Ababa Humanitarian Hub	https://medium.com/world-food-programme-insight/marking-100-days-of-the-addis-ababa-humanitarian-hub-7a41e773cc15
From outbreak to action: how WFP responded to COVID-19 – 31 October 2020	https://docs.wfp.org/api/documents/WFP-0000120632/download/?_ga=2.146591028.124497660.1622100576-106073558.1558353556
Twitter	https://twitter.com/WFP/status/1262434021453201408
Twitter	https://twitter.com/WFPLogistics/status/1326859121291833344
Webpage	https://www.wfp.org/publications/wfp-common-services

3.1 Project Report 20-RR-WFP-025

1. Project Information

Agency:	WFP	**Country:**	Global
Sector/cluster:	Logistics - Common Logistics	**CERF project code:**	20-RR-WFP-025
Project title:	Global service provision in support of humanitarian/health partners and governments response to the COVID-19 pandemic		
Start date:	25/03/2020	**End date:**	24/12/2020
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 350,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 278,029,458.95**
Amount received from CERF:	**US$ 20,000,000**
Total CERF funds sub-granted to implementing partners:	**US$ [0]**
Government Partners	US$ [0]
International NGOs	US$ [0]
National NGOs	US$ [0]
Red Cross/Crescent Organisation	US$ [0]

2. Project Results Summary/Overall Performance

Through this CERF grant, WFP delivered assistance and/or passengers to 162 countries – 82 percent of the world – and at one point even becoming the largest airline operating globally at the time.
Between the start of operations on 1 May 2020 until 31 March 2021, WFP transported 29,070 passengers to 68 destinations on behalf of 436 organizations.
Since its activation on 22 May, WFP has also played a key role in the UN medevac cell, used its access to a global network of contracted air ambulances. As of 31 March 2021, a total of 206 medevacs have been carried out under this mechanism, 129 of these by WFP and 77 by UNDOS. WFP embedded four staff in the Strategic Air Operations Centre (SAOC), based at SAOC/DOS in Brindisi. WFP also constructed two treatment centres, one in Accra and one in Addis Ababa, while a third field hospital has been prepositioned in Ghana to be immediately available for use should there be a need.
These WFP Common Services were critical to enable the humanitarian and health response, ensuring the critical movement of personnel and COVID-19 cargo despite supply chain disruptions caused by the pandemic.

3. Changes and Amendments

Following a peak in April and May, airfreight rates and capacity stabilized in July 2020 as restrictions in certain regions and countries were partially lifted. By August 2020, airfreight rates further re-adjusted to pre-COVID-19 levels, as a number of commercial carriers slowly resumed passenger and cargo operations.

In line with its mission to fill gaps in commercial transport markets rather than replace commercial capacity, WFP stood down its own passenger services where safe and reliable commercial services resume. As a result, as of 31 March 2021 were discontinued to 62 locations. The service continues beyond this date to and from destinations based on needs and available funding. Based on current availability of commercial options, remaining travel restrictions and the continued spread of the pandemic, WFP foresees that the requirement for some limited passenger services will continue throughout 2021, especially for hard-to-reach areas, with implementation contingent on funding availability, commercial gaps and partner demand. WFP continues its close monitoring of the commercial sector and stands ready to reinstate flights to and from discontinued locations if there is a need and subject to available funding.

Medevac services are guided by the Medevac Task Force, which therefore holds the role to inform and advise on the timeframe of this service.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Logistics - Common Logistics									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	[0]	[0]	[0]	[0]	**[0]**
Returnees	0	0	0	0	**0**	[0]	[0]	[0]	[0]	**[0]**
Internally displaced people	0	0	0	0	**0**	[0]	[0]	[0]	[0]	**[0]**
Host communities	0	0	0	0	**0**	[0]	[0]	[0]	[0]	**[0]**
Other affected people	0	0	0	0	**0**	[0]	[0]	[0]	[0]	**[0]**
Total	**0**	**0**	**0**	**0**	**0**	**[0]**	**[0]**	**[0]**	**[0]**	**[0]**
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	**[0]**	**[0**	**[0]**	**[0]**	**[0]**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

To address the needs of patients with severe cases of COVID-19 that require hospital care not available at their location, the Task Force also set up dedicated treatment hubs in which patients who are medically evacuated can receive the level of care deemed clinically necessary. These locations were identified on the basis of a careful assessment of the prevailing epidemiological situation, the UN's footprint, and an assessment of local healthcare capacity by United Nations Medical Directors (UNMD), including Member State consent to host such services.

6. CERF Results Framework

Project objective	Provide global services to enable the uninterrupted health and humanitarian response;
Output 1	Air passenger transport service provided

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☐

Sector/cluster	Logistics - Common Logistics			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Percentage of request of passenger movement fulfilled.	90%	96.6%	WFP/Humanitarian Hub
Indicator 1.2	Customer satisfaction rate	85%	85%	Passenger feedback survey
Indicator 1.3	Number of air passenger flights completed	30	1,550	WFP
Explanation of output and indicators variance:		WFP carried out a Passenger Needs Assessment Survey during the planning phase to quantify the demand, and analyzed partners' stated needs, overlaying them with the availability of commercial air services in close coordination with the Civil Aviation Authorities. Services were provided based on these needs. Daily assessments were also conducted of active/suspended commercial flights. Destinations and were defined in line with partial or full suspension of commercial services in countries or regions WFP continuously observed and reported on the gradual reopening of countries' airspace and adapted the Global Passenger flight schedule to the changing commercial Aviation situation.		

Activities	**Description**	**Implemented by**
Activity 1.1	Contracting of aircraft	WFP
Activity 1.2	Deployment of Aviation staff	WFP
Activity 1.3	Provision of scheduled air services	WFP

Output 2	Medical Evacuation service provided

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☐
Sector/cluster	Logistics - Common Logistics			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Number of air ambulances contracted	2	[16]	[WFP/ISOS]
Indicator 2.2	Percentage of Medevac provided vs requested	85%	[100%]	[WFP/ UN Medevac Cell]
Explanation of output and indicators variance:		WFP signed a contract with International SOS' (ISOS) Air Rescue Services for the tasking of various air ambulance operators (so far 16 operators have been used for a total of 129 medevacs In collaboration with UNDOS, WFP provided 100% of the medevacs requested/assigned. A small number of medevacs were canceled or interrupted due to external causes or circumstances not directly connected to WFP.		

Activities	**Description**	**Implemented by**
Activity 2.1	Contracting of specialized aircraft for medevac services	WFP
Activity 2.2	Deployment of Aviation experts	WFP
Activity 2.3	Provision of scheduled Medevac air services	WFP

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[31] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP) [32]:

Although the Common Services do not reach directly affected populations and individuals, they enable humanitarian and health partners, allowing a smooth delivery of services to enable partners to reach their goals and implement their activities.
29,070 passengers were transported to 68 destinations on behalf of 436 organizations, to allow humanitarian and health personnel to reach the frontlines of the response where no viable commercial options exist. 129 MEDEVAC services were carried out to ensure the wellbeing of health and humanitarian personnel and to minimise the burden on host country healthcare systems.

b. AAP Feedback and Complaint Mechanisms:

Two user feedback surveys were run in parallel at the end of October 2020: one for cargo and one for passenger services, with a total of 482 respondents. 55% of these belonged to NGOs, 19% to UN agencies.
The results were extremely positive with 93% of respondents either very satisfied or satisfied with the air passenger service, with over 50% of users stating that the services had been critical to their ability to access hard-to-reach destinations.

[31] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[32] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

Additionally, respondents would recommend WFP passenger services (85%) to their management to complement/support their organization's response capacity.
Through the survey, useful feedback was also received on how to improve the services. Although the majority of respondents expressed that nothing needed to be improved for the passenger services, suggestions were recorded in regards to the establishment of a 24/7 emergency phone number, the possibility to an earlier issuing of tickets, the improvement of the booking process and data protection. Results of the survey are available here.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

As the WFP Common Services do not target nor assist affected people directly, mechanisms for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints were not established. All WFP staff continue to complete courses on prevention of fraud, corruption and sexual exploitation and abuse (PSEA). PSEA and gender-based violence (GBV) prevention clauses are included in staff contracts per WFP standards. Employees are expected to comply with WFP internal codes of conduct. PSEA and anti-GBV clauses and guidelines continue to be included in awards for cooperating partners and service providers, including definition of terms, penalties for failure to comply and hotline information for reporting concerns.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

WFP's Common Services were designed for and provided to humanitarian and health organizations, irrespective of age and gender, and they did not target directly affected population, PSEA and gender-based violence (GBV) prevention clauses are included in staff contracts per WFP standards. Employees are expected to comply with WFP internal codes of conduct. PSEA and anti-GBV clauses and guidelines continue to be included in awards for cooperating partners and service providers, including definition of terms, penalties for failure to comply and hotline information for reporting concerns.

e. People with disabilities (PwD):

Just like previous points, this section does not apply to this project as it dealt with provision of logistics services, not programmatic activities directly targeting beneficiaries.

f. Protection:

Just like previous points, this section does not apply to this project as it dealt with provision of logistics services, not programmatic activities directly targeting beneficiaries.

g. Education:

Just like previous points, this section does not apply to this project as it dealt with provision of logistics services, not programmatic activities directly targeting beneficiaries.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	[0]

9. Visibility of CERF-funded Activities

Title	Weblink

Accra hosts regional COVID-19 response hub to maintain life-saving operations in Africa as coronavirus spreads	https://www.wfp.org/news/accra-hosts-regional-covid-19-response-hub-maintain-life-saving-operations-africa-coronavirus
New UN field hospitals will treat humanitarian workers with COVID-19	https://www.devex.com/news/new-un-field-hospitals-will-treat-humanitarian-workers-with-covid-19-97464
WFP flights between Europe and Africa prove critical during pandemic	https://medium.com/world-food-programme-insight/wfp-flights-between-europe-and-africa-prove-critical-during-pandemic-f021a01dd57b
Marking 100 days of the Addis Ababa Humanitarian Hub	https://medium.com/world-food-programme-insight/marking-100-days-of-the-addis-ababa-humanitarian-hub-7a41e773cc15
From outbreak to action: how WFP responded to COVID-19 – 31 October 2020	https://docs.wfp.org/api/documents/WFP-0000120632/download/?_ga=2.146591028.124497660.1622100576-106073558.1558353556
'One step forward, two steps back'	https://medium.com/world-food-programme-insight/one-step-forward-two-steps-back-3e6fb4d4247d

PART XVIII – AGENCY OVERVIEW: WHO

2. STRATEGIC PRIORITIZATION

Statement

The fast release of the two CERF global allocations at the onset of the pandemic enabled WHO to address the most urgent needs of 18 countries amongst the world's most vulnerable and at-risk of serious impact of the Covid-19 epidemic. These were Burkina Faso, Central African Republic, Chad, Ethiopia, Mali, Niger, Nigeria and South Sudan in Africa; DPR Korea in South-East Asia; Haiti and Venezuela in the Americas; Lebanon, Libya, Somalia, Sudan and Syria in the Eastern Mediterranean region, and Ukraine in Europe.

Each country prioritized its most pressing needs among the pillars of the Covid-19 Global Humanitarian Response Plan to contain the spread of the pandemic, to stop transmission and decrease morbidity and mortality while facing worldwide disruptions to movements of people and goods.

CERF support was essential in preventing that Covid-19 did not exacerbate pre-existing challenges and cause the collapse of already weak health systems. In most of these countries, CERF support was key to strengthening the capacity for surveillance, detection, case management and infection control through the procurement of biomedical equipment, personal protective equipment, ventilators and oxygen concentrators, PCR Tests, as well the training of hundreds of health care workers and rapid response teams.

CERF's Added Value:

CERF funds led to a fast delivery of time-critical assistance to people in need. For example, in Mali, CERF enabled WHO to bridge severe gaps in testing capacity. In Ukraine, CERF was the quickest financing mechanism to reach WHO Country Office for specific work in the Non-Government Controlled Areas. In all 18 beneficiary countries, CERF enabled most pressing needs to be addressed to stop Covid-19 transmission and care for those critically-ill.

CERF improved coordination amongst the humanitarian community. Through a joint allocation and selection of priority beneficiaries, the two CERF global grants fostered even greater collaboration between WHO and UNICEF at the global, regional and country levels, which enabled a more coherent and coordinated response from the two agencies. In Ethiopia, South Sudan and Somalia particularly, CERF funds were reported to have contributed greatly to strengthening the health cluster mechanism, enhancing the coordination of actions and leveraging available resources to the overall humanitarian response. In Haiti, CERF strengthened the health sector with WHO being key to the coordination of all partners involved in the response.
Another example is Lebanon, where sister UN agencies worked hand in hand across the response pillars, with UNDP supporting activities pertaining to pillar 1: National Coordination; UNICEF focussing on non- health facilities support with PPEs, on pillar 2: risk communication and community engagement, and on pillar 4: Points of Entry; WHO focussing on pillar 3: surveillance, pillar 5: laboratory, pillar 6: IPC and pillar 7: case management; UNHCR focussing its support on Syrian refugees and UNRWA focussing on Palestinian refugees in camps.

CERF support in some countries has improved resource mobilization from other sources. In Libya for example, CERF enabled fundraising under OFDA and EU grants for the scale-up of case management and IPC activities.

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

Yes ☒ Partially ☐ No ☐

Did CERF funds help respond to time-critical needs?

Yes ☒	Partially ☐	No ☐
Did CERF improve coordination amongst the humanitarian community?		
Yes ☒	Partially ☐	No ☐
Did CERF funds help improve resource mobilization from other sources?		
Yes ☐	Partially ☒	No ☐

Considerations of the ERC's Underfunded Priority Areas[33]:

Only the first two of the four ERC's underfunded priority areas are within WHO's scope of activities and mandate. Through CERF allocations, these areas were indirectly supported, since most country recipients reported that the CERF interventions benefitted all suspected Covid-19 cases, including those of vulnerable groups. With the entire population being at risk of Covid-19, WHO advocated for access to all groups of the society, including girls, boys, women, men, youth, persons with disabilities, and other groups to receive age and culturally appropriate health services when needed, without discrimination.

(1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment:

In Central African Republic for example, support for women and girls, including tackling gender-based violence, was targeted with half of community health workers and social mobilizers recruited being women. During sensitization sessions, women and girls were gathered out of men's eyes in certain communities to enable their active participation. Financial incentives were given to community health workers or social mobilizers to help reducing the economic vulnerability of women and girls.

(2) programmes targeting disabled people:

In Lebanon for example, WHO emphasized the importance of ensuring access to persons with disabilities to hospitalization services in all supported facilities. In Somalia, community health workers used home visits to reach people living with disabilities and others who might otherwise have been challenged in accessing health facilities. Additional country-specific reporting on this is found on Section 7 Effective Programming of this report.

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
WHO	20-RR-WHO-017	Health - Health	10,000,000
WHO	20-RR-WHO-022	Health - Health	10,000,000

[33] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

2. OPERATIONAL PRIORITIZATION:

People Directly Reached:

Depending on the health interventions and the specific country-setting, the estimations of direct beneficiaries and the measure of performance indicators can be quite straightforward (e.g. number of cases treated or detected, number of health care workers trained on IPC norms or case investigation, medical staff trained in oxygen therapy and respiratory rehabilitation that are easily recorded through established electronic systems such as daily epidemiological data) or more complex (e.g. number of suspected cases, number of people benefitting available health services, etc.). In the latter case, WHO uses standard or country-specific algorithms to refine estimates, on the basis of available data such as population census, incidence rate, etc.

To avoid double-counting beneficiaries, Libya used different datasets from various sources among health sectors partners. The focus on host communities, with IOM focussing on refugees, IDPs and migrants also helped.

People Indirectly Reached:

Estimates are more difficult for people indirectly reached, but these mainly are estimated to be those covered mainly by awareness campaigns and the expansion of delivery capacity. Overall in all beneficiary countries, entire populations benefitted indirectly from CERF supported activities such as essentially increased infection and control measures in health facilities or in the community, sensitisation through communications campaigns. Details are provided in Part II section 5.

PART XIX – PROJECT OVERVIEW: WHO

Project Report: 20-RR-WHO-17 and 20-RR-WHO-022

1. Project Information

Agency:	WHO	**Country:**	Global
Sector/cluster:	Health - Health	**CERF project code:**	20-RR-WHO-017 20-RR- WHO-022
Project titles:	Scaling up health emergency response to COVID-19 in humanitarian settings Early action response to Global containment of novel Corona virus outbreak		
Start dates:	03/02/2020 01/04/2020	**End dates:**	02/11//2020 31/12//2020
Project revisions:	No-cost extension ☒ Redeployment of funds ☒ Reprogramming ☐		
	Re-deployment to Ukraine No-cost extension for Mali, DPRK		

Funding

Total requirement for agency's sector response to current emergency:	**US$ 1,700,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 1,585,148,118** **As at 31 December 2020**
Amount received from CERF:	**US$ 20,000,000**
Total CERF funds sub-granted to implementing partners:	**US$ 1,583,576**
Government Partners	US$ 1,121,554
International NGOs	US$ 419,379
National NGOs	US$ 42,665 0
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Burkina Faso

WHO was able to prepare and respond to COVID-19 in the 13 regions of Burkina Faso, including these affected by the security and humanitarian crisis. This was achieved through the strengthening of capacities of 17 531 actors involved in response, of whom 15 666 were health personnel, community health workers, communicators and other technical profiles.

CERF funding enabled the development of a 24/7 Hotline, the strengthening of data collection and management at all levels, the training and deployment of 59 rapid response teams in 22 sanitary districts in 9 regions. Each team is composed of 5 members in charge of conducting the investigations on the alerts and collect the samples for the confirmation of the diagnostic, the procurement and distribution

of emergency kits, medical materials and other supplies to support the strengthening of diagnostic, the treatment of cases, infection prevention and control (IPC) and surveillance. These actions benefited about 1,9 million people.

In addition, WHO supported the construction of 25 triage stations and the strengthening of IPC in the regional hospital centers in two of the regions most affected (Ouagadougou and Bobo-Dioulasso), in regional hospitals and at points of entry including the airports of Ouagadougou and Bobo-Dioulasso. WHO also provided health facilities in the 5 regions most affected by insecurity with hygiene kits comprising hand washing devices, soaps and gels; disinfectant as well as support awareness raising through various channels (radio, television, interpersonal and mass awareness, etc.). WHO also carried out a socio-anthropological survey on perceptions relating to the observance of barrier gestures. Three international experts and 44 national consultants were deployed (IPC and public health specialists, socio-anthropologists, risk communication and community engagement, PCI, laboratory), including providing 17 vehicles to strengthen operations in the 13 regions of the country.

The two projects reached 2,800,535 beneficiaries through the various interventions and the 8 pillars of the response. The interventions were carried out during a very critical period of the epidemic evolution in a context of deterioration of the security situation, which often led to difficulties of access to certain areas and intense movements of internally displaced people.

CAR

The CERF was used to support the training of personnel and the coordination of interventions through the recruitment of an international expert in surveillance at points of entry and an expert in infection prevention and control (IPC), the recruitment and field deployment of three (3) national medical doctors to support the coordination of the response in four (4) health districts severely affected by the pandemic (Bouar-Baoro, Baboua-Abba, Gamboula and Berberati) and two (2) experts in risk communication and community engagement deployed in the Berbérati, Gamboula and Baboua-Abba health districts; and the deployment to Bangui of an international epidemiologist serving at the WHO sub-office in Kaga Bandoro for a period of six months.

In terms of logistical capacity building for case management and IPC, CERF was used to acquire and deliver to health facilities two ventilators for adults, two ventilators for children, 20 oxygen concentrators, 750 pulse oximeters, 130 infrared thermometers and 2.5 metric tons of personal protective equipment consisting of 155,000 surgical masks, 6,000 gowns, 400 protective goggles, 63,000 sets of latex gloves and 1,000 clear plastic face shields. In terms of the laborator y, CERF was used to acquire 14,000 PCR diagnostic kits (including transport media and swabs).

CERF was also used to investigate 1,560 confirmed cases through the training and deployment of four (4) investigation teams in the city of Bangui for two months; follow up 2,800 contacts through training and staffing contact follow-up teams with communication credits; ensure the functioning of the data management teams and ensure the monitoring and care at home of 1,390 people with COVID-19.

Finally, CERF was used to ensure the functioning of five (5) main entry points of the country through the supply of infrared thermometers, personal protective equipment, health control sheets and leaflets for communication.

The project benefited to a total of 1,223,980 people including returnees, IDPs and host community in Bangui I, Bangui II, Bangui III, Bimbo, Begoua, Bouar-Baoro, Baboua-Abba, Gamboula and Berberati.

Chad

CERF funds enabled training of more than 60 journalists, and more than 100 community leaders on key Covid-19 messages and risk communication. 5 000 posters on sanitary measures were produced as well as broadcasted community messages.
200 trainers were trained in surveillance and case management that further trained 1000 health care workers. 8 000 posters on case definition were produced for health centres and hospitals. 50 epidemiologists were deployed in provinces at risk to support the response. More than 100 laboratory workers were trained.

In terms of logistics, procurements of medicine, protective equipment and oxygen concentrators were made.
Overall, it is estimated that more than 500 000 people benefitted from the project.

DPRK

This project was implemented from 3rd February 2020 to 2nd November 2020 including a NCE. Under this project the total beneficiaries were 11,418,901 in 5 provinces and one city.

With this CERF grant, six RT PCR machines along with accessories and laboratory supplies were procured to upgrade five provincial laboratories and one central laboratory to strengthen diagnosis and surveillance.

For strengthening case management capacity of targeted hospitals, biomedical equipment which include Oxygen concentrators, pulse oximeter, ventilators, laryngoscope, portable ultrasound including probes with scanner, resuscitator for adult and children etc were procured. The IEHK kits were also procured. 600 infrared thermometers were procured to enhance COVID-19 surveillance.

As the procurement lead time for DPR Korea is exceptionally longer and compounded by high global demand due to COVID-19 pandemic, WHO releases the PPEs and lab supplies from its prepositioned stocks through early procurement and Regional Office also provided some PPE and lab reagents. Country deployed diagnostics and other equipment by diverting from other health and research institutes.

Ethiopia

The project targeted at-risk groups for Covid-19 including people living/travelling from highly infected countries, health-care workers caring for COVID-19 patients and other close contacts, schoolchildren and teachers, hospitality industry workers, nomadic pastoralists, IDPs and refugees, the homeless and residents of informal settlements. The project contributed to a cumulative total of 1,669,754 rT-PCR tests with 6.8% positivity (113,295 cases with 80,831 (71%) recoveries and 1,747 deaths). A total of 1,917 HCW infections, 13 deaths and recovery rate of 97% were reported.
In addition to surveillance, case management and IPC activities, coordination work was performed including COVAX planning; adaptation of the National Vaccine Deployment Plan document; completion of the cold chain inventory; and formation of related COVAX implementation Technical Working Groups e.g. planning and coordinating, M&E, IPC and surveillance.

Haiti

WHO provided direct support to 36,716 suspected COVID-19 cases through the support given to the Ministry of Public Health and Population (MSPP) for the preparedness and response to COVID-19. Through this grant, 9 departmental crisis were supported to improve coordination of response activities. Situation rooms were set-up in all 10 departments to share information and support decision making; the training, deployment and active maintenance of 49 investigation teams and 310 contact tracing teams throughout the country was facilitated, ensuring that all alerts were responded to as quickly and as effectively as possible.

Furthermore, 9 public laboratories across the country were provided with the capacity to test for COVID-19, 52 sampling sites were rehabilitated, and their staff trained in COVID sampling and 18 labo-moto nurses previously directed to cholera response were reoriented to support COVID response for the transport of COVID samples from sampling sites to National and regional laboratories.

To avoid cross contamination and ensure proper and safe provision of care, 1,830 healthcare workers and ambulance staff were trained in Infection Prevention and Control (IPC) norms, including the proper use of Personal Protection Equipment (PPE), and 180 health institutions set up a triage space and 113 set-up an isolation space. 27,394 PPE items were purchased through this grant, but jointly with other allocations over 978,000 priority PPE items were distributed for the response to COVID-19 to healthcare facilities, departmental response teams, ambulance staff, and points of entry staff, among others).

Finally, to ensure proper management of COVID confirmed cases, 520 medical staff were trained on oxygen therapy and respiratory rehabilitation, and support was provided to the Ministry of Health for the drafting of the guide for early detection of COVID-19 cases and a Strategic document for case management at the epidemic stage.

Lebanon

WHO procured and delivered 8 respirators, 4 mobile X-Rays, 8 lead aprons, 8 cassettes, 45 infrared thermometers, 1 automatic extractor and its laboratory reagents, and the following PPEs (10,000 N95 masks, 1,000 surgical facemasks, 10,000 disposable gowns, 8,000 goggles, 8,000 disposable coverall, 8000 nitrile gloves, 1350 boxes of latex gloves free powder, 45 boxes of powdered gloves, 8000 tyvek cover shoes, 100 packs of cover head, 200 packs of cover shoes, 2,430 zipped bags, 225 bacillol, 225 hand rub bottles, 30 lab coats, 45 clorox bottles, 90 baktolin bottles, 10,000 biohazard specimen bags, 1,000 eppendorf tubes).
The grant also allowed support to MOPH Epidemiological Surveillance team with transportation of samples and RRTs through salary support of drivers.

The project assisted a total of 3,621 patients and allowed for the strengthening of the case management. It also increased the laboratory testing capacities in the reference hospital (RHUH) significantly raising their daily testing capacity by Rt PCR from 250 tests per day to around 1,500 total tests per day.

Libya

WHO in collaboration with the MOH reached a total of 305,770 beneficiaries. Through this grant, WHO provided PPE including 10,000 medical coveralls, 100,000 N95 respirator face masks and 50,000 gloves for health care workers and RRTs across Libya. WHO purchased two PCR GeneXpert machines that were delivered to remote areas (Shahat and Derna municipalities) to support the diagnosis of suspected COVID-19 patients. WHO also distributed 4900 GeneXpert cartridges to tertiary hospitals and NCDC laboratories to support the rapid diagnosis of COVID-19 patients.
Six IPC officers provided technical assistance to the NCDC and MOH. In addition to the 614 health care staff trained by IPC officers, another 292 health care workers in isolation departments and triage centres were trained through five training workshops, and 906 HCWs are now better equipped to COVID 19 case management, and IPC. WHO also provided a total of 1466 litres of disinfectant (hand sanitizer) to support isolation centres and RRTs.
To mitigate the impact of constant power cuts that constitute a serious challenge for the RRTs who have to share their COVID-19 reports on a daily basis with the health authorities, WHO procured 50 electronic devices for data management with monthly internet connection cards, as well as 150 power banks and 300 pre-paid cards to facilitate their work.
To respond to acute shortages of oxygen, WHO provided oxygen concentrators to 50 isolation and triage centres across the country to help treat approx. 521 moderately ill COVID-19 patients suffering from respiratory distress.

Mali

In a context of a humanitarian crisis affecting the country, the project supported health system strengthening in order to contain the spread of the epidemic in the districts of Bamako and the regions of Kayes and Koulikoro. The project focussed on strengthening infection prevention and control activities at national and regional level, reinforcing regional and national laboratory capacity, strengthening the surveillance system in Bamako, Kayes and Koulikoro, strengthening psychosocial support to families impacted by Covid19, and improving case management.
WHO provided key support to the national crisis management committee from the onset of the crisis. Thanks to CERF support, laboratories were fully equipped, case management was largely improved, and crisis communications and community engagement interventions were sustained.

Myanmar

The CERF project facilitated delivery of health care services people including returning migrants passing through the points of entry and the vulnerable populations in Rakhine State.

The project strengthened the coordination of health sector for COVID-19 through Health Emergency Operations Centres, monitoring and supervision visits, and data management of cases. The project helped contained the outbreak through the deployment of trained MoHS health staff to IDP camps in Sittwe township of Rakhine State, support to facilities-based quarantine for patients, and surveillance at points of entry. Hospitals and laboratories were equipped with necessary supplies.

Niger

The MoH was supported by WHO in their efforts to reduce morbidity and mortality due to the Covid-19 pandemic and reduce transmission and geographic spread. Specific outputs included rapid detection of cases thanks to improved laboratory testing capacity, contact tracing,

and cross-border surveillance. Case management was also supported and infection prevention and control measures in health centres strengthened. Communications and sensitization efforts were implemented at health facilities.

Nigeria

WHO in the BAY States of North-east Nigeria reached 595,775 persons including women, men, boys and girls and persons living with disabilities in IDP camps and host communities with risk communication messages. Three isolation centres for COVID-19 were set up (1/state) across the BAY states; 153 (85F;68M) healthcare workers were trained on Case management; and 1,018 (532F; 486M) were trained on IPC.

WHO was able to provide support to the state governments to access relevant reference laboratories, protocols, reagents, and supplies. WHO provided technical support to the States Ministries of Health to adopt and disseminate standard operating procedures (as part of disease outbreak investigation protocols) for specimen collection, management, and transportation for COVID-19 diagnostic testing, ensuring specimen collection, management, and referral networks and procedures are functional.

The project has contributed to improving access of the target population in BAY states to essential health services. All target facilities now have COVID-19 triage points; IPC Guidelines and policies are being operationalized.

Somalia

WHO in collaboration with the MOHs reached a total of 1,882,834 beneficiaries. A total of 81,282 suspected COVID-19 cases were investigated which resulted in detection and laboratory-confirmation of 4,726 cases, including 130 associated deaths. 1,882, 834 people were reached with key health messages on COVID-19 prevention. 925 RRTs were trained at community, district, regional and state level and deployed in 51 districts, contributing to the detection of approximately 42 % of all reported cases in the country. A total of 156 new health facilities were added into the EWARN surveillance system to enhance health-facility and community-based surveillance, case detection, investigation and reporting, resulting in detection of 1,040 suspected COVID-19 cases through EWARN. 2,229 health care workers (HCW) were trained and deployed to support COVID-19 response (440 HCW on surveillance, 650 HCW on case management and 1,139 HCW on infection prevention and control measures at health facility).

WHO technically supported the establishment of 19 isolation centres across the country with 800+ isolation bed capacities. Whereas WHO financially and operationally supported five isolation centres (300-bed capacity in total) which admitted and treated 791 beneficiaries as of December 2020. Finally, WHO distributed: 12, 829 sets of PPEs, ten ventilators, 68 oxygen concentrators and 29 IEHKs.

Overall, this grant effectively contributed to containing the COVID-19 outbreak, limiting the spread of community transmission of the virus and reducing the associated morbidity and mortality associated.

South Sudan

WHO and the Ministry of Health provided COVID-19 preparedness and response services benefiting a total of 65,675 people, 21,968 of them were women, 36,309 men 3,358 girls and 4,041 boys. The beneficiary numbers include the 65,241 who were traced and tested for COVID-19 in the Country, the 165 health care workers trained in case investigation and rapid response, 140 health care workers trained on standard precautions and Infection Prevention measures for respiratory diseases, 10 people trained as ambulance teams on COVID-19 case transfer and transportation as well as the 119 health care workers trained on COVID-19 case management.

National RRTs were deployed to investigate Covid-19 alerts/suspected cases in Tonj East and Torit at the initial phase of the COVID 19. In total, seventeen (17) counties have reported confirmed COVID-19 cases out of 80 counties in the country and the RRTs have been deployed to respond and investigate 80% of alerts registered in the county since the outbreak with contact tracers across the country following up the contacts of the cases.

In addition, Hand washing soap, Chlorine Granule, Hand sanitizers, Infrared thermometers, buckets, taps, and hand warship posters) and IEC materials (case definition, investigation protocols, contact tracing, and case management guidelines) were distributed to all the states and prioritized counties.

By December 2020, South Sudan had traced and tested 65,675 people including travellers, cared for 3,511 confirmed cases and lost 65 people to COVID-19 representing a case fatality rate of 1.15% relative to other African countries affected by COVID-19.

Sudan

WHO as Health Cluster leader provided guidance to the MOH and UNHCT for the joint inter-sectoral response.

WHO printed 6200 Posters, 100,000 flyers, 70 stand up banners with risk communication messages and behaviour advice for increased

public awareness.

35 RRTs (245 medical and paramedical personnel) were trained and deployed in the 7 localities of Khartoum state. They contributed to early detection, isolation and contact tracing for suspected and confirmed cases. In addition, WHO supported community-based surveillance of COVID-19 through capacity building in 7 states. Points of Entry were supported with IPC material and PPE, disinfectants and WASH material for 6 months; and 67 staff received training on surveillance and international health regulations (IHR) in 12 Points of Entry in 3 states.
The outbreak situation and community transmission required a significant scale up of Sudan's testing capacities. With CERF funds, WHO supported the NPHL with laboratory consumables such as pipette tips and pipettes, reagents and small equipment necessary to strengthen laboratory capacity. Testing capacities were rolled out to other laboratories outside Khartoum in Red Sea State, Gezeira and Nyala. With CERF support, 17,300 COVID-19 PCR tests were procured and distributed through the NPHL to the laboratory network, thus scaling up significantly the availability and accessibility of COVID-19 specific testing in the country.

To improve IPC and the quality of health care on health care facility levels, 125 health staff from 8 localities in Kassala and Red Sea State were trained on case management and IPC. WHO procured 421,336 single pieces of PPEs (masks, gloves, gowns, aprons, head covers, face shields etc.), 22 patient monitors, 12 syringe pumps, 16 ICU beds, 4 ECG machines and 40 oxygen cylinders with valves and flow meters. Furthermore, WASH in isolation centres and hospitals receiving COVID-19 patients were supported with PPEs and heavy-duty material for hygiene and cleaning.

Syria

WHO and its partners scaled up their emergency response to COVID-19 through active surveillance system with 77 sites that conducted 1,604 surveillance visits. Equipment and supplies provided to Afrin lab (two PCR machines, DNA extraction devices, personal protection equipment (PPE), testing kits and swabs) allowed to test 10,078 people and detect 2,944 cases. The lab improvement was complemented by two training sessions on laboratory diagnosis of COVID-19 and Robotic Nucleic Acid Isolation, conducted in Ankara referral lab for two lab physicians in central surveillance team and the physician of Afrin lab. Lastly, outreach teams conducted individual and group awareness raising sessions on COVID-19 and ways of protection, directly reaching around 850,000 people and indirectly (through social media and IEC materials) – 500,000 people.

Ukraine

WHO delivered PCR test kits to the laboratories in Luhansk and Donetsk NGCA to perform testing on SARS-2 CoV. The lab staff in healthcare facilities also received technical support in the development of SOPs for PCR testing. Healthcare workers in Donetsk and Luhansk NGCA received 4 trainings on clinical management of Severe Acute Respiratory Infection (SARI) patients and critical care specialists participated in 9 trainings on respiratory infection treatment. In Donetsk GCA, lab technicians received a training to run PCR tests and 1 SOP on the verification of test kits was developed for Slovyansk. The Rapid Response Teams, RRTs, in the high transmission districts of Luhanska and Donetska oblasts received PPE and 2 trainings on swab collection, sample storage and transportation and appropriate use and disposal of PPE. The health cluster produced monthly bulletins and organized bi-weekly meetings. The MHPSS working group coordinated COVID-19 activities by partners in eastern conflict areas and produced an interactive dashboard showing partners presence by geographic location and type of intervention.

The project supported 10,704 COVID-19 cases in NGCA only (GCA patients supported by the Rapid Response Team are not counted in this number) with rapid response, laboratory testing and improved care, contributing to the overall goal of maintaining mortality and morbidity level resulting from severe and critical stage of COVID-19 within the global rates of 2% and 20% respectively.

Venezuela

323,620 patients were assisted immediately in each of the targeted territories with testing, care delivery and public health information and risk communication efforts. 15% (48,543) of those received medical treatment in COVID-19 wards for moderate patients and severe cases were placed in intensive therapies. 126,539 people were tested for COVID-19 in the centralized national PCR laboratory and the three supported states.
6,820 health workers were supported in each of the supported through procurement of PPEs and other essential supplies, training and technical guidance to improve case management of COVID-19 patients and application of IPC measures.

Overall, 30,777 units of medicines and healthcare supplies, 149 laboratory medical devices, 176 items of medical equipment for clinical assistance (oxygen concentrators and infusion pumps), as well as 640 units of materials were procured with CERF funds to increase hospital bed capacity for COVID-19 patients in healthcare facilities. In addition to these, 22 control and monitoring visits were made to the logistics network, clinical staff and authorities to provide technical guidance and adjust actions to improve operational capacity, limit transmission of the virus and save lives.

3. Changes and Amendments

Burkina Faso

The two projects achieved nearly 80% and 92% of their planned targets, respectively. Government restrictive measures to prevent the spread of the epidemic (including the closure of land and air borders, lockdowns and quarantine measures of some cities/areas, the adoption of the curfew, the closure of public spaces, including schools and markets) as well as the disruption at the international level of the supply chain, slowing transport and international travel etc., all had an impact on the smooth running of activities.

With the deterioration of the security situation in Burkina Faso, some areas have also remained isolated and negatively affected by the presence of armed forces hampering access to and provision of health care. Often, healthcare workers have fled areas following the increase of insecurity, which caused the closure of health facilities. These are the key challenges and difficulties encountered during the implementation of these projects in Burkina Faso.

CAR

Some changes were made in the project to align activities to the needs of the districts regarding the epidemiological situation in the country. In Bamingui Bangoran, Haute Kotto, Haut Mbomou, Mbomou, Ouham Pende, Sangha Mbaere and Vakaga where no COVID-19 case was reported during implementation period of the project, only PPE acquired with the CERF were distributed to the health staff. COVID-19 case investigation, case management at home and contact tracing strategies changed in August 2020. In this regards, COVID-19 case investigation, case management at home and contact tracing activities were suspended two months after the beginning of its implementation.

Chad

No amendments were made against initial programming and activities implemented within the project period.

DPR Korea

As DPR Korea is a UN sanction country, the procurement of equipment requires clearance from Sanctions Committee. Due to geopolitical situation only a few freight forwarders accept to transport goods into the country. There was increase in global demand, for COVID -19 items. The procurement lead time was exceptionally prolonged. Therefore, NCE for six months was requested but NCE was given for three months only. Meanwhile the cost of goods also increased. Procurement could be completed, but due to implementation of anti-COVID-19 measures by the government of DPR Korea all the ports are closed for uncertain period and these items have been stored in warehouses, at different locations. The enhanced cost of the goods and recurrent storage charges are being met through WHO corporate and internal funds.

Ethiopia

Security concerns in Tigray region and neighbouring zones of Amhara and Afar regions continue to impact on COVID-19 response activities. No report of COVID-19 response activities in Tigray region since 04 November 2020. There were no changes to the proposed implementation modalities as pandemic response activities in other regions were sustained.

Haiti

No changes or amendments were requested from Haiti for this CERF allocation.

Lebanon

Due to the global shortage in some IPC equipment and supplies, challenges were faced with procurement processes so WHO resorted to local procurement and local manufacturing/production, applying WHO rules and procedures.
Shipment of respirators from main suppliers were delayed due to the global lockdown. In view of longstanding relationship between WHO Lebanon and suppliers, the WHO orders were prioritized, and efforts were made by supplier to expedite shipment and delivery of respirators.
Delays in designation of COVID19 hospitals lead to some changes in timeline of delivery. The MOPH revisited final delivery destination to optimize access.
The MOPH Epidemiological Surveillance Team was supported with transportation of samples and RRT through salary support of drivers. The salaries of 8 drivers who were working with the MOPH ESU team on a part time basis were supported to become full time contracts that span the period of April until the end of July. This was a joint decision with MOPH, it was considered a more cost-effective option than payment for individual trips for transportation of samples.

Libya

The costs of cleaning contracts for 20 health facilities were reprogrammed with the approval of the CERF and used instead to support the implementation of IPC measures in hospitals and health facilities. Six IPC officers were recruited to support over 16 isolation departments and triage centres across the country. After discussion with the NCDC, funds earmarked to incentivise RRTs were instead used to procure equipment for the teams. The funds earmarked for the operating costs of six mobile clinics were reprogrammed as requested by the NCDC. The money was used to train 292 health care workers in health facilities treating COVID-19 patients on IPC.

Mali

WHO could not sub-contract Save The Children for reasons beyond WHO's scope and due to WHO's legal requirements on tobacco and arms, the signature of which caused issues of responsibilities between the HQ and country-office legal entities of Save the Children.

A no-cost extension was therefore requested, and the project was readjusted. This enabled to face a rapid increase in case number in November and December 2020 through strengthening of risk communications activities in the hotspots of Bamako and Kalabankoro, in the region of Koulikoro.

Myanmar
N/A

Niger
N/A

Nigeria
N/A

Somalia
N/A

South Sudan

At the design phase of the CERF funding proposal, South Sudan had not confirmed COVID-19 cases, as such the focus of the CERF action was to increase capacity for Coordination, Surveillance, IPC and case management in 7 priority states identified during the COIVID -19 risk analysis. On the 4th of April 2020, South Sudan confirmed its first case of COVID-19 a situation that changed the humanitarian landscape. In addition, the outbreak occurred, and the situation rapidly evolved in a context where there was inadequate capacity to trace, test and isolate creating a mass of suspected community transmission trends.
The CERF funding was therefore used to increase capacities in 10 states and 3 Administrative Areas in the country away from the 7 priority locations in the original design due to this change in the humanitarian context.

Sudan

The main challenge faced in this project came from a country-wide lockdown restricting movement and travel to, and through, 17 states since mid-April 2020. The lockdown slowed down the implementation of activities, notably the roll out of capacity building activities as trainers were prevented from travel limiting the initial planned activities. Due to the lockdown, construction material and fuel were not available, and movements were impaired. Therefore, only one out of three health structures were rehabilitated as planned and minor rehabilitation in Point of Entry was not implemented as planned due to access issues. The funds saved in construction were reallocated through a modification request which was accepted by the Secretariat. With the reallocated funds, WHO supported the operational costs for RRTs in the 7 localities of Khartoum between June to September 2020 where the RRTS played a key role in case detection, contact tracing and surveillance activities. Khartoum state was prioritised as the majority of COVID-19 cases were reported there. WHO supported supervision visits in order to monitor the performance of RRT and surveillance teams.

Syria
N/A

Ukraine

WHO submitted a re-programming request on August 20, which was approved by CERF. Overall, it did not affect the activities as planned in the original proposal. The effective partner coordination in the response to COVID-19 in GCA and NGCA has been assured through the full-time cluster coordinator (since September) who has been supported by a reporting and monitoring consultant (since May) recruited under CERF. According to the assessment of the cluster in August, there was no need to bring any additional consultants on board, as previously planned under output 1. With regards to operational and logistic support to Rapid Response Teams, RRTs, the initial plan was to provide logistical support through a local partner agency. However, in an assessment, we learned that the government had alleviated the operational challenges and allocated resources to the transportation of specimen to the labs. As a result, in discussions with the health department in the two regions, priority shifted to PPE for RRTs, especially gloves and medical masks which were short in supply.

In addition to the approved modifications, no training was organized for RRTs and family doctors on the basics of contact tracing due to the lack of a national strategy on contact. A specific training on sample collection, storage and transportation for RRT was organized instead.

Venezuela
N/A

4. A. Number of People Directly Assisted with CERF Funding*

4 A. Number of People Directly Assisted with CERF Funding* - 20-RR-WHO-017

Sector/cluster	Health – Health									
	Total numbers for all 8 country recipients									
	Planned					Reached- Lebanon				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	425,262	381,339	385,194	378,564	**1,570,359**	**424,274**	**380,550**	**254,638**	**249,167**	**1,308,629**
Returnees	237,876	241,839	183,864	173,332	**836,911**	**205,389**	**943,016**	**127,475**	**124,491**	**1,400,371**
Internally displaced people	2,667,866	2,507,365	2,002,114	2,089,167	**9,266,512**	**760,939**	**758,417**	**562,223**	**556,408**	**2,637,987**
Host communities	4,418,710	3,987,392	2,909,179	3,225,583	**14,540,864**	**1,019,955**	**1,007,557**	**825,011**	**821,326**	**3,673,849**
Other affected people	2,883	2,769	0	0	**5,652**	**179,418**	**161,650**	**123,574**	**129,459**	**594,101**
Total	**7,752,597**	**7,120,704**	**5,480,351**	**5,866,646**	**26,220,298**	**2,589,975**	**3,251,190**	**1,892,921**	**1,880,851**	**9,614,937**
People with disabilities (PwD) out of the total										
	3,080,172	2,987,107	2,278,133	2,380,437	**10,725,849**	**553,675**	**533,891**	**123,574**	**404,492**	**1,615,632**

B. Number of People Directly Assisted with CERF Funding* - 20-RR-WHO-022

	Health – Health									
Sector/cluster	Total numbers for all 11 country recipients									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	42,483	44,360	58,834	51,259	**193,936**	48,611	48,888	53,032	49,960	**200,491**
Returnees	50,903	56,657	86,684	74,804	**269,048**	61,527	64,933	86,962	79,418	**292,840**
Internally displaced people	400,985	355,944	473,159	424,061	**1,654,120**	338,675	277,171	346,126	295,482	**1,257,454**
Host communities	1,010,442	981,478	1,098,999	1,050,536	**4,141,415**	984,719	904,050	997,905	1,027,430	**3,914,104**
Other affected people	97,294	99,189	76,597	77,497	**350,577**	308,615	278,984	98,434	99,508	**785,541**
Total	**1,602,078**	**1,537,628**	**1,791,273**	**1,678,357**	**6,609,136**	**1,742,147**	**1,574,026**	**1,582,459**	**1,551,798**	**6,450,430**
People with disabilities (PwD) out of the total										
	37,661		33,509	26,391	26,483	**32,234**	**22,812**	**27,906**	**25,967**	**108,919**

5. People Indirectly Targeted by the Project

Burkina Faso

The indirect beneficiaries of these projects include women, young people, adolescents, girls, boys, children and men that had been sensitized through public and private media campaigns targeting public places such as markets, places of worship, local gathering points and schools. At the level of health facilities, indirect beneficiaries also included persons accompanying patients, visitors and other health facility workers benefiting from services at triage stations built with the support of WHO and its partners. Associations of traders, community leaders, associations of the elderly are also among the indirect beneficiaries. Finally, all the people who have called the toll-free number (3535) for information, alerts, etc. were indirectly supported by the projects in Burkina Faso.

CAR

About 1,500 travellers entering the country from abroad and not residing in the targeted districts benefited from awareness/information sessions on COVID-19 and temperature screening at the points of entry. About 2,000 traders residing in the targeted health districts benefited from sensitization sessions organized in weekly markets.

Chad

Indirectly targetted populations included men, women, young people, adolescents, girls, boys, and disabled in: Ndjaména Nord (185 513), Ndjaména Sud porte d'entrée Nguéli (446 436), Ndjaména East (414 024), Ndjaména center (423 634) , 9th district (159 128) , Adre frontier Soudan, province Ouadai (434 978), Bol frontier Niger and Nigeria, Lake province (159996), Laramaye Toubouro, frontier Cameroun, province Logone Oriental (66 493), Maro Sido, frontier Central Africa, province Moyen Chari (114 984).

DPR Korea

The project targeted to cover five provinces of DPR Korea and Pyongyang city. The interventions intended directly to benefit suspected and confirmed cases of COVID-19. However, by supporting preparedness, containment and mitigation the total population 11,418,901 (47% of total population of the country) in these provinces and city were also reached.

Ethiopia

The unaffected (COVID-19 free) population of Ethiopia were considered to be indirect beneficiaries. They benefited from the improvement in coordination, case identification, control measures (contact tracing, isolation), public health messaging, and case management. The improvement in early warning and surveillance systems and patient care was health security safety net for the wider community, as well as for any other potential outbreaks that were likely to affect them directly. To reduce the financial burden on individuals and families, COVID-19 services were provided at no cost, ensuring that free, accessible health care was available for – at the very least - the most vulnerable population.

Haiti

An estimated total of 165,222 people indirectly benefitted from the project's activities, including all suspected COVID-19 cases who were tested and received health care services. Furthermore, their immediate household contacts also benefitted from the project through the provision of personal protective equipment and sensitization activities aimed at raising awareness regarding infection prevention and control measures against COVID-19.

Lebanon

This project contributed to expansion of case management and laboratory capacity in 7 hospitals, supported national epidemiological surveillance activities, and allowed for the strengthening of infection prevention and control measures among health care workers. Since service delivery capacity was expanded and strengthened, the estimated 18,000 persons who were at risk of hospitalization because of COVID were indirectly targeted by the project to be able to access hospitalization services when and if required.

Libya

The six IPC officers hired by WHO supervised the application of basic IPC precautionary measures for COVID-19 in 14 isolation and 4 triage centres across the country. They also trained 614 healthcare workers throughout Libya. This helped improve patient safety in isolation centres as well as general health care facilities. In the longer term, the improved IPC measures in health care facilities will benefit all patients. 1,300 patients in health care facilities that are not treating COVID-19 patients benefited indirectly from the project. The availability of PPE allowed 6667 health care workers to continue working in safety and security, knowing their chances of catching (and transmitting) the virus was greatly reduced. This made health care workers less reluctant to report for duty and helped keep other essential health care services running during the pandemic benefitting the entire population.

Mali

In terms of indirect beneficiaries, WHO held several training sessions for journalists, community leaders and developed sensitisation programmes for information to be disseminated in the media and broadcasted. Sensitisation caravans – one in each region for a month – were set-up, with the support from WHO doctors.

Myanmar

Some migrant workers who returned from other countries were indirect beneficiaries of this project as they received COVID-19 services at quarantine facilities. Some host communities in the vicinity of IDP camps in Sittwe were also indirect beneficiaries for mobile clinic services. People with disabilities indirectly benefitted from the project activities during the conduct of COVID-19 response activities. The people with disabilities identified at COVID-19 response activities will receive available local services from the Ministry of Health and Sports.

Niger

The project has targeted indirectly 17,056,585 people including 164,342 IDPs, 172,232 refugees, 22,954 returnees as well as all the populations that benefitted from sensitisation activities.

Nigeria

Through the various risk communication activities including house-to-house sensitization, mass media communications, community outreaches by the mobile medical Hard-to-Reach teams, over 3,385,876 people were reached with services ranging from integrated case management of childhood illnesses treatment, provision of essential health services, disease outbreak control, mental health services, medical response to gender-based violence and health systems strengthening activities.

Somalia

The entire population of Somalia (approximately 15 million people), indirectly benefited from response activities, including surveillance, laboratory testing, case management, risk communication and community engagement messaging. On the long run, the enhanced health workforce's capacity the medical equipment and supplies distributed as part of this project will continue to serve the population of Somalia and expand the health services delivery beyond the COVID-19 outbreak.

South Sudan

Indirect beneficiaries to the CERF activities were the 320,258 people residing in 10 states and 3 administrative areas in South Sudan who are at risk of contracting or dying with COVID-19. CERF funding supported the Public Health Emergency Operation Centre that coordinated alert investigations, sample collection and testing benefiting direct and indirect beneficiaries. CERF funding increased the capacity of health facilities and health care workers in disease surveillance, Infection Prevention and Control, case management which increased the country's overall capacity for preparedness and response.

Sudan

The total country population of approximately 45 million indirectly benefits from the strengthening of national laboratories resulting in increased multi-state capacity to scale up testing facilities and provide care through medical equipment to assist with severe COVID-19 related cases. The MOH estimated based on data and modelling efforts that about 10% of the population were at risk of transmission

over the implementation period and therefore the number of indirectly targeted people is 4.5 million. In addition, the multi-sectoral and multi-agency response coordinated by WHO is expected to result in strengthening of the health system with capacity building and through screening at points of entry as well as infection control reducing transmission, with RRTs across the capital for case investigations and case management.

Syria

Project activities indirectly targeted 2.4 million people, both host communities and IDPs living in northwest Syria benefitted from information on COVID-19 awareness and protection messages. In addition, the community of Afrin with a total population of around 442,000 were indirectly benefitting from the active surveillance and availability of quality laboratory diagnostics that helped to identify and isolate positive cases of COVID-19.

Ukraine

Expanding the testing capacity of the laboratories and improving the quality of emergency and critical care provided to hospitalized COVID-19 patients in NGCA and the improved skills of lab technicians and more efficient interventions by the Rapid Response Teams in GCA is expected to have benefitted all suspected COVID-19 cases, their contacts and the entire communities. In Donetsk and Luhansk NGCA, the donated equipment, reagents and supplies allowed to increase the number of performing tests to 200 tests per day per territory, which means the testing capacity was 96'000 for 8 months. The health cluster coordination of activities related to COVID-19 are furthermore expected to have indirectly benefitted the entire population in GCA and NGCA.

Venezuela

An estimated 495,660 indirectly benefitted from this project, which include individuals identified as direct contacts of positives who received guidance and information of transmission, isolation, quarantining measures, as well as were supported in isolation measures at homes in conjunction with the measures applied by the health authorities,
In the case of infection prevention measures in health centres, indirect beneficiaries are those who visited the services for reasons other than COVID-19 and who used disinfectants. Indirect beneficiaries also include family members of health personnel who benefited from personal protective equipment, since being a preventive and protective measure, it covers the whole family.

6. CERF Results Framework

Project objective	Stop transmission of COVID-19 in affected countries, decrease mortality and mitigate the impact of the outbreak. Please refer to the operational planning guidelines for country response plans for a description of activities amongst each of the pillars of the response. On grant implementations, recipient countries will provide their specific results framework with detailed prioritised activities and related indicators; as well as specific budget. See GHRP for overall response monitoring framework.
Output 1	**Country-level coordination, planning, and monitoring (Pillar 1)** **Burkina Faso, CAR**, **Haiti, Sudan** **Burkina Faso, Ethiopia, Libya, Mali, Myanmar, Niger, Nigeria, Somalia, South Sudan, Ukraine and Venezuela**

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health – Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	% of Countries with COVID-19 national preparedness and response plan	100%	100%	Availability of plan
Indicator 1.2	% of Countries with a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response	100%	100%	Health Cluster meetings reports Epidemiological biweekly bulletins disseminated

Explanation of output and indicators variance:	South Sudan exceeded targets in establishing coordination in 10 States instead of 7 Ukraine did not need an additional coordination consultant upon revised assessment of health cluster staffing

Activities	**Description**	**Implemented by**
Activity 1.1	Activate multi-sectoral, multi-partner coordination mechanisms to support preparedness and response	WHO, Ministries of Health, Governments
Activity 1.2	Establish an incident management team, including rapid deployment of designated staff from national and partner organizations, within a public health emergency operation centre (PHEOC) or equivalent if available	WHO, Ministries of Health
Activity 1.3	Conduct regular operational reviews to assess implementation success and epidemiological situation, and adjust operational plans as necessary	WHO, Ministries of Health

Output 2	**Risk communication and community engagement (Pillar 2)** **Burkina Faso, CAR, Sudan, Syria** **Burkina Faso, Niger, Nigeria, Ukraine**
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Health – Health

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	% of Countries which have COVID-19 community engagement plan	100%	100%	Ministry of Health report Risk communication and community engagement action plan (RCCE plan, "Plan CREC")
Indicator 2.2	% of Countries which implemented COVID-19 risk communication plan, containing specific prevention and preparedness messages	100%	100%	Ministry of Health report COVID-19 Situational Reports Meetings minutes Facebook page (Ukraine)

Explanation of output and indicators variance:	In addition, Chad estimated at 150,000 the number of people that received adequate messages. In Syria, the activities were implemented through complementary funding Nigeria assessed at 595,775 the number of individuals reached with tailored risk communication messages

Activities	**Description**	**Implemented by**
Activity 2.1	Implement national risk-communication and community engagement plan for COVID-19, including details of anticipated public health measures	Ministries of Health WHO Community health champions/volunteers (Nigeria)
Activity 2.2	Establish and utilize clearance processes for timely dissemination of messages and materials in local languages and adopt relevant communication channels	Ministries of Health WHO UNICEF (Sudan) Community health champions (Nigeria)

Activity 2.3	Systematically establish community information and feedback mechanisms including through: social media monitoring; community perceptions, knowledge, attitude and practice surveys; and direct dialogues and consultations	Ministries of Health WHO

Output 3	**Surveillance, rapid response teams, and case investigation (Pillar 3)** **Burkina Faso, CAR, Haiti, Lebanon, Sudan** **Burkina Faso, Ethiopia, Libya, Mali, Myanmar, Niger, Nigeria, Somalia, South Sudan, Ukraine and Venezuela**
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Health – Health

<table>
<tr><th>Indicators</th><th>Description</th><th>Target</th><th>Achieved</th><th>Source of verification</th></tr>
<tr><td>Indicator 3.1</td><td>Number of new confirmed cases nationwide, disaggregated by age group and sex</td><td>n/a</td><td>Burkina Faso: 6828
(W: 2514, M: 4314)

CAR: 4735

Ethiopia: 122,864

Haiti: 9,319 new confirmed cases from 19 March 2020 to 30 November (58% men, 42% women)

Lebanon: 183,888 cases distributed in 0-9 (2.4%), 10-19 (8.1%),20-29 (24.5%), 30-39 (22.5%), 40-49 (15.5%), 50-59 (12.5%), 60+ (14.6%)
No gender segregation

Libya: 140,688
NCDC does not disaggregate by age group and sex

Mali 7,090

Myanmar
Total: 124,630

<table>
<tr><th>Age</th><th>Male</th><th>Female</th><th>No data</th></tr>
<tr><td>60-100</td><td>7,263</td><td>8,258</td><td>1,024</td></tr>
<tr><td>45-59</td><td>9,836</td><td>11,583</td><td>1,323</td></tr>
<tr><td>30-44</td><td>15,753</td><td>14,467</td><td>2,016</td></tr>
<tr><td>15-29</td><td>20,930</td><td>19,716</td><td>2,726</td></tr>
<tr><td>6-14</td><td>2,880</td><td>2,647</td><td>304</td></tr>
</table>
</td><td>Ministry of Health report,

DHIS2 platform (Burkina Faso)

COVID-19 Situation report

official website of national centre for disease control (NCDC) (Libya)

WHO COVID-19 dashboard</td></tr>
</table>

			<table><tr><td>2-5</td><td>934</td><td>881</td><td>122</td></tr><tr><td>0-1</td><td>484</td><td>537</td><td>85</td></tr><tr><td>No data</td><td>294</td><td>334</td><td>259</td></tr></table> Niger 3327(W:998; M: 2329) Nigeria: NA Somalia 4,726 confirmed cases (3,497 male and 1,229 females). 86% of cases are in the 20-50 years age group South Sudan: NA Sudan Total: 14,058 Women 5651 Men 8348 59 cases no sex registered Age groups 1-9 years: 281 cases 10-19 y: 843, 20-29: 3374 30-39: 2320 40-49: 1617 50-59: 1506 60-69: 1687 >70: 1687 703 age group data non available No sex-age disaggregation available in national data set Ukraine: NA Venezuela 107,583	
Indicator 3.2	Total number of deaths in confirmed cases, nationwide, disaggregated by sex by week	n/a	Burkina Faso: 86 (*15-29yo*: 3; *30-44 yo*: 5; *18 de 45-59 yo*: 18; *60yo+*: 60) CAR: 62 Ethiopia: 1909 Haiti: 233 deaths from 19 March 2020 to 30 November 2020 Lebanon: 1,866 deaths associated with COVID-19 No gender segregation Libya 2297	Ministry of Health report, DHIS2 platform (Burkina Faso) COVID-19 Situation report

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>NCDC does not disaggregated by age group and sex

Mali 269

Myanmar
Total: 2,697

<table>
<tr><th>Age</th><th>Male</th><th>Female</th><th>No data</th></tr>
<tr><td>60-100</td><td>1,133</td><td>777</td><td>0</td></tr>
<tr><td>45-59</td><td>317</td><td>224</td><td>1</td></tr>
<tr><td>30-44</td><td>80</td><td>51</td><td>0</td></tr>
<tr><td>15-29</td><td>17</td><td>12</td><td>0</td></tr>
<tr><td>6-14</td><td>3</td><td>3</td><td>0</td></tr>
<tr><td>2-5</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>0-1</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td>No data</td><td>1</td><td>0</td><td>76</td></tr>
</table>

Niger: 104

Nigeria: NA

Somalia
130 deaths in total (99 male and 31 females). 83% of deaths are in the 50-80 years age group

South Sudan: NA

Sudan
1115 total in reporting period
332 women
783 men

Ukraine: NA

Venezuela: NA</td>
<td></td>
</tr>
<tr>
<td>Indicator 3.3</td>
<td>Number of hospitalized confirmed cases, by week</td>
<td>n/a</td>
<td>Burkina Faso: 1230
(M: 739; W:491)

CAR: 12

Ethiopia: 122,864

Haiti: 1,577 hospitalized confirmed cases which corresponded to 17% of all confirmed cases as of 29 November 2020</td>
<td>Ministry of Health report,

DHIS2 platform (Burkina Faso)

COVID-19 Situation report</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lebanon: Not available by week

Libya: Not reported by NCDC

Mali 2,235

Myanmar
Same data as confirmed cases as all confirmed cases are hospitalized as per MoHS protocol

Total: 124,630

<table><tr><th>Age</th><th>Male</th><th>Female</th><th>No data</th></tr><tr><td>60-100</td><td>7,263</td><td>8,258</td><td>1,024</td></tr><tr><td>45-59</td><td>9,836</td><td>11,583</td><td>1,323</td></tr><tr><td>30-44</td><td>15,753</td><td>14,467</td><td>2,016</td></tr><tr><td>15-29</td><td>20,930</td><td>19,716</td><td>2,726</td></tr><tr><td>6-14</td><td>2,880</td><td>2,647</td><td>304</td></tr><tr><td>2-5</td><td>934</td><td>881</td><td>122</td></tr><tr><td>0-1</td><td>484</td><td>537</td><td>85</td></tr><tr><td>No data</td><td>294</td><td>334</td><td>259</td></tr></table>
Niger: 132

Nigeria: NA

Somalia: 791

South Sudan: NA

Sudan N/A Indicator not available in national data

Ukraine: NA

Venezuela: NA</td>
<td></td>
</tr>
<tr>
<td>Indicator 3.4</td>
<td>Number of countries testing for COVID and reporting routinely through sentinel surveillance (ILI, SARI, ARI) or non-sentinel surveillance sites through the GISRS or another WHO platform</td>
<td>100%</td>
<td>100%</td>
<td>Ministry of Health report,

DHIS2 platform (Burkina Faso)</td>
</tr>
<tr>
<td colspan="2">Explanation of output and indicators variance:</td>
<td colspan="3">Burkina Faso: a total of 6828 confirmed cases and 86 deaths were recorded since the start of the pandemic.</td>
</tr>
</table>

	In addition, Chad trained 54 RRTs Nigeria measured at 85% its laboratory results available within 72 hours. 3 RRTs were mobilized South Sudan achieved 80% of alerts investigated within 24 hours and trained 165 HCW on surveillance, case detection and contact tracing. Ukraine did not conduct any training to RRT and family doctors due to lack of a national strategy on contact tracing. A specific training on sample collection, storage and transportation for RRT was organized instead.

Activities	Description	Implemented by
Activity 3.1	Enhance existing surveillance systems to enable monitoring of COVID-19 transmission and adapt tools and protocols for contact tracing and monitoring to COVID-19	Ministry of Health WHO + IOM (Libya)
Activity 3.2	Train and equip rapid-response teams to investigate cases and clusters early in the outbreak, and conduct contact tracing within 24 hours	Ministry of Health WHO UNICEF (Somalia)
Activity 3.3	Produce weekly epidemiological and social science reports and disseminate to all levels and international partners	Ministry of Health WHO

Output 4	**Points of entry (Pillar 4)** **CAR, DPRK, Sudan** **Myanmar, Niger**

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health - Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 4.1	% of Countries which produce and distribute messages at Points of Entry for both travellers and those using the PoE facilities	100%	100 %	Country Strategic Plan to Support Preparedness and Response to COVID-19 (DPRK) MoH report (Myanmar)
Indicator 4.2	of Countries in which all designated PoE have public health emergency contingency plans	100%	100%	Country Strategic Plan to Support Preparedness and Response to COVID-19 (DPRK)
Explanation of output and indicators variance:		In addition, Chad trained 126 health care workers available at points of entry Myanmar supported the operational costs of the presence of 156 health staff at 33 points of entry. The country does not have a public health emergency contingency plan per se but there is the screening SOPs at PoE for suspect cases		

	In Sudan, not all PoE were opened in reporting period as the country went into lockdown and closed most borders

Activities	Description	Implemented by
Activity 4.1	Develop and implement a points of entry public health emergency plan	Ministry of Health WHO
Activity 4.2	Disseminate latest disease information, standard operating procedures, equip and train staff in appropriate actions to manage ill passenger(s)	Ministry of Health WHO
Activity 4.3	Prepare rapid health assessment/isolation facilities to manage ill passenger(s) and to safely transport them to designated health facilities	Ministry of Health WHO

Output 5	**National laboratories (Pillar 5)** **Burkina Faso, CAR, DPRK, Haiti, Lebanon, Sudan, Syria** **Libya, Mali, Myanmar, Niger, Ukraine and Venezuela**
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Health - Health

Indicators	Description	Target	Achieved	Source of verification
Indicator 5.1	% Countries with COVID-19 laboratory test capacity	100%	100%	Ministry of Health report
Indicator 5.2	Number and % of countries participating in EQAP	13	13 – 100%	Ministry of Health report
Indicator 5.3	% of countries scoring 100% on EQAP	100%	100% except: Burkina Faso: 87% scoring Lebanon: NA – under process Libya: under progress Ukraine: results not yet received	Ministry of Health report
Indicator 5.4	% of suspected cases tested	100%	Burkina Faso: 75% scoring CAR: 98% DPRK: 100% Haiti: 100%	Ministry of Health report COVID-19 Situation reports

			Lebanon: NA: has the capacity to test all suspected cases but no data on % of suspected cases tested in 2020 Libya: 100% Mali: 95% Myanmar: 100% Niger 100% Sudan: 100% Syria: NA - 10,078 cases tested Ukraine: 100% Venezuela: NA	

Explanation of output and indicators variance:	Burkina Faso established 15 operational laboratories. At the end of December 2020, 13 laboratories out of 15 operational, participated in EQAP In addition, Chad trained 20 lab technicians in detecting and diagnosing COVID-19 DPRK is not yet participating in EQAP due to port closure – Panel reserved Haiti has 9 Public sector laboratories with the capacity to test for COVID-19 Lebanon by end of 2020 had 87 Labs with COVID-19 testing capacity with the ability to conduct 24,000 tests per day In Syria one nnational laboratory of Afrin was established and fully equipped with PCR and DNA extraction devices, testing kits and PPEs In Ukraine, the llaboratory international consultant in NGCA was turned into staff for security and protection reasons

Activities	**Description**	**Implemented by**
Activity 5.1	Establish access to a designated international COVID-19 reference laboratory	Ministry of Health WHO Syrian Expatriate Medical Association (SEMA) (Syria). Instituto Nacional de Higiene Rafael Rangel (Venezuela)
Activity 5.2	Adopt and disseminate standard operating procedures (as part of disease outbreak investigation protocols) for specimen collection, management, and transportation for COVID-19 diagnostic testing	Ministry of Health WHO Syrian Expatriate Medical Association (SEMA) (Syria). Instituto Nacional de Higiene Rafael Rangel (Venezuela)

Activity 5.3	Adopt standardized systems for molecular testing, supported by assured access to reagents and kits	Ministry of Health WHO Syrian Expatriate Medical Association (SEMA) (Syria). Instituto Nacional de Higiene Rafael Rangel (Venezuela)

Output 6	**Infection prevention and control (Pillar 6)** **Burkina Faso, CAR, Haiti, Lebanon, Sudan** **Burkina Faso, Ethiopia, Libya, Mali, Niger, Nigeria, South Sudan and Venezuela**
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Health - Health

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 6.1	% of countries that have a national IPC programme and WASH standards within all healthcare facilities	100%	60% (i.e. 5 countries achieving the target and one partially so among the 9 countries out of 12 with available data) Note: Burkina Faso: partially CAR, Libya: not achieved Sudan: 0% : structural problem with the majority of health care facilities not having access to water Data not available: Haiti: Nigeria South Sudan	Ministry of Health report
Indicator 6.2	% of COVID-19 healthcare facilities with triage capacity	80%	Burkina Faso :39% CAR: 38% Ethiopia: 76% Haiti: All COVID case management facilities in Haiti were 100% dedicated to COVID and therefore did not	Ministry of Health report

			have a specific triage space. However, 180 non-COVID health institutions set up a triage space and 113 set-up an isolation space to detect COVID suspected cases and ensure safe Lebanon 100% Libya: not achieved Mali: 70% Niger: 60% Nigeria: 100% South Sudan NA Sudan: NA Venezuela: 53%	
Indicator 6.3	Number of new confirmed cases in healthcare workers	n/a	Burkina Faso cumulative 243 CAR: NA Ethiopia: 2403 by Dec 31,2020; 17 deaths Haiti: 257 March to November 2020 Lebanon: 1992 Libya: NA Mali: 300 Niger: 188 Nigeria: NA South Sudan NA Sudan: NA Venezuela: NA	Ministry of Health report

Indicator 6.4	% of countries that have national occupational safety and health plans or programmes for health workers	100%	Burkina Faso :0% CAR: 0% Ethiopia: 100% Haiti: NA Lebanon: NA Libya: not achieved Mali: 0% Niger 100% Nigeria: NA South Sudan NA Sudan: NA Venezuela: 100%	Ministry of Health report

Explanation of output and indicators variance:	Chad also reported a number of 1500 heath facilities with WASH standards In Ethiopia, HFs in hard to reach areas were found to fall below some IPC scores including lack of triage capacities and hand washing stations. Poor disposal of used PPEs and other clinical wastes also posed a concern in majority of the HFs at all levels Haiti reported 279 health institutions not designated for COVID case management that benefitted from technical support for the set-up of early detection measures and IPC norms partly with the support of this grant Nigeria reported 1200 HCW trained in IPC and 200 health facilities equipped South Sudan was able to equip 15 health facilities with IPC measures and train 140 HCW on IPC – these numbers were less than planned due to low budget planning and availability.

Activities	**Description**	**Implemented by**
Activity 6.1	Assess IPC capacity at all levels of healthcare system, including public, private, traditional practices and pharmacies. Minimum requirements include functional triage system and isolation rooms, trained staff (for early detection and standard principles for IPC); and sufficient IPC materials, including personal protective equipment (PPE) and WASH services/hand hygiene stations	Ministry of Health WHO UNICEF (Lebanon)
Activity 6.2	Implement triage, early detection, and infectious-source controls, administrative controls and engineering controls; implement visual alerts (educational material in appropriate language) for family members and patients	Ministry of Health NGOs (CAR)

	to inform triage personnel of respiratory symptoms and to practice respiratory etiquette	
Activity 6.3	Provide prioritized tailored support to health facilities based on IPC risk assessment and local care-seeking patterns, including for supplies, human resources, training	Ministry of Health WHO UNICEF (CAR)

Output 7	**Case management (Pillar 7)** **Burkina Faso, CAR, DPRK, Haiti, Lebanon, Sudan** **Burkina Faso, Ethiopia, Mali, Myanmar, Niger, Nigeria, Somalia, Ukraine and Venezuela**

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health - Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 7.1	% of countries that have a clinical referral system in place to care for COVID-19 cases	100%	80% (i.e. 11 countries achieving the target among the 12 out of 14 with available data reported) Note : Haiti not yet Data not available: Nigeria: Somalia	Ministry of Health report
Indicator 7.2	% Case Fatality amongst probable and/or confirmed hospitalized COVID cases by age groups and sex	n/a	Burkina Faso :1,2% CAR 1,4% DPRK: NA Ethiopia: 1.6% Haiti: 10% as of 30 November 2020 Lebanon: 0.8% Mali: 3.7% Myanmar: 2,697 deaths of total confirmed cases of 124,630 Niger: 3.1% Nigeria: NA	Ministry of Health report

			Somalia: NA Sudan: 7.9 % among confirmed cases, no data about hospitalised cases specifically available Ukraine: NA Venezuela: NA	
Indicator 7.3	Number of ICU beds provided to priority countries to complement national capacity	n/a	Burkina Faso 72 CAR: 124 DPRK: NA Ethiopia: 527 Haiti: 19 Lebanon: 73 Mali: 1200 Myanmar: no data Niger: 620 Nigeria: NA Somalia: NA Sudan: 16 Ukraine: NA Venezuela: NA	Ministry of Health report
Explanation of output and indicators variance:		Burkina Faso's total capacity for confirmed COVID-19 cases is 357 beds, 72 of which are equipped with ventilators. More than 90% of this reception capacity is concentrated in Ouagadougou in the Center region and in Bobo-Dioulasso, Hauts-Bassins region. Haiti did not have a proper referral system in place before January 2021. However, with PAHO support, daily bed occupancy was monitored in COVID 19 centres to support transfer of patients to the nearest and better equipped COVID centre. Nigeria achieved a number of 6 healthcare facilities with isolation capacity and trained 130 HCW on Covid-19 case management		

	In addition, South Sudan trained 10 ambulance teams on case transfer, 119 HCW on case management. The country reports a Case Mortality Rate of 1.1%

Activities	Description	Implemented by
Activity 7.1	Disseminate regularly updated information, train, and refresh medical/ambulatory teams in the management of severe acute respiratory infections and COVID-19-specific protocols based on international standards and WHO clinical guidance; set up triage and screening areas at all healthcare facilities	Ministry of Health WHO Red Cross (Lebanon)
Activity 7.2	Establish dedicated and equipped teams and ambulances to transport suspected and confirmed cases, and referral mechanisms for severe cases with co morbidity	Ministry of Health NGOs (CAR, Mali) Red Cross (Lebanon)

Output 8	**Operational support and logistics (Pillar 8)** **CAR, Syria** **Myanmar, Nigeria, Somalia and Ukraine**

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☐

Sector/cluster	Health – Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 8.1	% of medical masks (3 plies) provided against need	n/a	CAR: 42% Myanmar: 730,000 Nigeria: 100% Somalia: 5% Syria: NA Ukraine: NA	COVID-19 Logistics Dashboard WHO logistics documents
Indicator 8.2	% of country supported to surge oxygen capacity (of those requesting)	n/a	CAR: 36% Myanmar: Oxygen cylinder (big) 50L (Local) Nigeria: NA Somalia: 68 oxygen concentrators distributed, WHO is in the process of establishing 3 oxygen Plants	COVID-19 Logistics Dashboard WHO logistics documents

			Syria: NA Ukraine: NA	
Explanation of output and indicators variance:		Chad reported that 9 Points of Entry were equipped in surveillance and protective equipment Nigeria procured 3200 PPEs		

Activities	**Description**	**Implemented by**
Activity 8.1	Map available resources and supply systems in health and other sectors; conduct in-country inventory review of supplies based on WHO's a) Disease Commodity Package (DCP) and b) COVID-19 patient kit, and develop a central stock reserve for COVID-19 case management	WHO MOH UN agencies inventory list
Activity 8.2	Assess the capacity of local market to meet increased demand for medical and other essential supplies, and coordinate international request of supplies through regional and global procurement mechanisms	WHO

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[34] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

Burkina Faso

a. Accountability to Affected People (AAP) [35]:

The populations affected by the projects, including internally displaced persons and host communities were involved during the implementation of the projects. The needs analysis and assessment phase took into account the different age groups (women, girls, boys and men, children, adolescents, young adults, middle-aged or older adults) who were targeted and were involved in all phases of the projects, thereby improving access to information and health care. Activities were carried out in the community and with the community, but also in health care structures. Within each health structure, there is a management committee (COGES) which has been involved in the planning as well as in the monitoring of the activities implemented.

b. AAP Feedback and Complaint Mechanisms:

In Burkina Faso, an alert cell had been set up by the Government, with support from WHO and CERF funding. WHO also organized a KAP survey in Dori in the Sahel region and a socio-anthropological survey in Ouagadougou and Bobo Dioulasso

[34] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

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on perceptions related to the observance of barrier gestures against COVID-19, which made it possible to collect feedback from communities to guide the response. Also, within each care structure, a management committee represents the community and the local authorities and is involved in the management of complaints and the evaluation of the satisfaction of the health care services provided. These management committees act as the interface between the health structures and beneficiary communities. Also, the supervision and response monitoring missions in the field made it possible to discuss with the beneficiaries to get their impression on the impact of project activities and trends, which allowed us to reorient certain activities to broad coverage of populations in need.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

WHO has put in place PSEA's risk prevention and management organizational strategy and clarified its commitments under a zero-tolerance approach. (see https://www.who.int/about/ethics/sexual-exploitation-abuse) WHO has worked with the community to ensure community engagement but also with implementing partners to demonstrate their capacities and mechanisms for SEA management. WHO upholds its core principles of integrity, responsibility, independence, impartiality, respect and professional commitment among partners as outlined in the Code of Ethics and Professional Conduct.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

In Burkina Faso, the projects paid particular attention to the specific needs of women, girls, women of childbearing age, pregnant and breastfeeding women, including in areas affected by insecurity where nearly half of the displaced population is made up of women. Also, gender mainstreaming has been taken into account since the formulation of the projects. Women and girls were involved through the participatory community approach, their implications throughout the implementation of interventions and a feedback mechanism. Women, girls and survivors of GBV had access to medical care and psychological support.

e. People with disabilities (PwD):

In Burkina Faso, the projects did not take into account the specific needs of people with disabilities. However, people living with a disability, because they combine several types of vulnerability, have benefited from assistance through the various response interventions including health care provided to the population through these projects.

CAR

a. Accountability to Affected People (AAP) [36]:.

An official briefing meeting on the project activities and outcomes was held with the Minister of Health and his team in Bangui. The Humanitarian country team, Intercluster coordination groups and Health cluster members were also briefed during their ordinary meetings in Bangui. At the operational level, regional health cluster partners were briefed about the project in Bouar and Berberati. Local authorities and community leaders were also briefed on the project in Bangui, Bouar, Baboua, Gamboula and Berberati. During the implementation of the project, community health workers/social mobilizers were selected by the district medical team members in collaboration with community leaders and local associations. Progress on the project accomplishments was provided during bimonthly coordination meetings in Bouar, Bangui, Bimbo, Begoua, Berberati, and Baboua. On a weekly basis, situational reports were produced, and copies were shared with stakeholders as well as the partners.

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b. AAP Feedback and Complaint Mechanisms:

Feedbacks were retained during coordination meetings both at local and national levels. Sheet boxes to collect beneficiaries' suggestions and complaints were put in place in 14 health facilities in Bangui, Bimbo, Begoua, Bouar, Baboua, Berberati and Gamboula. Theses sheets were collected monthly and exploited to highlight various concerns of the beneficiaries. A summary of the content of the sheet boxes was raid by a local authority and discussed during the coordination meetings at the local level. Recommendations following the analysis of the complaints and suggestions of the beneficiaries were jointly adopted, implemented and followed-up.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

All the WHO's staff involved in the implementation of the project provided an up to date certificate for Zero Tolerance training on PSEA. All the locally recruited staff for the implementation of the project were briefed on PSEA. The feedback mechanism put in place monitored Sexual Exploitation and Abuse (SEA)-related complaints and one staff who was guilty was sanctioned. During Monitoring/ coordination meeting, awareness was raised on SEA and participants were encouraged to report suspected cases in line with confidentiality protocols.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

About 50% of community health workers and social mobilizers recruited for the implementation of community-based activities of this CERF project were women or girls. Specific sensitization sessions were organized for women and girls in certain communities (i.e. Muslim community) to enable their active participation, interaction and feedback. Financial incentives were made available to community health workers and social mobilizers was used to help reducing the economic vulnerability of women and girls recruited during the implementation of the CERF project. In certain location education level of women and girls didn't enable the recruitment of enough girls and women.

e. People with disabilities (PwD):

One of the implementing strategies of the project is home visit by investigation, case management and contact tracing team. This strategy improved access to physically disabled and elderly people and promote their protection and safety. The inclusion of psychologists within of the investigation teams helped to provide psychosocial support to those suffering from mental health issues.

Chad

a. Accountability to Affected People (AAP) [37]:

An assessment with all health actors of the 23 provinces was done by the national committee of epidemics management. This provided a forum for discussions on feedback from beneficiaries that helped to orient the national response plan.

b. AAP Feedback and Complaint Mechanisms:

A complaint mechanism was set at community leader levels with direct reporting to local health authorities. WHO reviews the complaints received and respond to the community leader

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

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WHO follows its organizational policy on PSEA

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

N/A

e. People with disabilities (PwD)

The project did not focus specifically on people with disabilities but considered disability as part as a broader criterion of vulnerability

DPRK: NA (Note PSEA policy applying to all WHO Country offices)

Ethiopia

a. Accountability to Affected People (AAP) [38]:

Several joint UN/NGO multi cluster/sector rapid assessments have been conducted in the priority regions in the country and the health needs and gaps were identified in discussion with local health authorities. This project has been designed and planned based on the findings of these different assessments. In line with the Health Cluster strategy, WHO will maintain a commitment to engage with various subsets of affected communities (women, men, youth, the elderly and people living with disability) through the most appropriate means, taking into consideration the need for social distancing, on issues concerning their health. Whenever possible recruitment of local community members to participate in COVID-19 response activities is one example of sustainable and accountable community engagement for appropriate needs–based responses. A COVID-19-specific complaint/feedback mechanism will be established and regularly monitored to ensure that relevant community inputs are generated during the response.

A Do No Harm approach will be enhanced, and human rights modalities employed especially in regard to use of security personnel in enforcement of partial or complete lockdowns. This approach will also be employed when delivering diagnostics and therapeutics as they become available.

b. AAP Feedback and Complaint Mechanisms:

NA

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

WHO follows its organizational policy on PSEA

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

The pandemic has compounded pre-existing gender inequalities and increases the risks of gender-based violence. The protection and promotion of the rights of women and girls have been prioritized. For instance, Ethiopia sought to apply

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gender analysis when developing public health outreach messages to include tailored messaging directed to men and women, as specificity will be needed to resonate with these audiences.

e. People with disabilities (PwD)

COVID-19 mitigation strategies have been designed to be inclusive of PLWD to ensure they maintain respect for "dignity, human rights and fundamental freedoms, and avoid widening existing disparities.

Haiti

a. Accountability to Affected People (AAP) [39]:

PAHO/WHO has continuously collaborated with the Haitian Ministry of Public Health and Population (MSPP) to improve the quality of healthcare services, the quality of case management, and epidemiological and laboratory surveillance provided to the Haitian population to help save lives. Within the scope of this project, the design and planning were done in conjunction with all MSPP units involved in the Preparedness and Response to COVID-19 and following the National Plan for COVID Response drafted with PAHO/WHO's support, following WHO and PAHO's recommendations for the region.

b. AAP Feedback and Complaint Mechanisms:

No specific complaint and feedback mechanisms were set in place specific to this project.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

WHO follows its organizational policy on PSEA

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

Interventions conducted through this grant did not target specific groups. However, throughout the response to COVID and through other grants community activities were conducted targeting women (UF CERF for obstetrical emergencies) and young girls.

e. People with disabilities (PwD)

No specific activities were conducted through this grant to ensure accessibility for people with disabilities.

Lebanon

a. Accountability to Affected People (AAP) [40]:

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The gaps and needs that were targeted in this project were selected based on a rigorous assessment done at the targeted hospitals by a national expert recruited by WHO and through the involvement of the healthcare workers at the hospitals. WHO closely coordinates with the hospitals to ensure that the supplies that were procured matched their needs and that their specifications meet the standards/are technically cleared by WHO, and were in line with the hospitals' requirements to ensure that the hospitals can serve the affected populations with the necessary services. WHO monitored delivery of healthcare services at the designated hospitals. WHO advocated at all time that all COVID-19 patients –regardless of nationality, gender, or age- should be able to access designated hospitals and receive adequate healthcare access.
b. AAP Feedback and Complaint Mechanisms:
A person or institution with a complaint can reach the MOPH through telephone, Qada health units, health sector and working group meetings. Any complaint is followed up closely and addressed in complete confidentiality. A hotline for COVID 9 was already established at the MOPH to assist in any query or complaint. During the implementation phase, WHO did not receive any formal complaint pertaining to this project.
c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:
All WHO staff have completed the mandatory PSEA training and refresher training are regularly offered to staff. Moreover, WHO PSEA focal points were assigned and trained. A well-established mechanism allows them to respond to and report any sexual exploitation and abuse incidents that might occur. PSEA training was also offered to partners and NGOS during 2020.
d. Focus on women, girls and sexual and gender minorities, including gender-based violence:
Although the project was not particularly focusing on gender-based response, the enhanced health system capacity allowed for service provision to all genders based on need. All COVID-19 patients, regardless of their age or gender, can access the health services in any of the supported hospitals.
e. People with disabilities (PwD):
The project does not focus specifically on persons with disability but considered disability as part of a larger vulnerability-based beneficiary selection criteria. Many people with disability suffer from chronic diseases and are hence more prone to complications if they are infected with the SARS-CoV-2. In this project WHO emphasized the importance of ensuring access to persons with disabilities to healthcare hospitalization services in any of the supported hospitals. Moreover, the initial assessment on which this project is based included an assessment of the status of accessibility for the disabled in the supported health facilities.

Libya

a. Accountability to Affected People (AAP) [41]:

WHO Libya initiated AAP in the early stages of the project by engaging authorities acting on behalf of beneficiaries in needs assessments. Their needs, concerns, suggestions and perceptions were taken into account during the project design. AAP measures were considered during the implementation process and were framed within the context of Libya. Beneficiaries' perspectives and partner reviews were incorporated into project impact assessments. WHO has a well-established network of local expertise and strategic partnerships. It maintains this network through close collaboration with local, subnational and national health authorities and health sector partners. This allows it to contribute to the enhancement of AAP.

b. AAP Feedback and Complaint Mechanisms:

The COVID-19 response allowed WHO and the health sector to strengthen community engagement across the country. Under WHO's leadership, the health sector developed tools to analyse feedback from beneficiaries. Behavioural assessments were conducted to understand target audiences' perceptions, concerns, influencers and preferred communication channels. Health messages were tested

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on trusted community groups. WHO built an extensive network of media contacts to disseminate public health messages through TV, radio, the Internet, newspapers and social media. Messages and materials were adapted and communicated in local languages and those of the main migrant and refugee populations. WHO's field coordinators throughout the country regularly visited health care facilities and reported back to the WHO country office in Tripoli. Reports were assembled following interviews with staff and health authorities and discussions with community leaders. The data include gender-disaggregated reports on the number of consultations provided, in accordance with WHO's data collection and monitoring requirements.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

In line with the UN Protocol on allegation of SEA, all WHO national and international staffs have completed the training related to sexual harassment and abuse. The training programme is mandatory for all uniformed and civilian personnel and is intended to strengthen training on the standards of conduct, as well as the expectations of accountability and individual responsibility in matters of conduct and discipline, with a special focus on sexual exploitation and abuse. The training programme covers the UN Standards of Conduct concerning sexual exploitation and abuse, including what qualifies as prohibited behaviour and the consequences and impact of sexual misconduct on peacekeeping personnel, operations and host populations.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

The project indirectly helped to improve support for women and girls, who benefited from improved IPC in health care facilities. CERF funds were used to procure large quantities of PPE for health care workers to allow them to work in safety and security. This helped maintain other essential health care services such as obstetric care and pre- and post-natal health services. Key challenges include the acute shortages of nurses and midwives in Libya. WHO is addressing this through other donor contributions and is collaborating with the United Nations Population Fund (UNFPA) on the development of a strategy to strengthen the country's nursing and midwifery workforce

e. People with disabilities (PwD):

N/A

Mali

a. Accountability to Affected People (AAP) [42]:
Project activities are based on humanitarian principles of impartiality, neutrality, operational independence and the « do no harm » policy. Oversight is being conducted by the « Fédération nationale des associations de santé communautaire (FENASCOM) that coordinates all community health NGOs. Implementation was done in partnership with NGOs that ensured supervision and accountability
b. AAP Feedback and Complaint Mechanisms:
WHO set up a direct feedback system involving health care workers that also were members for some of supervision and contact tracing visits.
c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:
WHO adheres to PSEA principles and all staff has received compulsory training on effective behaviours. No incident was reported
d. Focus on women, girls and sexual and gender minorities, including gender-based violence:
NA
e. People with disabilities (PwD):

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NA

Myanmar

a. Accountability to Affected People (AAP) [43]:

The feedback of beneficiaries collected through the implementing partner in previous projects was used in planning phase of this project. Local authorities informed the date and time of mobile clinics and availability of quarantine services to the beneficiaries through multiple communication channels. The implementing partner collaborated with local volunteers in implementation of health care activities in IDP camps and quarantine facilities. During the joint field visit of WHO and MoHS, feedbacks from the beneficiaries were collected through interviews with the beneficiaries, analysis was made and incorporated in the monitoring report.

b. AAP Feedback and Complaint Mechanisms:

During the joint monitoring visit conducted by MoHS and WHO, beneficiary interviews were conducted with regards to their overall feedback regarding the mobile clinic services. This included questions on how they received the information regarding the clinic visit beforehand, mechanisms available for referral to designated COVID-19 treatment facilities, as well as other services still needed. As the interview was done during the joint visit, real time feedback was discussed with MoHS colleagues for action as needed. The feedbacks from beneficiaries were collected through the implementing partner in quarantine facilities.
Additionally, WHO remained engaged with the inter-cluster coordination group based in both national and subnational level. WHO also co-facilitated three COVID-19 technical coordination groups meetings, i.e., Laboratory & surveillance, Case management and Risk communication and community engagement coordination groups. As such, health-related feedback detected by other partners as well as other clusters and sectors were referred and discussed as necessary.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

PSEA reporting mechanism is in place even before this project. Corporately, WHO has a publicly available document on WHO Sexual Exploitation and Abuse Prevention and Response, link here: https://www.who.int/about/ethics/sexual-exploitation_abuse-prevention_response_policy.pdf?ua=1. Reporting mechanisms in place is detailed in Chapter 6, page 12. All WHO Myanmar personnel were required to complete the mandatory online training entitled “UN Inter Agency: To Serve with Pride - Zero Tolerance for Sexual Exploitation and Abuse by our own staff”. The WHO staff members followed the internal reporting process of PSEA by ensuring confidentiality. The follow ups were made through existing protocol.
Additionally, Awareness strengthening workshop on PSEA was facilitated by WHO Myanmar to health managers of the Ministry of Health and Sports in collaboration with the PSEA Network Myanmar focal point on 3 December 2020.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

This project was designed through the participation of women and men health staff and volunteers to contribute to empowerment and protection of women and girls, as well gender-based violence. The mobile clinics staff received orientation on gender-based violence and monitored and reported GBV cases according to standard procedure. GBV monitoring was included as a part of the staff worked in quarantine facilities.

e. People with disabilities (PwD):

This project promoted (as indirect beneficiary and mainstreaming approach) accessibility of people with disabilities including women and girls to a range of health services through mobile clinics, quarantine centres and surveillance activities.

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Niger

a. Accountability to Affected People (AAP) [44]:
AAP was done by including vulnerable people in the determination of needs, presenting the project to the MoH and community leaders and involving local health authorities during all implementation phases, including final evaluation of the project.
b. AAP Feedback and Complaint Mechanisms:
WHO set up boxes to collect suggestions and feedback on the project implementation. WHO also organised focus groups discussions on identification of needs
c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:
WHO zero tolerance policy is applicable for all projects implemented by WHO and its partners, including with mechanisms for reporting and protecting those reporting.
d. Focus on women, girls and sexual and gender minorities, including gender-based violence:
Gender balance was taken into account in selecting communities.
e. People with disabilities (PwD):
NA

Nigeria

a. Accountability to Affected People (AAP) [45]:
At the design and planning phase, WHO took into account the diversity of the communities and ensured the beneficiaries were clearly disaggregated by social markers (age and sex) throughout the lifecycle of the project. WHO periodically solicited opinions and thoughts of beneficiaries (including of the vulnerable groups and those with special needs) through community engagement sessions. During implementation, WHO gave updates of the progress of health interventions and discuss way forward with stakeholders through key informant interviews and focused group discussions.
b. AAP Feedback and Complaint Mechanisms:
Through established network of LGA facilitators and availability of Toll-Free lines, the beneficiaries will be able to give feedback on the quality of service delivered and how well the activities have addressed their needs. This will serve as a participatory monitoring and evaluation process.
c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:
WHO zero tolerance policy is applicable for all projects implemented by WHO and its partners.

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d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

People with specific vulnerabilities, including pregnant women, persons with disabilities, elderly and people suffering from chronic diseases, newly displaced population coming from the bush and population living in hard to reach areas with low or no access to basic health care were prioritized. Survivors of rape and other GBV are systematically referred for specialized medical services and their cases followed-up.
Health workers were trained on available services in the GBV referral pathway. 155 cases of GBV were seen and treated during the reporting period.

e. People with disabilities (PwD):

See above

Somalia

a. Accountability to Affected People (AAP) [46]:

The project proposal was developed based on a risk assessment conducted by WHO as well as on the UN and the government's COVID-19 response plans. Local health authorities and implementing partners were also consulted. The needs assessment was done by the MoH, UN agencies, health cluster and implementing partners were involved during the process of the assessment.

WHO ensured vulnerable population groups were reached, including internally displaced persons (IDPs), nomadic people and people living in inaccessible districts. Members of affected communities were involved, and community health workers involved in RRTs were selected in consultation with local authorities and community members, thereby ensuring that all community members are reached. Additionally, regular coordination meetings were held at district level, thereby ensuring that community feedback was gathered, and that the response was adjusted to effectively address affected communities' specific needs.

M&E was done by WHO's newly established M&E unit. A list of indicators was developed and adopted to monitor activity implementation in line with the global COVID-19 response monitoring plan. Their progress was discussed during regular WHO IMST meetings and decisions taken accordingly. Regular joint supportive supervision and field monitoring were conducted on a monthly basis throughout the project's implementation. Additionally, table-top data audit and verification was conducted to ensure quality data and reporting. Achievements were reported in the state-based Public Health Officers weekly reports. Finally, regular COVID-19 situation reports were jointly developed, published and disseminated on a weekly basis to a wider audience

b. AAP Feedback and Complaint Mechanisms:

WHO monitored complaints through different mechanisms throughout the project implementation. At the field level, WHO monitored complaints through regional and subnational Health Cluster meetings as well as through visits to the affected districts whereby WHO staff discussed with elders and beneficiaries. Through Health Cluster partners working on the ground, WHO is able to gather feedback and complaints regarding the project implementation, should they arise. Additionally, WHO has its own mechanism by which complaints can be reported directly to WHO, including via the WHO Somalia country office website, social media (e.g. Twitter, Instagram), emails and through telephone. Any such complaints which are received by WHO are treated with the utmost seriousness, confidentiality, and professionalism. As part of this AAP project, however, no formal complaints were received.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

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In line with the UN Protocol on allegation of SEA, all WHO national and international staffs at the head office and sub-offices have completed the mandatory training related to sexual exploration and abuse. PSEA focal points were assigned and trained at the country office and sub offices. The focal points are in charge of monitoring and responding to such situations, should they arise, and reporting through the established mechanism. Moreover, all health workers involved with project implementation participated in refresher trainings and awareness-raising sessions related to PSEA and what actions must be undertaken during any such incident. In these respects, WHO continues raising awareness about PSEA during Health Cluster and subnational reproductive working group meetings.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

During the project planning, implementation and monitoring, gender equality as well as the specific needs of minority groups, including IDPs and nomadic population, were considered. Women were prioritised when selecting community health workers for capacity-building activities and gender equality was given due attention to ensure equal opportunity to males and females in all COVID-19 trainings. Although the project was not particularly focusing on gender-based response, during community health surveillance and awareness raising activities women and girls were encouraged to utilize the available services.

e. People with disabilities (PwD):

Health messages targeting people with disabilities were included in community mobilization and health messaging activities. Additionally, specific awareness-raising sessions were held during health cluster meetings and national and subnational coordination meetings on the importance of addressing the needs of people with disabilities, with a focus on ensuring access to COVID-19 testing, treatment and follow-up. As part of health workers and community rapid response teams' trainings, due attention was given to the importance of including PWD in COVID-19 response activities. Community rapid response teams delivered health message during house-to-house visits and assisted PWD in receiving relevant health messages on COVID-19 and having access to testing and follow-up at household level.

South Sudan

a. Accountability to Affected People (AAP) [47]:

At the design phase, WHO, the Ministry of Health and health partners carried out risk analysis and mapped out 7 priority locations. Some of the priority locations prioritized as COVID-19 hotspots were Juba, Yambio, Renk, Wau Bentiu and Paluich. The risk assessment phase was participatory involving health cluster partners, National and State Ministry of Health as well as voices from the County Health Departments (CHD) and health facilities. Through these structures, information from affected people including men, women, and other marginalized groups was obtained to inform the design of the project, thus the CERF project design was a reflection of all voices.

b. AAP Feedback and Complaint Mechanisms:

During the COVID-19 preparedness and response, WHO, Ministry of Health and the health partners implemented several levels of Feedback and complains mechanisms with support from the Risk Communications pillar. IEC materials produced and distributed had hotlines for reporting, there were radio programs conducted by media outlets where information on COVID-19 was shared and road drives where COVID-19 information was broad cast to the general public using loud speakers. WHO also sanctioned a community survey on COVID-19 community cases, this is in addition to the state and the National Coordination meetings where partners and community representatives share feedback and complains about redress were critical in increasing accountability to affected people.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

WHO has an established framework for the prevention of sexual exploitation and abuse (PSEA), in the COVID-19 response context, a contact person and hotline remained operational where complains are reported and feedback provided. WHO also conducted a series of PSEA activities aimed at increasing awareness among its staff, partners and contractors on PSEA risk and reporting. The activities included ensuring 100% coverage of staff with PSEA training, production and dissemination of IEC materials to contractors, staff and

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partners and states focal points among others. In addition to the hotlines, the COVID-19 coordination mechanisms were used to strengthen PSEA policy and feedback among partners and community leaders.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

The project targeted men, women, girls and boys in equal proportion during design phase to ensure equity in access to COVID-19 services. During implementation activities such as trainings attracted the participation of both Female and male health care workers. In the communities, age and gender disaggregated data was collected by the contact tracers, surveillance officers and the National laboratories where COVID-19 samples were collected and tested. Again, age and Gender disaggregated data was collected to show number of contacts under follow up, test performed, confirmed cases, recoveries and death caused by COVID-19. This data is used to support reporting of response activities.

e. People with disabilities (PwD):

No data was captured

Sudan

a. Accountability to Affected People (AAP) [48]:

As the nature of the COVID-19 pandemic was unprecedented and required immediate and timely response to protect all of the population, there was limited consultation with beneficiaries. WHO was, however, part of the national technical and medical committees, which had a broad participation of medical practitioners and members of the civil society which developed the national guidance, response and action plans. The planning referred to high level discussions with FMOH and was based on global standards in order to plan a comprehensive response. During the design and planning phase in close collaboration with the FMOH, the SMOH and the WHO field response teams took into account assessments at Points of Entry and health facilities in priority states.
The implementation was closely monitored through joint FMOH/WHO supervision missions in health facilities and Points of Entry in the targeted priority states. Random interviews with health care providers, patients and community members were carried out as well as community leaders' consultations to assess their perception of needs and concerns of the communities. COVID-19 was initially linked to a strong stigma and the feedback from communities helped to shape further actions. Monitoring was conducted in close coordination with FMOH and SMOH for planning of the visits, trainings and distribution. The visits were jointly conducted and followed by subsequent visits to follow up on the findings of previous missions. Field staff communicated closely with partners to ensure that supplies reached their destination.

b. AAP Feedback and Complaint Mechanisms:

The WHO complaint mechanisms remained in place as per standard during the implementation of the project. The beneficiaries had access through the WHO Complaint mechanism/hotline. In addition, to accommodate for the remote areas where accessibility to networks is low to none, there were also complaint boxes available in WHO offices in all the fields.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

WHO has put in place PSEA's risk prevention and management strategy and clarified its commitments under a zero-tolerance approach. In Sudan in the context of the COVID-19 response, WHO also collected and analyzed sex, age and disability aggregated data to monitor and respond to implications of COVID-19 on different community groups. The proposed actions considered the specific challenges of the COVID-19 response related to fear, rumors and stigma in the communities. Gender balance in the RRTs was promoted to ensure that female workers were accessible to meet the medical, social and protection needs of women and children in this unprecedented situation.

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d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

Aspects of special needs of elderly, pregnant/lactating women and children with disabilities and to sensitize health workers to protection risks including Gender Based Violence (GBV) were addressed during the trainings of RRTs and isolation center staff. Feedback from relevant gender and age groups was integrated during implementation and evaluation of action.
However, this is a public health response; all efforts were done in training to include women amongst the trained health teams and in community-based programmes to give access to female staff for female patients. However, the response to the public health crisis was dedicated to the entire population and the transmission of COVID-19 is indiscriminate to the entire population in the country.

e. People with disabilities (PwD):

The Government of Sudan estimates that about 10% of the population were at risk of transmission in the initial phase of transmission. WHO intervention targeted the at-risk population including people with disabilities. Priority was given to access to testing, case management, IPC and public health measures to prevent further transmission in the entire population.

Syria

a. Accountability to Affected People (AAP) [49]:

During this project, WHO followed a number of formal and informal mechanisms, standards and practices that ensure engaging the population at various stages in the intervention as follows:

1. Information-sharing: WHO supported providing the targeted communities with adequate information and awareness raising about COVID-19 and conducted a 2-way communication for identifying their needs and designing the right messages for them.

2. Information-gathering and consultation: WHO supported obtaining information from different communities and groups through focus group discussions, for assessing, prioritizing, monitoring and evaluating service delivery.

b. AAP Feedback and Complaint Mechanisms:

WHO supported individuals and communities with access to safe and confidential ways to make complaints and feedback on health services through complaint boxes, phone and WhatsApp numbers, emails, verbal complaints and direct feedback to the field staff. The feedback was recorded and then reported to responsible people for action.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

WHO has PSEA as a solid component of its interventions. WHO provides several trainings for health workers on PSEA through coordination with IOM. WHO also shares information on its PSEA strategy with posters, banners and awareness sessions, and complemented with the complaints and feedback mechanism.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence

WHO's corporate framework for gender mainstreaming calls for gender equality and the empowerment of women as a cross-cutting objective in all its programmes. This policy is operationalized through the requirement to disaggregate data by gender and age when reporting health related data (health consultations). WHO's NGO partners are also required to disaggregate data by gender and age in their reports. Furthermore, WHO ensures there is a gender balance between participants at training courses supported by WHO and

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promotes more. These requirements help ensure that project assessments, planning, designing, implementing, monitoring and evaluating can be performed with due consideration to gender equality issues.

e. People with disabilities (PwD):

NA

Ukraine

a. Accountability to Affected People (AAP) [50]:

Activities were designed based on discussions and assessments with health authorities and specialists as well as with health cluster partners in order to meet unmet needs on both sides of the 'contact line'. An assessment in August with health authorities and specialists and consultations with cluster partners led to changes in the initial plan because of changing needs and priorities. The final project goal and objectives were shared with health partners (local and international NGOs) on both sides of the 'conflict line' at the sub-national cluster meetings and with local authorities.

The implementation of activities was done in coordination with local health authorities and in close collaboration with health specialists and partners. WHO's field coordinators regularly visited selected labs and hospitals and discussed project implementation with participants (lab technicians, rapid response teams, critical care specialists) to ensure expected results were achieved.

b. AAP Feedback and Complaint Mechanisms:

The project was designed to support the existing health care system, and hence no standalone complaint mechanism for affected people, i.e. COVID-19 cases, was put in place by WHO. Feedback with regards to the collaboration between WHO and the health structures was collected from health professionals, however, on a regular basis.

c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:

Intervention did not directly interact with the affected population but WHO staff and consultants engaged in the programme as well as all Health cluster partners have been briefed and trained on PSEA as per organizational policy.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

A significant proportion of medical personnel engaged in COVID-19 treatment is nurses which is a very female-gendered profession in Ukraine. This is also true of administrative personnel in facilities, and medical doctors too. All efforts have been made to ensure that PPE accessibility is not only for the medical doctors but also for the nurses and administrative personnel so that all frontline workers are well protected. Outreach efforts have also been made so that nurses participate in the training provided by WHO to provide them strong on-the-job skills and opportunity for growth in medical professions

e. People with disabilities (PwD):

Intervention did not directly interact with the affected population, however, the MHPSS technical working group provided a training on how to adapt programming during Covid-19 and published an analysis on access to healthcare services for older persons and persons with disability.

Venezuela

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a. Accountability to Affected People (AAP) [51]:
In order to prioritize interventions according the country's specific needs, respective consultations were carried out with the MPPS authorities, civil society and professional experts, who endorsed the results of the project as well as the purchases and reported the current existence in the records of the MPPS and the contributions of other cooperation agencies and funds of the United Nations system in VEN, or other contributors.
b. AAP Feedback and Complaint Mechanisms:
No specific complaint/feedback mechanism established for this project. PAHO/WHO operates a 24/7 hotline which can be used by communities and constituents to provide anonymous feedback. No complaint or recommendation were received regarding the interventions carried out under this project.
c. Prevention of Sexual Exploitation and Abuse (PSEA)[2]:
PAHO/WHO operates a 24/7 hotline (online of via phone) which can be used by anyone to register a complaint or report wrongdoings which then get investigated by PAHO/WHO independent's investigation office. In addition, there is, within the United Nations system, the office of OCHA and the representation of the High Commissioner for Human Rights, as well as the UNMFA.
d. Focus on women, girls and sexual and gender minorities, including gender-based violence:
The implementation of this interprogrammatic project was coordinated closely with UNICEF and UNMFA. Support to care delivery services was directed to increase equitable access to services in each place of care through the provision of free testing and free medical services., In addition, the medicines, supplies and medical equipment procured were adapted to the condition of the patients (adult, paediatric, obstetric) in order to guarantee timely access to treatment for all.
e. People with disabilities (PwD):
The project targeted the general population, focusing on most at-risk individuals given their health and socio-economic conditions. Unfortunately, no specific statistics are available regarding PWD.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	0

9. Visibility of CERF-funded Activities:

Available from Burkina Faso, Ethiopia, Lebanon, Libya, Somalia, South Sudan, Ukraine, Venezuela

Title	Weblink
Burkina Faso Briefing with elderly people groups on COVID-19 in the	***https://twitter.com/OMS_Burkina/status/1364156945951825923***

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regions affected by the pandemic	
Ethiopia	
Ethiopia Covid19 Response Bulletin, November 2020.	https://drive.google.com/file/d/18OT4NAaSxQ3tNdYBJTkj09fOxLXQZ-Wk/view?usp=sharing
Lebanon	
WHO COVID Response infographics (CERF mentioned in each infographic)	WHO EMRO | WHO support to the COVID-19 response in Lebanon | Information resources | Lebanon
Facebook post	A new batch of... - World Health Organization Lebanon Office | Facebook
Twitter post	WHO Lebanon on Twitter: "Youth volunteers giving a hand with the shipment of PPEs that arrived from WHO hub in Dubai and is temporarily stored at the UNRWA warehouse as it start dispatching to 23 health facilities in Beirut. Incoming health supplies is an ongoing process. @WHOEMRO @WHO #Beirut https://t.co/k1Ts8xxNmY" / Twitter
Facebook post	As part of its... - World Health Organization Lebanon Office | Facebook
Instagram post	WHO Lebanon on Instagram: “As part of its support to the COVID response in Lebanon, and through the CERF grant, WHO procured an automatic extractor, respirators…”
Twitter post	WHO Lebanon on Twitter: "As part WHO's support to the #COVID response in Lebanon and through the CERF grant, an automatic extractor, respirators, mobile XRays, PPEs, and PCR lab reagents were procured to improve the lab testing &case management capacities in hospitals. #CERF #HealthforAll https://t.co/jLsTF5FVUt" / Twitter
Libya	
Two-day training workshop on COVID19 case management & infection prevention and control in Tripoli.	https://www.facebook.com/WHOLIBYA/posts/3882284381782752
Training workshop for community representatives & health workers in Al-Jufra (south of Libya)	https://www.facebook.com/WHOLIBYA/posts/3882155148462342 https://www.facebook.com/WHOLIBYA/posts/3882113201799870
Workshop COVID-19 case definition, IPC and case management	https://www.facebook.com/WHOLIBYA/posts/3872133962797794

Arrival of COVID19 personal protective equipment & medicines to Banina Airport-Benghazi. (Videos)	https://www.facebook.com/WHOLIBYA/videos/419798525871876/ https://www.facebook.com/WHOLIBYA/videos/742799872989128/
Train 40 medical doctors along with nurses and laboratory technicians, a training workshop was concluded at Ibn Sina Hospital in Sirt	https://www.facebook.com/WHOLIBYA/posts/3832204776790713 https://www.facebook.com/WHOLIBYA/posts/3832202300124294
Two PCR devices &their testing kits have been provided to Al-Mansoura Chest Hospital in Shahhat and Health Service Directorate in Derna	https://www.facebook.com/WHOLIBYA/posts/3783748451636346

Somalia	
WHO Somalia website – "donors and partners" section and "information resources" page	http://www.emro.who.int/somalia/donors-partners/index.html http://www.emro.who.int/somalia/information-resources/index.html
Tweet & Instagram post (4 May 2020) #FactsNotFear – Coronavirus Disease (COVID-19): *protecting the vulnerable* (March – April)	https://twitter.com/WHOSom/status/1257299823935410178 https://www.instagram.com/p/B_xCV6FguCk/?utm_source=ig_web_copy_link
Tweet & Instagram post (11 June) Coronavirus Disease (COVID-19): *protecting the vulnerable* (May 2020)	https://twitter.com/WHOSom/status/1271089074909122561?s=20 https://www.instagram.com/p/CBTo-06JKvF/?utm_source=ig_web_copy_link
Tweet, Facebook posts (16 August) Coronavirus Disease (COVID-19): *protecting the vulnerable* (July 2020)	*https://twitter.com/WHOSom/status/1294969696761061376?s=20* *https://www.facebook.com/100783878363467/photos/a.101500934958428/1430326741385 87/?type=3&eid=ARB1JdQVSx_ WQO49XcVMJ_BusG4BH1adooqjIQKku4imTYnYCYMO9RHUXLCnSZycd7ruX-y5hNlpbDgj&_rdc=2&_rdr*
Tweet & Instagram post (10 Sept. 2020) Coronavirus Disease (COVID-19): *protecting the vulnerable* (August 2020)	https://twitter.com/DrMohamedABDIK3/status/1304064995970383873?s=20 https://www.instagram.com/p/CE894qtn4Fr/?utm_source=ig_web_copy_link
Tweet, Facebook & Instagram posts (14 Oct. 2020) COVID-19 information note 6	https://twitter.com/WHOSom/status/1316277928490151937?s=20 https://www.facebook.com/permalink.php?story_fbid=165363915238796&id=100783878363467

	https://www.instagram.com/p/CGUMLegHi7s/?utm_source=ig_web_copy_link
Tweet, & Facebook posts (26 Oct. 2020) COVID-19 information note 7	https://twitter.com/WHOSom/status/1320698195782107136?s=20 https://www.facebook.com/permalink.php?story_fbid=169601658148355&id=100783878363467
Tweet, Facebook & Instagram posts (9 Nov. 2020) Coronavirus Disease (COVID-19): *protecting the vulnerable* (October 2020)	https://www.instagram.com/p/CHXhFT0Hgmb/?utm_source=ig_web_copy_link https://www.facebook.com/permalink.php?story_fbid=174168684358319&id=100783878363467 https://www.instagram.com/p/CHXhFT0Hgmb/?utm_source=ig_web_copy_link
Tweet, Facebook & Instagram posts (24 Nov. 2020) COVID-19 information note 8: The gender gap;	https://twitter.com/WHOSom/status/1331175690503413760?s=20 https://www.facebook.com/100783878363467/photos/pcb.182996370142217/182994406809080/?type=3&theater https://www.instagram.com/p/CH-DOtYnWSx/?utm_source=ig_web_copy_link
Web-story: Life-saving disease prevention and mitigation efforts continue in Somalia under anticipatory action framework	http://www.emro.who.int/somalia/news/life-saving-disease-prevention-and-mitigation-efforts-continue-in-somalia-under-anticipatory-action-framework.html
Web-story: Protecting children in Kismayo from measles: funding from anticipatory action framework proves impactful	http://www.emro.who.int/somalia/news/protecting-children-in-kismayo-from-measles-funding-from-anticipatory-action-framework-proves-impactful.html
South Sudan	
CERF Support to COVID-19	https://www.facebook.com/WHOSOUTHSUDAN
CERF Support to COVID 19 in South Sudan	https://twitter.com/WHOSouthSudan/media https://www.afro.who.int/countries/876/news?page=0
CERF Support to COVID-19	https://www.facebook.com/WHOSOUTHSUDAN
CERF Support to COVID 19 in South Sudan	https://twitter.com/WHOSouthSudan/media
Strengthening Disease surveillance for COVID-19 in South Sudan	https://www.afro.who.int/countries/876/news?page=0
Ukraine	
OCHA humanitarian snapshots	https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/ukraine_humanitarian_snapshot_20201110-eng.pdf

WHO monthly COVID-19 reports	No link (WHO doesn't do visibility on NGCA activities not allowed by de facto authorities), but CERF credited as WHO contributor in all monthly reports done since March 2020
UN reports on COVID-19	https://ukraine.un.org/sites/default/files/2020-12/Ukraine%20-%20COVID-19%20SITUATION%20OVERVIEW%20No.9.pdf

Venezuela	
La OPS redobla cooperación técnica con el INHRR	***https://www.paho.org/es/noticias/23-11-2020-ops-redobla-cooperacion-tecnica-con-inhrr***
OPS fortalece capacidades en vigilancia en salud pública en Bolívar	***https://www.paho.org/es/noticias/12-3-2021-ops-fortalece-capacidades-vigilancia-salud-publica-bolivar***
Venezuela amplía su red de diagnóstico de la COVID-19 con el apoyo de la OPS	***https://www.paho.org/es/noticias/10-9-2020-venezuela-amplia-su-red-diagnostico-covid-19-con-apoyo-ops***

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	CERF Sector	Agency	Implementing Partner Type	Total CERF Funds Transferred to Partner in USD
20-RR-FAO-019	Food Assistance	FAO	20-RR-FAO-019	Food Assistance
20-RR-FAO-019	Agriculture	FAO	20-RR-FAO-019	Agriculture
20-RR-FAO-019	Agriculture	FAO	20-RR-FAO-019	Agriculture
20-RR-FAO-019	Agriculture	FAO	20-RR-FAO-019	Agriculture
20-RR-FAO-019	Food Assistance	FAO	20-RR-FAO-019	Food Assistance
20-RR-FAO-019	Food Assistance	FAO	20-RR-FAO-019	Food Assistance
20-RR-FAO-019	Food Assistance	FAO	20-RR-FAO-019	Food Assistance
20-RR-FPA-022	Gender-Based Violence	UNFPA	20-RR-FPA-022	Gender-Based Violence
20-RR-FPA-022	Gender-Based Violence	UNFPA	20-RR-FPA-022	Gender-Based Violence
20-RR-FPA-022	Gender-Based Violence	UNFPA	20-RR-FPA-022	Gender-Based Violence
20-RR-FPA-022	Gender-Based Violence	UNFPA	20-RR-FPA-022	Gender-Based Violence
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Gender-Based Violence	UNFPA	20-RR-FPA-022	Gender-Based Violence
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Protection	UNFPA	20-RR-FPA-022	Protection
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Gender-Based Violence	UNFPA	20-RR-FPA-022	Gender-Based Violence
20-RR-FPA-022	Protection	UNFPA	20-RR-FPA-022	Protection

20-RR-FPA-022	Protection	UNFPA	20-RR-FPA-022	Protection
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Health	UNFPA	20-RR-FPA-022	Health
20-RR-FPA-022	Gender-Based Violence	UNFPA	20-RR-FPA-022	Gender-Based Violence
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Nutrition	UNICEF	20-RR-CEF-025/-CEF-030	Nutrition
20-RR-CEF-025/-CEF-030	Child Protection	UNICEF	20-RR-CEF-025/-CEF-030	Child Protection
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene	UNICEF	20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene
20-RR-CEF-025/-CEF-030	Education	UNICEF	20-RR-CEF-025/-CEF-030	Education
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Nutrition	UNICEF	20-RR-CEF-025/-CEF-030	Nutrition
20-RR-CEF-025/-CEF-030	Protection	UNICEF	20-RR-CEF-025/-CEF-030	Protection
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health

20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene	UNICEF	20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene
20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene	UNICEF	20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene
20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene	UNICEF	20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene
20-RR-CEF-025/-CEF-030	Child Protection	UNICEF	20-RR-CEF-025/-CEF-030	Child Protection
20-RR-CEF-025/-CEF-030	Child Protection	UNICEF	20-RR-CEF-025/-CEF-030	Child Protection
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene	UNICEF	20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene	UNICEF	20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene
20-RR-CEF-025/-CEF-030	Child Protection	UNICEF	20-RR-CEF-025/-CEF-030	Child Protection
20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene	UNICEF	20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene
20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene	UNICEF	20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health

20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Health	UNICEF	20-RR-CEF-025/-CEF-030	Health
20-RR-CEF-025/-CEF-030	Nutrition	UNICEF	20-RR-CEF-025/-CEF-030	Nutrition
20-RR-CEF-025/-CEF-030	Nutrition	UNICEF	20-RR-CEF-025/-CEF-030	Nutrition
20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene	UNICEF	20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene
20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene	UNICEF	20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene
20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene	UNICEF	20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene
20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene	UNICEF	20-RR-CEF-025/-CEF-030	Water, Sanitation and Hygiene