UGANDA
UNDERFUNDED EMERGENCIES
ROUND II
DISPLACEMENT
2020

20-UF-UGA-45310

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PART I – ALLOCATION OVERVIEW

Reporting Process and Consultation Summary:		
Please indicate when the After-Action Review (AAR) was conducted and who participated.	28 January 2021	
N/A		
Please confirm that the report on the use of CERF funds was discussed with the Humanitarian and/or UN Country Team (HCT/UNCT).	Yes ☒	No ☐
Please confirm that the final version of this report was shared for review with in-country stakeholders (i.e. the CERF recipient agencies and their implementing partners, cluster/sector coordinators and members and relevant government counterparts)?	Yes ☒	No ☐

1. STRATEGIC PRIORITIZATION

Statement by the Resident/Humanitarian Coordinator:

As the UN Resident Coordinator in Uganda, I am pleased to introduce the final RC/HC report within the CERF UFE allocation of US$ 4,999,336 to humanitarian operations in Uganda implemented by UNFPA, UNHCR, UNICEF, UN Women and WHO.
I want to appreciate our partners who have joined the meeting and who have been critical in delivering this assistance. This CERF allocation aimed to address urgent needs related to displacement and the impact of the COVID-19 pandemic on the most vulnerable people. It focused on a multi-sectoral response to the rise in GBV, triggered by displacement, and exacerbated by COVID-19.

CERF funds supported protection interventions in the underfunded refugee settings. Implementing agencies scaled-up GBV prevention and response to refugees – including case management and child protection case management. UNHCR offered legal aid clinics and Mobile Courts in refugee settlements to bring services closer to communities and improve access to justice; WHO supported surveillance and COVID-19 testing for better management of GBV; UNICEF provided life-saving nutrition services to the most vulnerable families in refugee hosting districts and in Kampala; and UNFPA supported improved SRHR and GBV service provision in refugee hosting districts, as well as strengthening demand for SRHR and GBV services.

CERF's Added Value:

- CERF enabled UN and partners to respond to current and urgent SRHR and GBV needs of women and girls in the refugee settlements and the host communities. Trainings and support provided contributed towards an increased quality of care.
- CERF enabled urgent response to the impact of COVID-19 on the protection of refugees, particularly women and children in Uganda. Multi-purpose cash assistance to women at risk had a great impact on the lives of most vulnerable women and girls. CERF supported in strengthening the case management through additional recruitment and establishment of one-stop centres.
- CERF scaled up of SAM management services to increase the current 21 percent coverage by allocating more funding for RUTF procurement, family led MUAC and other simplified approaches in the country.
- Strengthened the community engagement and mobilization, social and behaviour change for the prevention and timely identification and care for SAM.
- Prioritised funding for integrated psycho-social, stimulation and play for SAM care and prevention at facility and community level.
- CERF enabled prompt deployments of Ministry of Health staff and WHO to also address cholera outbreak among the refugees in Nakivale settlement.

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

Yes ☒ Partially ☐ No ☐

CERF enabled UN and partners to respond to current and urgent SRHR and GBV needs of women and girls in the refugee settlements and among the host communities. Trainings and support provided contributed towards an increased quality of care. CERF addressed urgent response to the impact of COVID-19 on the protection of refugees, particularly women and children in Uganda.

Did CERF funds help respond to time-critical needs?

Yes ☒ Partially ☐ No ☐

CERF enabled UN and partners to respond to current and urgent SRHR and GBV needs of women and girls in the refugee settlements and among the host communities, addressing multi-purpose cash assistance

Did CERF improve coordination amongst the humanitarian community?

Yes ☐ Partially ☒ No ☐

CERF AAR informed that CERF created a space for a need for an increased coordination among UN agencies in terms of how the UN system implements GBV activities. While dedicated for a exist such as the Human Rights and Gender Group of the UNCT (chaired by OHCHR and UNWOMEN), the CERF related GBV coordination has been hosted within the Refugee Response coordination sub-group

chaired by UNFPA and UNHCR with the UNFPA as the established global sector lead of the GBV emergency response including Child Protection sector led by UNICEF and UNHCR as two strong mechanisms operating in the refugee context. These also include health and nutrition sectors. UNCT recommended to take this discussion forward.

Did CERF funds help improve resource mobilization from other sources?

Yes ☒ Partially ☐ No ☐

CERF served as the catalytic seed funding to roll out critical interventions and allowed agencies to leverage from donors for additional resources. CERF also allowed to mobilize additional partnerships, e.g., national NGOs focusing on disabilities (UNWOMEN). Informed by CERF outcomes and AAR consultations, UNHCR as the lead for refugee response committed to look at innovative ways to mobilize resources. CERF agencies have also underlined the continued critical role of the RC in leading efforts that enable agencies to mobilize resources.

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

Support for women and girls, including tackling gender-based violence, reproductive health and empowerment:
The COVID-19 pandemic created a national humanitarian situation for Uganda, including the upsurge in GBV, both in refugees settlements and in urban hot spot areas. This required immediate coordinated humanitarian response within the UN as well as with government actors and civil society. The UN Country Team launched an Emergency Appeal on COVID-19 with the aim of mobilizing US$316M to support 12.8 million people (approx. 52% women and girls). Considerable funding gaps remained. The CERF allocation has been envisaged to scale-up critical interventions prioritized by the UNCT.

Funding Envelope for Gender-based Violence Programming:

CERF has served as the catalytic seed funding to roll out critical interventions allowing agencies to leverage the resources and partnerships also building on the UN agencies presence in the field. CERF has enabled to respond to the impacts of COVID-19 on the protection of refugees, particularly women and children. CERF emergency funding allowed the UN system and partners to quickly support people that have been affected by the pandemic, and also learning that working through a local organization to ensure better reach to beneficiaries in the communities, especially those living with disabilities.

UNFPA: a total of 63,504 people (18,946 refugees (30%); 44,558 nationals (70%)) enjoyed improved SRHR and GBV services across 28 health facilities.

UNICEF: The project provided lifesaving support for the management of Severe Acute Malnutrition (SAM) in children under five years in refugee-hosting districts of Kampala, Adjumani, Lamwo, Yumbe, Obongi, Kikuube, Kamwenge and Kyegegwa.
Focused mostly on the procurement and last mile distribution of therapeutic foods—RUTF, F100, F75 and ReSoMal.
Residual support on capacity building of health workers in the National Referral Hospitals of Mulago, Kawempe, Naguru in Kampala on the updated Integrated Management of Acute Malnutrition (IMAM).

[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.

UNWOMEN: Three-fold Programme approach for addressing SGBV in the context of Covid-19: 1) increased access to emergency SGBV services through integrated and survivor-centered life-saving service delivery; 2) strengthened capacity of existing community-based mechanisms for enhanced protection, prevention and response to SGBV; and 3) reduced GBV risks by supporting access to time-critical, life-saving, protection services as well as unrestricted, multi-purpose cash transfers for access to basic life-saving needs, and livelihoods for GBV survivors.

WHO: 100,000 tests of Biosensor (Standard Q COVID 19 RDT test kit) procured and provided to support response; 10,000 BGI Real-time fluorescent RT-PCR kit for detecting 2019-nCoV and related accessories with procured and provided to diagnostic laboratories in the catchment of the refugee settlements; 5 short term staff were recruited and deployed in West Nile and Acholi operations areas; Prompt deployments of Ministry of Health staff and WHO were conducted to address cholera outbreak among the refugees in Nakivale settlement.

Table 1: Allocation Overview (US$).

Total amount required for the humanitarian response	**316,000,000**
CERF	4,999,336
Country-Based Pooled Fund (if applicable)	N/A
Other (bilateral/multilateral)	N/A
Total funding received for the humanitarian response (by source above)	4,999,336

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

Agency	Project Code	Sector/Cluster	Amount
UN Women	20-UF-WOM-004	Protection - Gender-Based Violence	960,054
UN Women	20-UF-WOM-004	Multi-Purpose Cash	240,014
UNFPA	20-UF-FPA-035	Health	489,499
UNFPA	20-UF-FPA-035	Protection - Gender-Based Violence	209,785
UNHCR	20-UF-HCR-028	Protection - Gender-Based Violence	1,200,000
UNHCR	20-UF-HCR-028	Protection	600,000
UNHCR	20-UF-HCR-028	Protection - Child Protection	200,000
UNICEF	20-UF-CEF-055	Nutrition	600,000
WHO	20-UF-WHO-035	Health	499,984
Total			**4,999,336**

Table 3: Breakdown of CERF Funds by Type of Implementation Modality (US$)

Total funds implemented directly by UN agencies including procurement of relief goods	**2,440,980**
Funds sub-granted to government partners*	229,442
Funds sub-granted to international NGO partners*	1,426,325
Funds sub-granted to national NGO partners*	902,589

Funds sub-granted to Red Cross/Red Crescent partners*	0
Total funds transferred to implementing partners (IP)*	**2,558,356**
Total	**4,999,336**

* 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.

2. OPERATIONAL PRIORITIZATION:

Overview of the Humanitarian Situation:

Uganda faced significant humanitarian needs because of the Covid-19 crisis as well as displacement. It registered its first case on 21 March 2020. By August 2020, Uganda had registered 1,313 cases, including 58 refugees and 55 children, and nine deaths (as of 12 August). Hotspots included border communities and Kampala. The pandemic had far-reaching socioeconomic impacts and disproportionally impacted vulnerable groups, exacerbated already high levels of gender-based violence (GBV). GBV cases increased during the lockdown period: GBV Shelters experienced a 60.5 percent increase (March to June). In refugee communities, the reported cases of GBV increased by 55 percent. The pandemic occurred against the backdrop of one of the world's largest refugee responses – Uganda hosts 1.4 million refugees the largest in Africa (82 percent women and children) – and emerging humanitarian emergencies, including devastating floods and landslides (affecting 55 districts, 470,825 people, displacing 66,860) as well as new swarms of Desert Locusts (threatening the food security of 1.32 million people). The delivery of essential and lifesaving services, including essential GBV and SRMH services, and social protection were disrupted, resulting in long-term impacts and loss of life for affected communities. Many protections, legal aid and psychosocial support service providers were restricted to remote services, limiting access by the most vulnerable and worsening already low levels of reporting and help-seeking behaviour. There was a decline in utilization of antenatal care and facility deliveries in refugee hosting districts since onset of COVID-19, as well as among adolescents nationally. and the number of reported maternal deaths since the COVID-19 lockdown were increased by 7 percent. By June 2020, 54 percent of refugees in settlements and 26 percent of host communities had inadequate food consumption, with relatively worse consumption in female-headed households. Stunting was also reported (up to 32.6 percent) in six refugee settlements. Economic loss and hunger exacerbate existing protection risks, leading to child labour, GBV, transactional sex and trafficking, SEA, and child marriage. COVID-19 also negatively impacted food security and livelihoods – especially for women and youth, who make up 86 percent of the informal sector, urban slum residents, and refugees. Access to and consumption of nutritious foods fell; the proportion of urban Uganda nationals with poor or borderline food consumption increased from 11 percent to 16 percent between May to June 2020.

Operational Use of the CERF Allocation and Results:

This allocation was part of the second UFE round of 2020. It aimed to address the needs related to displacement and the impact of the COVID-19 pandemic on the most vulnerable people. It focused on a multi-sectoral response to the rise in GBV, triggered by displacement, and exacerbated by COVID-19. Activities targeted refugee settlements and urban "hot spot" areas and included: Protection, SGBV Coordination and response in refugee settlements, health, and food security and nutrition in hot spot areas including refugee camps, People with Disabilities. Uganda hosts 1.4 million refugees (82% are women and children), the largest caseload in Africa, and CERF funds supported protection interventions in these underfunded refugee settings. CERF funding also enabled agencies to scale-up GBV prevention and response to refugees – including case management and child protection case management. UNHCR offered legal aid clinics and Mobile Courts in refugee settlements to bring services closer to communities and improve access to justice; WHO supported surveillance and COVID testing for better management of GBV; and UNICEF provided life-saving nutrition services to the most vulnerable families in refugee hosting districts and in Kampala. The CERF allocation was implemented in eight districts of Uganda: Kampala and surrounding urban areas as well as in seven refugee settlements in Bidibidi, Adjumani, Palorinya, Palabek; Kyangwali, Rwamwanja and Kyaka II, and targeted 400,000 people. The target population included an estimated 36,000 persons living with disabilities in eight districts. the elderly, women and girls, refugees, widows, female-headed households, market women, street vendors, people living with HIV and TB, and migrants.

People Directly Reached:

- The number of people directly assisted with CERF fund, by cluster/sector (presented in Table 4) was estimated by taking the figures reported by the UN agency that reached the largest population. This was the case where more than one agency had interventions in the same sector/cluster. But in instance where a single UN agency implemented activities in a particular sector/cluster, that agency's figures were reported. This reduced the risk of double counting.
- For figures reported in Table 5, we considered the agency that reached the largest number of people per category in each sector/cluster. The same criteria were applied to figure reported in table 6.

People Indirectly Reached:

The project indirectly benefited 3,026,769 people. A total of 112,479 women, men, boys, and girls were reached thorough messaging on gender-based violence awareness. These were reached by duty bearers, He or She champions that were directly supported by the project. This resulted into improved knowledge on GBV, women's rights and improved understanding of domestic violence law and punishment. Another 3,000,000 people are estimated to have been reached through radio and Television programs with messages on SGBV and PSEA.

Through the multipurpose cash transfer, the project is estimated to have benefited 16,302 who are household members of the cash transfer beneficiaries. Multipurpose cash transfer beneficiaries used the money to meet basic needs in the home and establish income generating enterprises from which they can support their families.

A large population in the districts benefited from the surveillance systems established by the short-term staff. This is estimated at approximately 70,000 individuals.

Table 4: 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**
Health	34,404	3,602	39,096	1,090	78,192	93,578	5,467	22,597	1,284	**122,926**
Nutrition	0	0	4,240	4,074	8,314	0	0	4,243	6,503	**10,746**
Protection	7,338	6,338	7,657	6,817	28,150	3,263	875	2,094	2,094	**6,985**
Protection - Gender-Based Violence	0	3,602	4,240	4,074	11,916	46,040	562	14,406	104	**61,112**

* 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.

Table 5: Total Number of People Directly Assisted with CERF Funding by Category*

Category	Planned	Reached
Refugees	107,287	58,400
Returnees	0	0
Internally displaced people	0	0
Host communities	51,230	69,526
Other affected people	500	7,450
Total	**159,017**	**135,376**

Table 6: 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	74,241	93,578	2,008	1,246
Men	13,542	12,698	385	146
Girls	55,233	22,597	617	286
Boys	16,001	6,503	219	154
Total	**159,017**	**135,376**	**3,229**	**1832**

3. LESSONS LEARNED:

- Continued and more focused support towards GBV
- Targeted youth friendly services required
- Prioritisation of health system strengthening, continued advocacy for budget allocations
- Enhanced sustainability of interventions
- Holistic approach around cash support
- Strengthen community engagement and mobilization, social and behaviour change for the prevention
- Prioritise funding for integrated psycho-social support
- Increased need to protect PwD being disproportionately affected by lockdown restrictions
- Supplies to refugees should be delivered through dedicated mechanisms to prevent unnecessary delays and/or loss

OBSERVATIONS FOR THE CERF SECRETARIAT

Lessons learned	Suggestion for follow-up/improvement
Resource mobilization	While CERF plays a catalytic role, seek opportunities for RM that contribute to the sustainability of interventions, building on successes of CERF outreach to new and existing donors. Seek any additional CERF funding opportunities as needs remain.

Lessons learned	Suggestion for follow-up/improvement
Enhancing GBV coordination	Engage UNCT in consultations on how to bring better coherence between sector GBV coordination within Refugee Response led by UNFPA and UNHCR and UN Human Rights and Gender Group led by OHCHR and UNWOMEN. It has been agreed to make use of the existing platforms to a best extent.
Resource mobilization	While CERF plays a catalytic role, seek opportunities for RM that contributes to sustainability of interventions, building on successes of CERF outreach to new and existing donors. Seek any additional CERF funding opportunities as needs remain.
Coordination	Enhance programmatic coordination / planning structures/mechanisms in ways that enhance operational effectiveness and build on agencies strengths. Stronger coordination and planning will better complement the resource distribution process of the CERF and minimize the 'political' challenges of funds distribution among agencies.
Equity	It was also discussed and proposed to ensure equity so that there is a balanced approach in prioritization of needs, people in need across the country, across various sectors, etc.

PART II – PROJECT OVERVIEW

4. PROJECT REPORTS

4.1 Project Report 20-UF-WOM-004

1. Project Information

Agency:	UN Women	**Country:**	Uganda
Sector/cluster:	Protection - Gender-Based Violence Multi-Purpose Cash	**CERF project code:**	20-UF-WOM-004
Project title:	Emergency Protection and GBV Response for Women and Girls in Host Communities and GBV Shelters.		
Start date:	17/11/2020	**End date:**	16/11/2021
Project revisions:	No-cost extension ☒ Redeployment of funds ☐ Reprogramming ☐		

Funding		
	Total requirement for agency's sector response to current emergency: **GUIDANCE**: Figure prepopulated from application document.	**US$ 12,000,000**
	Total funding received for agency's sector response to current emergency: **GUIDANCE**: Indicate the total amount received to date against the total indicated above. Should be identical to what is recorded on the Financial Tracking Service (FTS). This should include funding from all donors, including CERF.	**US$ 4,500,000**
	Amount received from CERF:	**US$ 1,200,068**
	Total CERF funds sub-granted to implementing partners: **GUIDANCE**: Please make sure that the figures reported here are consistent with the ones reported in the annex.	**US$ [865,791]**
	Government Partners	US$ [210,998]
	International NGOs	US$ [355,608]
	National NGOs	US$ [299,185]
	Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through this CERF UFE grant, UN Women and its partners provided life-saving unrestricted multi-purpose cash transfers to 3,677 people, including 403 PWDs, 164 girls and 81 boys with disabilities to reduce economic stress that renders them vulnerable to gender-based violence (GBV).

Access to justice was enhanced for 7,961 women and girls SGBV survivors through provision of legal aid services. The legal aid services enabled timely access to justice through provision of on spot legal advice because of the mobile legal aid clinics; securing of convictions because of legal representation being availed while justice was also enhanced through plea bargain sessions, which resulted in conviction of accused persons who were willing to admit their wrongdoing and serve sentences. Peaceful coexistence has also been enhanced and relationships restored through mediation as perpetrators recognised their respective misdeeds and asked for forgiveness from their complainants. Mediation contributed to speedy resolution of cases thereby promoting reconciliation and peaceful coexistence between conflicting parties.

12,556 GBV survivors are in a better state of mind having received mental health psychosocial support and trauma counselling, which enabled them to adopt better coping mechanisms. 83.8% of the participants in the Cognitive Behavioural Therapy (CBT) sessions have reported a significant reduction in depression, anxiety, and stress symptoms as well as increase in life satisfaction levels. The intervention helped them realize their potentials, whereby some of the beneficiaries have participated in leadership positions due to this empowerment.

190 women were offered emergency medical aid, 337 received emergency shelter through GBV shelters; 1,725 women and girls were referred to access other services; 115 men were trained as male champions to advocate for ending GBV; 531 community-based actors and key duty bearers were trained on GBV prevention, identification, and response; and a total number of 112,479 women, men, boys, and girls were reached with GBV and SEA prevention messages.

In total, the project directly assisted 26,446 women and girls with emergency GBV services: including 843 people with disabilities. GBV and PSEA messaging reached total number of 112,479 women, men, boys, and girls.

3. Changes and Amendments

Uganda experienced the second wave of COVID-19 and the 45 days lockdown that was instituted by the government from June 6 – August 2, 2021. Whereas the lockdown slowed down the implementation of project activities, UN Women worked with Implementing Partners to develop business continuity plans to ensure timely completion of the planned activities. The lockdown further increased the need for Mental Health and Psychosocial Support (MHPSS) services, GBV cases and affected business, which made the project interventions not only relevant but very timely. Working with the existing community structures such as the Volunteer Psychosocial Assistants (VPAs), paralegal, Village Health Teams (VHTs) and became a bridge between the project and the beneficiaries during this lockdown period. Implementing partners also adopted alternative and safer implementation strategies that involved virtual engagements and smaller cluster training where appropriate. Furthermore, the continued closure of some sections of the economy increased the economic distress of women and girls.

There was an overachievement in the number of PWDs reached (700 planned and 843 reached) due to the increased vulnerability that the lockdown instituted on their already existing vulnerability. This slightly raised the number of those supported by multipurpose cash (2800 target and 3677 achieved). Additionally, the project did not target to support refugees, but due to the increased vulnerability for refugee women and girls in Kampala, the project reached 595 refugee women and girls with multipurpose cash and GBV services.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Protection - Gender-Based Violence									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	195	0	0	0	**195**
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	11,000	0	6,000	0	**17,000**	10,000	800	5000	184	**15,984**
Other affected people	4,300	0	2,070	0	**6,370**	4200	64	2326	0	**6,590**
Total	**15,300**	**0**	**8,070**	**0**	**23,370**	**14,395**	**864**	**7326**	**184**	**22,769**
People with disabilities (PwD) out of the total										
	300	0	100	0	**400**	**309**	**124**	**0**	**0**	**449**

Sector/cluster	Multi-Purpose Cash									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	400	0	0	0	**400**
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	1,000	0	500	0	**1,500**	2160	0	300	0	**2,460**
Other affected people	1,000	0	300	0	**1,300**	572	0	164	81	**817**
Total	**2,000**	**0**	**800**	**0**	**2,800**	3132	0	**464**	**81**	**3677**
People with disabilities (PwD) out of the total										
	200	0	100	0	**300**	152	0	161	81	394

* 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

The project indirectly benefited 3,026,769 people. A total of 112,479 women, men, boys, and girls were reached thorough messaging on gender-based violence awareness. These were reached by duty bearers, He or She champions that were directly supported by this project. This has resulted into improved knowledge on GBV, women's rights and improved understanding of domestic violence law and punishment. Another 3,000,000 people are estimated to have been reached through radio and Television programs with messages on SGBV and PSEA.

A large population in the districts benefited from the surveillance systems established by the short-term staff. This is estimated at approximately 70,000 individuals.

Through the multipurpose cash transfer, the project is estimated to have benefited 16,302 who are household members of the cash transfer beneficiaries. Multipurpose cash transfer beneficiaries used the money to meet basic needs in the home and establish income generating enterprises from which they can support their families.

6. CERF Results Framework

Project objective	[To enhance Protection of the most vulnerable women and girls affected by impacts of Covid-19, GBV and SGBV in urban Kampala and host communities in Uganda's refugee-hosting districts]
Output 1	[Increased access to emergency SGBV services through integrated and survivor-centered life-saving service delivery]

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

Sector/cluster	Protection - Gender-Based Violence			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	[Number of women and girls accessing life-saving mental and psychosocial support services]	[13,270]	13,083	[IP progress and activity reports, client database, IP client case files, admission forms]
Indicator 1.2	[Number of women and girls accessing legal services]	[9,700]	7,961	[IP Activity reports, IP quarterly and annual report]
Indicator 1.3	[Number of women and girls accessing lifesaving GBV response services through referrals]	[400]	1,725	[IP referral forms and register]
Explanation of output and indicators variance:		The 2021 surge in COVID-19 cases led to a national 45-day lockdown which affected the program. The lockdown and travel restrictions made it challenging for survivors to access services. The courts were non-functional during the lockdown; access to GBV shelters in the night was a big challenge for both the shelter staff and survivors. Some of the cases of violence are reported to happen in the night during curfew time but due to travel restrictions, it was challenging to offer timely services to survivors. Perpetrators in GBV cases dishonored invitations for mediation, complicating the process of dispute resolution. At the beginning of the project, it was quite hard to collaborate with husbands of the women GBV survivors as interaction with the women was causing continued risk for the women which limited their ability to access MHPSS.		
Activities	**Description**		**Implemented by**	

Activity 1.1	[Provide lifesaving psychosocial services to GBV survivors, to include individual and community-based counselling and psycho-economic activities in host communities including in GBV Shelters]	Action Aid International Uganda (AAIU), Tunaweza Foundation (Tunaweza), Transcultural Psychosocial Organization (TPO), Uganda Network on Law, Ethics and HIV/AIDS (UGANET)
Activity 1.2	[Provide Legal Aid support services to SGBV survivors, including toll free line, mobile aid clinics, referrals, case management and court assistance to women and girls in host communities including in GBV shelters]	Uganda Network on Law, Ethics and HIV/AIDS, Refugee Law Project, School of Law, Makerere University (RLP), Action Aid International Uganda
Activity 1.3	[Provide Referrals for women and girls GBV Survivors in host communities and GBV shelters to access life-saving services including health, security, CMSRH, nutrition support and livelihoods support	Tunaweza Foundation, Transcultural Psychosocial Organization

Output 2	[Strengthened capacity of existing community-based mechanisms to enhance protection and prevent and respond to SGBV]
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Multi-Purpose Cash

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	[Number of women and girls (inc men and boys) sensitized on SGBV and PSEA]	[34,000]	112,479 (4,173 M and 108,306 F)	IP Activity reports, IP quarterly and annual report
Indicator 2.2	[Number of key duty bearers trained on gender, GBV, PSEA and women's/human rights]	[100]	457	IP training reports, IP quarterly and annual report
Indicator 2.3	Number of community support structures such as paralegals and volunteer psychosocial counsellors trained]	[80]	74	IP training reports, IP quarterly and annual report
Explanation of output and indicators variance:		The project adopted mass media for sensitizations. Radio was the main channel used to raise awareness on SGBV. While overall more people are estimated to have been reached through radio and TV. There was increased need to train duty bearers on GBV response since they were frontline and essential workers, hence increasing the achievement as per set targets.		

Activities	**Description**	**Implemented by**
Activity 2.1	[PSEA and SGBV awareness raising within communities, Shelters and including engaging men and boys (HeForShe)] This will increase knowledge and awareness of communities on SGBV prevention and associated risks; it will empower women and girls to identify SGBV as human rights issues and enable them to detect and mitigate risks of SGBV in their communities. This will improve confidence and collective efforts to report any incident of SGBV in their community. Awareness raising on PSEA provides a duty of care to beneficiaries and also ensures that in all of the interventions, women, men, boys and girls are aware of their rights and are treated with respect and dignity.	Uganda Network on Law, Ethics and HIV/AIDS, Tunaweza Foundation, Transcultural Psychosocial Organization, Refugee Law Project, School of Law, Makerere University, Institute for Social Transformation (IST), Action Aid International Uganda

	Moreover, all aid workers maintains a certain minimum standards of behavior in carrying out their responsibilities to the persons of concerns (POCs).	
Activity 2.2	[Build capacity of and awareness-raising for the host community leaders on issues of gender, SGBV and women's/human rights] This will increase local leaders' sensitivity to women and girls issues and instill in them a sense of responsibility for respect of the rights of women and girls, and response to SGBV. This will also support their ability to take action and facilitate enhanced access to services available including sensitization of community against SGBV.	Uganda Network on Law, Ethics and HIV/AIDS, Tunaweza Foundation, Transcultural Psychosocial Organization, Refugee Law Project, School of Law, Makerere University, Action Aid International Uganda
Activity 2.3	[Support to community based SGBV protection mechanisms such as para legal and volunteer psychosocial assistants with airtime, transport to facilitate their response to GBV] This will strengthen referral mechanisms, reporting and utilization of available comprehensive SGBV services that demonstrates the illegality of such acts thereby reducing SGBV in the community	Transcultural Psychosocial Organization, Refugee Law Project, School of Law, Makerere University

Output 3	Reduce GBV risks by supporting access to protection, time-critical life-saving unrestricted multi-purpose cash transfers for access to basic needs, and livelihoods for survivors of GBV. This will enable survivors to for example secure residential housing away from perpetrators, enable them access food, clothing and other lifesaving needs as a way of regaining and sustaining recovery, self-confidence, self-reliance and attainment of their dignity.

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

Sector/cluster				
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	[Number of women and girls Identified in need of support for multipurpose cash transfer]	[2,800]	**3677**	IP beneficiaries list, IP training and mentoring reports
Indicator 3.2	[#of women and girls' survivors of SGBV supported with multipurpose cash transfer]	[2,800]	**3677**	IP beneficiaries list, IP training and mentoring reports
Indicator 3.3	[Number of women and girls' survivors of SGBV trained in Financial literacy and linked to livelihoods opportunities]	[2800]	**3677**	IP training repots and attendance lists, IP training and mentoring reports

Explanation of output and indicators variance:	The 45 days COVID-19 lockdown that was instituted from June – to August 2021 and the continued closure of some sections of the economy exacerbated the socioeconomic condition of women and girls in need of economic support. The needs of the identified women and girls in some instances were greater than the planned amounts that had been initially set out for the multipurpose cash payment, especially in instances where cash transfer disbursements were made based on needs assessment of each woman. This led to an increase in the overall number of women and girls that received the cash transfer.

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

Activity 3.1	[Identification of women, and girls in need of support for multipurpose cash transfer]	Uganda Network on Law, Ethics and HIV/AIDS, Tunaweza Foundation, Institute for Social Transformation (IST), Transcultural Psychosocial Organization, Care International Uganda (Care)
Activity 3.2	[Support for women and girls SGBV survivors with multipurpose cash transfer]	Uganda Network on Law, Ethics and HIV/AIDS, Tunaweza Foundation, Institute for Social Transformation (IST), Transcultural Psychosocial Organization, Care International Uganda (Care)
Activity 3.3	[Financial literacy training and linkages to livelihoods opportunities for women and adolescent beneficiaries if multipurpose cash as an exit strategy]	Uganda Network on Law, Ethics and HIV/AIDS, Tunaweza Foundation, Institute for Social Transformation (IST), Transcultural Psychosocial Organization, Care International Uganda (Care)
Activity 3.4	Provide technical support for mainstreaming of gender into GBV response in refugee, and host communities, including in GBV Shelters	UN Women

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[2] 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 addressed through project activities and should highlight the achieved impact wherever possible.**

a. Accountability to Affected People (AAP) [3]:

The project organized awareness meetings at the start of the project at the district and community levels. Due to COVID-19, large gatherings were not allowed and more, smaller-scale community meetings were held. This approach enabled targeted populations, local community structures such as the local council leaders, Refugee welfare council committees and leaders to be informed about the project. State actors such as the police, judiciary, Office of the prime minister, District leadership were also informed and kept updated on the implementation of the project activities. The process of identifying multipurpose cash transfer beneficiaries was collaboratively done with support the local structures and after every disbursement, a mini-post distribution exercise was done to collect feedback from beneficiaries. Community support structures supported the identification and making referrals for all persons of concern with any form of vulnerabilities. IP Staff were oriented on the provision of appropriate services to beneficiaries bearing in mind the Leave No One Behind principle.

b. AAP Feedback and Complaint Mechanisms:.

[2] 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.

[3] 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 utilized the existing community structures that include LCs, Paralegals and RWCs as feedback mechanisms. Additionally, the project included a mini-post distribution exercise after every cash disbursement and closed WhatsApp group communication incorporating community-based facilitators and Community Development Officers. UN Women implementing partners recommend integrating a robust feedback mechanism with other systems such as the UNHCR feedback reporting and response Mechanism for more client responsible programming

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

UN Women has intethe rnal expertise to advance PSEA in Uganda and is a member of the National and local PSEA networks through the RCO and UNACs at the field level. UN Women engaged these forums to provide technical expertise and to share information on cases of PSEA and strategies and support the joint implementation of PSEA activities. The networks utilized agreed and standardized SOPs for receiving, recording, and reporting of PSEA networks.

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

The project's main objective was to enhance SGBV protection and services for women and girls in host communities and GBV Shelters in Kampala. The overall goal was to enhance life-saving protection services for the most vulnerable women and girls and promote the adequate integration of gender equality and women's empowerment. The project used a holistic approach to gender equality and women empowerment: it combined economic support to women with improved access to GBV services, both by raising awareness among communities on GBV and by training key duty bearers, both on GBV and mental health, increased access to legal aid was also ensured. Finally, the women that received cash transfers, and were able to empower themselves economically, also participated in financial literacy training and leadership training, and joined together in groups, supporting each other financially and emotionally.

e. People with disabilities (PwD):

UN Women partnered with Tunaweza foundation for this project, who work specifically with people with disabilities. They have targeted women and families of children with disabilities for their activities in the Kampala area. Because of COVID-19, the team of Tunaweza had to do outreach in the communities, going door to door, instead of organizing big events at their own office. This approach enabled them to reach more PWDs who would otherwise not come to organized activities due to limited mobility, fear of stigma and lack of other care options for their children. Tunaweza staff also includes PwDs which enabled people in the communities to see them play a visible role as champion for PWDs thereby improving the self-esteem of PWDs and increasing their participation in activities. The provision psychosocial support and legal aid services by TPO and RLP also ensured inclusion of PWDs.

f. Protection:

The project ensured that activities related to protection were integral in all project interventions, and ensured that awareness on SGBV, PSEA, women's rights were incorporated in training targeting beneficiaries. This helped to mitigate exposure to risk and promote household dialogue that reduced conflicts in the households because of joint decision-making on cash use.
At the GBV shelters supported through CERF funding, all survivors regardless of their gender, age, disability, HIV status, employment status and education level, accessed legal aid and medical support which enhanced access to justice for survivors.

The project included vulnerable urban refugee women and girls who often are not identified for support because they do not live in designated refugee settlements. As a result, 400 Refugee women and girls are now implementing group level projects and individual businesses beyond saving and loaning/ borrowing. Members of the groups have embraced peer to peer skills transfer of different enterprises, for example craft making, tailoring, liquid soap making, jewellery making, bags and food stuff.

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	3677

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.

Vulnerable women and girls have enhanced access to basic needs and reduced negative coping strategies through the receipt of multipurpose cash grants. Multi-purpose cash (MPC) transfers were provided to vulnerable women and girls, particularly those living with disabilities. Identification of the MPC beneficiaries was based on a given criteria developed in a participatory manner with the community and cash transfers were made using mobile money to beneficiary contact numbers.

Beneficiaries of MPC have been linked to either already existing VSLA groups or supported created new groups. A total of 60 new VSLA groups were established while 300 women were linked to existing 30 groups that were already established within their localities. This has enhanced access to savings and loans for members but also provided a support mechanism for vulnerable women and girls. For example, PwD and parents of children with disability have been linked in groups together to advocate for themselves and their families, which has enabled the women in those groups to look out for their group members and speak up for their more vulnerable group members to duty bearers.

As a result of financial literacy training that was provided to MCT beneficiaries, they have been able to start income generating activities. The women reached through this intervention are now implementing group level projects and individual business beyond saving and loans or borrowing and have embraced peer to peer skills transfer of different enterprises, for example craft making, tailoring, liquid soap making, jewellery making, bags and food stuff. 94 businesses belonging to PWDs have been rebirthed following the Covid19 economic depression and 40 new enterprises started.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
Activity 3.2 Support for women and girls SGBV survivors with multipurpose cash transfer	**3677**	US$ 10	Multi-Purpose Cash	Restricted

9. Visibility of CERF-funded Activities

Title	Weblink
CERF Visibility materials	https://unwomen.sharepoint.com/:f:/t/WPSHAUgandaCO/EvIcBX8CvAxOreAOn-XD22oBbpRoEzOMtGHNF9pyfHMttA?e=JeMfVR

4.2 Project Report 20-UF-FPA-035

1. Project Information

Agency:	UNFPA	**Country:**	Uganda
Sector/cluster:	Health Protection - Gender-Based Violence	**CERF project code:**	20-UF-FPA-035
Project title:	Provision of integrated lifesaving SRHR and GBV services in refugee hosting districts in Uganda		
Start date:	23/11/2020	**End date:**	22/11/2021
Project revisions:	No-cost extension ☐ Redeployment of funds ☐ Reprogramming ☐		

Funding

Total requirement for agency's sector response to current emergency: **GUIDANCE**: Figure prepopulated from application document.	**US$ 13,796,891**
Total funding received for agency's sector response to current emergency: **GUIDANCE**: Indicate the total amount received to date against the total indicated above. Should be identical to what is recorded on the Financial Tracking Service (FTS). This should include funding from all donors, including CERF.	**US$ 6,476,692**
Amount received from CERF:	**US$ 699,284**
Total CERF funds sub-granted to implementing partners: **GUIDANCE**: Please make sure that the figures reported here are consistent with the ones reported in the annex.	**US$ 446,245**
Government Partners	US$ [0]
International NGOs	US$ [446,245]
National NGOs	US$ [0]
Red Cross/Crescent Organisation	US$ [0]

2. Project Results Summary/Overall Performance

Through the CERF UFE grant, UNFPA and its implementing partner, the Lutheran World Federation (LWF), supported access to sexual and reproductive health and rights (SRHR) and GBV services in five districts in Uganda (Kikuube, Terego, Yumbe, Adjumani and Obongi), while strengthening capacity of 28 target facilities to provide quality SRHR and GBV services. The project resulted in:

- A total of 63,504 people (18,946 refugees (30%); 44,558 nationals (70%)) enjoying improved SRHR and GBV services in 28 health facilities over the project period. Broken down by services received:
    - Modern family planning services: 34,493
    - Antenatal care (1st visit): 29,011
    - Delivery services: 29,499
    - Postnatal care: 39,315
    - GBV services: 1,690

Service provision was strengthened through the dispatch of 13 midwives, strengthened referral systems through the engagement of 5 ambulances, the training of 145 health workers and support to conduct regular Maternal and Perinatal Death Surveillance and Response (MPDSR) committee meetings, including follow up regarding implementation of identified recommendations.
Communities in the five target districts were engaged through community dialogues and health education sessions to strengthen demand for SRHR and GBV services.

- 150 community volunteers were trained on SRHR and GBV and reached 135,311 individuals through community dialogues.
- 59,422 women were reached with SRHR/GBV and PSEA information, 170% higher than the target of 21,987, through the introduction of regular health education sessions conducted at the health facilities, in addition to the planned outreach activities.

In total, the project enabled 122,926 people (female=116,175; male=6,751) to access SRHR/GBV services and information in targeted areas. This represents a reach of 142% of the planned beneficiary target (86,274) while the utilisation of SRHR and GBV services increased by 6.2% and 142%, respectively, compared to the baseline.

3. Changes and Amendments

- As reported in the interim report, UNFPA engaged LWF as the sole IP for the project as LWF had a presence in all project locations, thereby supporting efficient coordination and use of funds.
- The strict COVID-19 restrictions introduced by the Government of Uganda in June-July 2021 slowed the rate of implementation, although through amended modalities, project targets were achieved. Trainings were conducted in smaller groups, and for integrated outreaches, closer collaboration with Village Health Teams (VHT) and other community volunteers ensured that communities were aware of ongoing activities and service provision and received information regarding COVID-19 measures and precautions. The change in modalities and delays in implementation resulted in savings across activities implemented by LWF.
- The pandemic affected the procurement of ERH kits. Delays were experienced both due to the impact on suppliers and global shipping. While procurement was completed, several kits were only received in November 2021 and the final kits distributed to target health facilities in late January 2022. The cost of shipping increased significantly early in the project period. UNFPA adjusted procurement plans accordingly, however, due to delays in the supply chain, these costs had reduced at the time of shipping. Consequently, UNFPA has savings under the procurement budget. Delays in the hiring of the GBV Analyst (Yumbe) further resulted in savings under the HR budget line.
- UNFPA will return unspent funds in the amount of USD 20,741. 75% will be refunded following submission of the interim certified financial reports on 15th February 2022, and the remaining balance at the end June following submission of the certified final report.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	34,465	4,063	7,931	1,251	**47,710**	40,798	1,981	12,110	511	**55,400**
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	27,858	3,285	6,410	1,011	**38,564**	52,780	3,486	10,487	773	**67,526**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**62,323**	**7,348**	**14,341**	**2,262**	**86,274**	**93,578**	**5,467**	**22,597**	**1,284**	**122,926**
People with disabilities (PwD) out of the total										
	1,246	146	286	45	**1,723**	9,324	651	1,615	153	**11,743**[4]

Sector/cluster	Protection - Gender-Based Violence									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	8,263	1,921	1,902	591	**12,677**	27,184	129	9,611	37	**36,961**
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	6,680	1,552	1,537	478	**10,247**	18,856	433	4,795	67	**24,151**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**14,943**	**3,473**	**3,439**	**1,069**	**22,924**	**46,040**	**562**	**14,406**	**104**	**61,112**
People with disabilities (PwD) out of the total										
	298	69	68	21	**456**	244	67	51	12	**374**[5]

[4] PWDs reached have been estimated using results of a baseline survey conducted by UNFPA in 15 districts in West Nile & Acholi subregion usin the scale developed by the Washington Group on Disability Statistics. Disability is currently not captured in the HMIS system. The baseline survey revealed that 18.8% (F=19.1%, M=11.9%) of clients that received SRHR/GBV services had a disability (UNFPA ANSWER Programme Baseline Survey, 2021). This is a slightly higher rate than that reflected in the Uganda Bureau of Statistics (UBOS) 2019 household survey, which reflected 17% of persons surveyed in Acholi and 13% in West Nile. UNFPA's baseline survey, however, focused on the disability rate of persons who have received SRHR/GBV services at a health facility.

[5] PWDs reached have been estimated using results of a baseline survey conducted by UNFPA in West Nile region that showed 18.8% (F=19.1%, M=11.9%) of clients that received SRHR/GBV services had a disability (UNFPA ANSWER Programme Baseline Survey, 2021). See footnote 4.

* 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

The project strengthened clinical management of rape (CMR) through the training of 105 health workers (69 female; 36 male) working at 73 health facilities across the four districts targeted in West Nile. The trainings targeted predominantly HC III level facilities, but included HC II and referral level facilities, to strengthen GBV response across different levels of service delivery. The project further supported the training of 40 (38 female: 2 male) health workers from 9 health facilities in Post-Abortion Care and Essential Training in Operative Obstetrics (ETOO) in Kikuube district. While the number of persons indirectly benefitting from the SRHR trainings under the project has not been quantified, the trainings provided will contribute to improved service delivery going forward, serving the populations in the catchment areas of the 73 facilities supported.

A further 183 persons, health workers and district local government staff, across the five districts were oriented on the basic principles of MPDSR to improve auditing, follow-up on recommendations and prioritisation of budgeting within the district to ensure capacity to conduct regular audits, thereby contributing to safer and more effective maternal health response across the five districts.

Under activities 1.2 and 2.1, 150 (57 female; 93 male) community volunteers were trained to share SRHR and GBV information on topics such as family planning, prevention, and root causes of GBV, types and effects of GBV, where to obtain GBV services, importance of antenatal care visits, importance of delivery with skilled attendance and HIV prevention. Community health education took place during village meetings, marketplaces, community functions and during community mobilisation for outreaches. Over the project period the community volunteers reported reaching a total of 135,311 (Refugees = 86,724; Nationals = 48,587) persons through community sensitisation activities, not captured in the project achievements reflected below.

6. CERF Results Framework

Project objective	To improve sexual reproductive health and GBV services and service uptake for refugees and host communities in Uganda.
Output 1	Strengthened district response capacity to ensure the provision of lifesaving SRHR services
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	Number of beneficiaries served with SRHR services in target health facilities in the past 12 months.	64,287 (Refugees=27,097, Nationals=37,190)	63,504 (Refugees= 18,946, Nationals= 44,558) (99% achieved)	Health facility records, quarterly reports
Indicator 1.2	Number of pregnant women mapped and linked to care/services	9,200 (Refugees=3878, Nationals=5322)	12,275 (Refugees=9,856, Nationals= 2,419) (133% achieved)	Pregnancy mapping reports
Indicator 1.3	Number of births attended by skilled health personnel in the target districts.	24,616 (Refugees=10376, Nationals=14240)	29,499 (Refugees=8,743, Nationals=20,756) with 8,906 (Refugees= 4,058, Nationals= 4,848) delivering at facilities with a stationed CERF supported midwife. (120% achieved)	Health facility records, quarterly reports
Indicator 1.4	Number of pregnant women (disaggregated by age) referred for emergency obstetric care through the strengthened ambulance system.	994 (Refugees=419, Nationals=575)	1,517 (Refugees= 430, Nationals 1,087) (153% achieved)	Ambulance log sheets
Indicator 1.5	Number of people reached with family planning services (new and continuing users) disaggregated by age	17,505 (Refugees=7,379, Nationals=10,126)	34,493 (Refugees=9,369, Nationals=25,124) (197% achieved)	Health facility records, quarterly reports
Indicator 1.6	Number of health facilities serving refugees that are equipped through the programme to provide essential and emergency lifesaving interventions in reproductive health.	28	28 (100% achieved)	Training reports
Explanation of output and indicators variance:		The number of mothers and infants requiring emergency referral was higher than projected, resulting in a higher number of ambulance referrals than targeted. While maternal and neonatal cases were prioritised, in cases where the ambulance was available and a facility health worker determined the need, the ambulance supported additional emergency referrals. In addition to the 1,517 ambulance referrals reported, an additional 533 emergency referrals were supported through the CERF supported ambulances. These cases included severe anaemia, severe malaria, and accident victims, among others. The long distances between health facilities and referral level		

	facilities, as well as challenging roads, with COVID-19 restrictions periodically restricting transportation, made the presence of an ambulance service particularly valuable. Nationals make up a larger proportion of beneficiaries seeking SRHR services and delivering at health facilities than initially anticipated. This is due to the final selection of facilities. A number of facilities were identified through a needs assessment and based on key SRHR indicators prior to the project start, a further gap analysis and prioritisation in collaboration with District Health Officers (DHO) determined the selection of the 28 target facilities, and the facilities to be prioritised for the CMR and ETOO trainings. The 28 facilities supported serve both refugee and host communities, but several had a higher proportion of nationals making up the catchment population. The inverse can be seen for the pregnancy mapping, which was prioritised in areas within the refugee settlements. UNFPA noted a significant over achievement in the number of persons served with family planning services over the project period. As UNFPA has not seen a significant rate of increase across other indicators, this achievement can be attributed to under-reporting prior to the project start impacting the target baseline; increased awareness of health workers and VHTs to capture actual use of FP through UNFPA advocacy, as well as a shift in attitude among the target population through the ongoing sensitisation through integrated outreaches and health education sessions. 28 health facilities were equipped to provide essential and emergency lifesaving interventions in reproductive health through the provision of dignity kits, ERH kits, tents (2x 24m^2, 3x 48m^2), however, an additional 54 facilities benefitted from trainings. In addition to the planned support, in response to the destruction of a tent functioning as a maternity ward at one of the target facilities, Luru HC III in Palorinya settlement, in a storm in mid-May 2021, the project supported the procurement of an additional 72m^2 tent, and the replacement of a delivery bed and an examination table, both of which were irreparably damaged during the storm. In order to prevent untimely damage to the new tent and ensure the functioning of the maternity ward, UNFPA provided a contribution through own-funds towards strengthening of the tent to better withstand the frequent storms, through the provision of a cement base and thatched roofing. Damage to tents due to storms in areas hosting refugees is a frequent and regular occurrence. As such, a tent provided to Adjumani Hospital through

	the CERF funded project was likewise damaged during a storm in late September 2021. In light of anticipated savings under the procurement budget, the repair and strengthening of the Adjumani Hospital tent was implemented through CERF funds.

Activities	Description	Implemented by
Activity 1.1	Support the provision of youth friendly SRHR/GBV outreach services to the effected populations across the targeted districts to provide services closer to the affected population since distances to health facilities are far for some refugee communities. This entails health facility outreaches where youth are provided with SHRH/GBV information and services (SRHR health education, GBV awareness, STI screening, GBV screening, Family planning services, Antenatal care, postnatal care) and are referred to health facilities for follow up or more advanced procedures.	Lutheran World Federation; District Local Governments
Activity 1.2	Community information and health education. This activity involves, sensitisations by implementing partners in all target districts and settlements through drama groups, out reaches by community volunteers, community dialogues. Expected outcome is to improve awareness of GBV/SRHR/PSEA, challenge gender norms and empower communities, prevent GBV and to improve uptake of GBV and SRHR services (incl. HIV testing, Antenatal, post natal care, safe delivery services) and SEA reporting.	Lutheran World Federation
Activity 1.3	Conduct pregnancy mapping for Identification of High-risk pregnancies, timely referrals for Antenatal Care (ANC), screening for GBV and link to delivery services at appropriate level of health facilities across the targeted districts	Lutheran World Federation; District Local Governments
Activity 1.4	Deploy 15 midwives across the targeted districts to provide SRHR/GBV services	Lutheran World Federation; District Local Governments
Activity 1.5	Support referral services (Hire, functioning and maintenance of ambulance services)	Lutheran World Federation; District Local Governments
Activity 1.6	Reproduce SRHR/GBV job aids	Lutheran World Federation

Activity 1.7	Orientation and mentoring skills of health workers in EmONC/Post-abortion care, standard precautions, and Essential Operatives Obstetrics (ETOO) at points of care in Kyangwal i/Kikuube. This is needed to support implementation of other proposed health systems strengthening components (ERH kits etc).	Lutheran World Federation; District Local Governments
Activity 1.8	Undertake Maternal Perinatal Deaths Surveillance and Response (MPDSR). Support MPDSR committee lead champions at HCIVs and Hospitals to strengthen notification, monthly review and follow up on recommendation in all targeted districts. This will include providing allowances, transport and fuel for monthly meetings, notifications, community follow-up, and responding to the recommendations. Each maternal and neonatal death will be reviewed by a team comprising of health workers in the facility where the death occurred working with a team of senior specialist including community follow up to ascertain the delays (at home, during transportation to facility and at health facility) and use this findings to inform district level MPDSR committee discussions and dissemination to other health facilities to avoid future occurrence of the same.	Lutheran World Federation; District Local Governments
Activity 1.9	Procure and distribute dignity kits (mama and baby packs) to new arrival refugee pregnant women delivering during the project period. These kits will be provided to vulnerable women who come to deliver at health facility level, comprising of some material for the mother and baby to address the vulnerability of mothers who come without any thing to cater for the deliveries and act as motivation for health facility delivery.	UNFPA
Activity 1.10	Procure and distribute emergency reproductive health kits and other medical equipment for SRHR/GBV service delivery. These kits will be distributed by UNFPA to the 28 health facilities based on a needs assessment.	UNFPA

Output 2	Increased uptake of GBV reporting and case management services

Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☒
Sector/cluster	Protection - Gender-Based Violence			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Number of women (including women with disabilities and girls/adolescence), reached with SRHR and GBV information and PSEA information.	21,987 (Refugees=9,268, Nationals=12,719)	59,422 (Refugees = 36,454, Nationals = 22,968)	Monthly humanitarian data sheets
Indicator 2.2	Number of GBV survivors supported to receive GBV services in targeted districts.	693 (Refugees=293, Nationals=400)	1,690 (Refugees=507, Nationals=1,183) across the 28 facilities targeted, of which 557 (Refugees = 254, Nationals= 303) were supported at the 13 facilities supported with a CERF funded midwife. (244% achievement)	HMIS2, Monthly humanitarian data sheets
Indicator 2.3	Number of sexual violence survivors provided with post rape services (including emergency contraception, post exposure prophylaxis, first aid - psychosocial counselling, etc.) within 72 hours.	153 (Refugees=65, Nationals=88)	191 (Refugees=26, Nationals=165) at the 28 supported facilities.	Monthly humanitarian data sheets
Explanation of output and indicators variance:		The number of women reached with SRHR/GBV and PSEA information was higher than anticipated through the introduction of regular health education sessions conducted at the health facilities, as well as during the planned outreaches. Following the training on clinical management of rape (CMR) there was an improvement both in identification and management of cases, as well as in documentation at the target facilities, which contributed to the over-achievement of number of GBV survivors provided with post rape services within 72 hours. UNFPA's work to strengthen GBV referral pathways in target district through our nexus programming, as well as collaboration with other partners has also contributed to this result.		

Activities	Description	Implemented by
Activity 2.1	Support community health education and mobilization among refugees and host communities with a theme of GBV (integrated with SRHR and HIV) and PSEA to increase reporting of GBV and PSEA and uptake of GBV services. This will be done by implementing partners who shall reach out to refugees and host communities with accurate information on SRHR services, and GBV prevention messages, how to report cases of PSEA – (same activity as 1.2, GBV and SRHR messages are integrated because of the strong linkages between SRHR and GBV, so this is applicable both under GBV and Health sector.)	Lutheran World Federation
Activity 2.2	Produce, print and distribute IEC translated materials on GBV and PSEA.	Lutheran World Federation
Activity 2.3	Establish and functionalise in collaboration with UNHCR one stop centers where survivors can access all services in one place (health, psychosocial and police and legal advice) The contribution from UNFPA will include: Support orientation of district and health services providers on clinical management of rape; GBV reporting and basic psychosocial and trauma management.	Lutheran World Federation

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 addressed through project activities and should highlight the achieved impact wherever possible.**

[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]:

Programme beneficiaries and stakeholders were involved in UNFPA's rapid assessments in affected districts, based on which the facilities selected were targeted. Assessment methodologies included focus group discussions and interviews with community members and district leadership, as well as a review of MPDSR audits in refugee-hosting districts. Assessment results were used to determine project priorities and approach.During project implementation the involvement of the VHTs, which are made up of community volunteers, ensured both a presence and a link to the communities reached through the project. UNFPA conducted three monitoring visits with the implementing partner on a regular basis, at which point input and feedback is sought from community volunteers, beneficiaries, and stakeholders. Key concerns, potential challenges were addressed on the spot, recommendations and good practises were documented for integration into future programmes.

b. AAP Feedback and Complaint Mechanisms:

The refugee settlements have in place a community-based complaint mechanisms (CBCM) and community volunteers, which makes up the PSEA and GBV coordination system. The CBCM made PSEA reporting possible, as it enabled PSEA survivors to report at any point without having to go through a bureaucratic process. UNFPA worked with district authorities in refugee hosting districts to ensure that GBV referral pathways are up-to-date and that stakeholders were aware of their roles within the referral pathway, to strengthen GBV response both as part of UNFPA programme implementation, and district response in general.
In case of feedback or complaints that could not be raised directly through the VHTs or the PSEA and GBV coordination system (see below), beneficiaries were made aware of the UNHCR protection toll free line and the government child helpline (SAUTI), with further guidance shared with the community through PSEA posters and signposts.

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

UNFPA abides by the *Uganda Protection Against Sexual Exploitation and Abuse (SEA) Task Force: Inter Agency Standard Operating Procedures (SOPs) for Receiving, Recording and Processing SEA Complaints*, which outlines standards and processes to ensure confidentiality, that complaints can be made through multiple avenues and that action is taken in a prompt manner.
Awareness raising and advocacy for PSEA and effective complaints mechanisms was integrated into project activities, including through the inclusion of PSEA in the community volunteer orientation (Activity 2.1). PSEA and GBV materials were printed and distributed to district officials, health facilities and VHTs. The type of materials produced were determined in consultation with district authorities and health facility in-charges. 344 A3 size posters were distributed in Kyangwali and Adjumani refugee settlements; 10 PVC banners were distributed to health facilities in Imvepi settlement; and 6 mini billboards were erected outside health facilities, 3 in Bidibidi and 3 in Palorinya.

[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.

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

[The project contributed to improved gender equality through the provision of improved access to sexual and reproductive health and GBV services, thereby strengthening the agency of women and girls to lead productive and healthy lives. Access to quality SRHR and GBV services and information contributes to a decrease in unwanted pregnancies, teenage pregnancies, and early marriages, thereby supporting empowerment and protection of women and girls. Community engagement through the VHTs and community volunteers, contributing to awareness raising and sensitisation on GBV and modern family planning, further contributes to behavioural change and supports gender equality through engagement of both sexes.
The gender disaggregation of persons reached over the project period reflects those strategies to increase male engagement both for SRH and GBV need to be strengthened and prioritised going forward.

e. People with disabilities (PwD):

Disability inclusion is a priority for UNFPA, in line with our commitment to leave no one behind and as set out in the IASC guidelines on disability inclusion in humanitarian settings. The IP sensitised health workers and community volunteers to counter discrimination and ensure access to activities and services by all. This was particularly important in light of COVID-19 restrictions, as community volunteers were mobilised to reach communities, including those most vulnerable. The provision of integrated outreaches was noted as an important component in strengthening access of PWDs to access SRHR/GBV services and information, as travelling long distances to the health facility can be a barrier.
Continued advocacy for mainstreaming of PWD inclusion across all sectors is required going forward. This included working for improved accessibility of health facilities and SRHR/GBV services to address physical, environmental and attitudinal barriers encountered.

f. Protection:

UNFPA and implementing partners worked to ensure a holistic approach is adopted for both SRHR and GBV initiatives. This included working closely with protection partners to ensure wider protection services were incorporated and functioning within the district GBV referral pathways, i.e., case management and psycho-social support, etc. This was implemented through the GBV One-Stop-Centres (OSC) established in collaboration with UNHCR through the CERF grant and advocated for across all target districts and facilities.

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	Choose an item.	[Fill in]

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.

UNFPA recognises CVA as an efficient and appropriate response option. The CERF funded project design assumed that UNFPA and UNHCR would coordinate closely to ensure that women identified as at risk and/or GBV survivors had access to unrestricted multi-purpose cash assistance, provided for under UNHCR's component of the response.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	**Weblink**
Prepared with knowledge, expected refugee mothers are embracing skilled care at birth services	https://uganda.unfpa.org/en/news/prepared-knowledge-expected-refugee-mothers-are-embracing-skilled-care-birth-services
Thanks to family planning, refugee women are having babies by choice, not chance	https://uganda.unfpa.org/en/news/thanks-family-planning-refugee-women-are-having-babies-choice-not-chance

PART II – PROJECT OVERVIEW

5. PROJECT REPORTS

6.1 Project Report 20-UF-HCR-028

1. Project Information			
Agency:	UNHCR	**Country:**	Uganda
Sector/cluster:	Protection - Gender-Based Violence Protection Protection - Child Protection	**CERF project code:**	20-UF-HCR-028
Project title:	Urgent Response to the Impact of COVID-19 on the protection of refugees, particularly women and children in Uganda		
Start date:	13/11/2020	**End date:**	12/11/2021
Project revisions:	No-cost extension ☒ Redeployment of funds ☐		Reprogramming ☐

Funding		
	Total requirement for agency's sector response to current emergency: **GUIDANCE**: Figure prepopulated from application document.	**US$ 10,587,500**
	Total funding received for agency's sector response to current emergency: **GUIDANCE**: Indicate the total amount received to date against the total indicated above. Should be identical to what is recorded on the Financial Tracking Service (FTS). This should include funding from all donors, including CERF.	**US$ 0**
	Amount received from CERF:	**US$ 2,000,000**
	Total CERF funds sub-granted to implementing partners: **GUIDANCE**: Please make sure that the figures reported here are consistent with the ones reported in the annex.	**US$ 1,227,876**
	Government Partners	US$ 0

	International NGOs	US$ 624,472
	National NGOs	US$ 603,404
	Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

UNHCR received critical gap-filling financing from the CERF-UFE which enabled the agency to significantly augment the quality of its refugee protection response in the five refugee settlements jointly targeted by the United Nations Country Team. Through the CERF-UFE grant, UNHCR provided cash-based intervention support to 1,500 women at risk (out of which 1,427 were GBV survivors); established eight (8) one-stop centres that offered multi-sectoral services to 551 survivors; provided quality individual case management to 1,238 GBV survivors and 650 children; provided mental health and psychosocial support (MHPSS) services and legal services to 1,289 and 376 GBV survivors, respectively (under the GBV sector); supported 91 survivors to access safe-houses for protection; conducted 162 community-level GBV prevention campaigns; supported 785 trained refugee community structure members to adapt their work modalities to observe the COVID-19 prevention measures; supported 1,263 persons with MHPSS counselling sessions out of which 934 GBV/VAC survivors accessed MHPSS services under the protection sector; provided training and material support to 54 Child Protection Committees; and 2,461 children participated in community-based child protection activities.

This project covered five (5) refugee settlements, including Kyangwali (Kikuube District), Adjumani (Adjumani District), Palorinya (Obongi District), Bidibidi (Yumbe District) and Rhino Camp (spanning Madi Okollo and Terego districts). 13,356 persons (10,268 females; 3,088 males) were directly reached by the project according to UNHCR and partner field reports. UNHCR estimates that the number of indirect beneficiaries who will sustainably access the services augmented through the CERF-UFE support is 36,200[8]. All activities envisioned by the CERF-UFE proposal were delivered successfully on time in the five refugee settlements although achievement of some of the targets were affected by the COVID-19 lockdown and government restrictions. Case management was strengthened through the recruitment of additional GBV and Child Protection (CP) caseworkers and case managers. 24 GBV caseworkers and 18 CP staff (11 caseworkers; 7 case managers) were recruited with CERF-UFE funding. The partner staff were trained on the Sexual and Gender-based Violence Module and CP Module of ProGres V4, UNHCR's case management tool which uses data from the Office of the Prime Minister's Biometric Identity Management Systems (BIMS). This intervention has seen a significant increase in the inputting, updating and management of GBV and CP cases in the ProGres V4.

[8] 36,200 indirect beneficiaries is UNHCR's best estimate based on the population of women of reproductive age (15-49) living in the catchment areas where the eight one-stop centers were established and the community-based GBV response has been significantly enhanced (Adjumani: 15,400; Kyangwali: 6,000; Palorinya: 14,800).

3. Changes and Amendments

UNHCR envisioned that unrestricted multi-purpose cash transfers would be provided to the targeted beneficiaries through its existing agreements with national telecom providers. However, many of the targeted beneficiaries either did not have SIM cards or were using SIM cards registered to other persons (e.g., SIM cards registered to acquaintances who are nationals[9]). In accordance with the UNHCR, OPM and World Food Programme policy, refugees' SIM cards must be linked to their own refugee registration identity documents (i.e., Refugee or Asylum Seeker attestations or refugee ID card) in accordance with the established agreement between UNHCR, the Office of the Prime Minister (OPM) and the Uganda Communications Commission (UCC). While some beneficiaries needed to register new SIM cards, others faced challenges related to settlement-level kiosks not being able to establish the link between the attestation documents and the SIM cards without support from the telecommunications providers at national level. This problem was mainly faced by the Airtel service provider which was initially considered for the mobile money transfer and required a coordinated intervention by UNHCR, OPM and the UCC. The Airtel system still experienced challenges, therefore, UNHCR reacted quickly and another service provider, MTN, was brought on board as the mobile money service provider for the project. While this process cleared up the challenge for future mobile money transaction processes, this challenge necessitated a change in modality for the first disbursement. Cash over the counter through Post Bank (under a pre-existing contract between Post Bank and UNHCR) was used for the first disbursement while mobile money through MTN and Airtel was used for the second and third disbursements. UNHCR supported a total of 1,676 women at risk and GBV survivors (of which 1,500 were supported with CERF-UFE funding) out of which the additional cost for the surplus beneficiaries was borne by the UNHCR's flexible unearmarked funding contributed against the Global Appeal.

The partners were able to recruit 42 GBV/CP staff and establish eight (8) One Stop Centres (OSCs) with the same budget allocated to them under CERF-UFE funding. Both the staffing recruitment and OSCs are four more than what was envisioned in the CERF-UFE proposal. This was helpful in strengthening case management. The overall achievement under the protection sector was slightly higher than the target as more refugee community structures were supported than planned across the five refugee settlements. Under the GBV sector, the number of GBV survivors receiving MHPSS and legal services were slightly lower than the target as fewer individuals than the planning assumption approached the service providers with such needs. Also, fewer survivors accessed one stop centres as it took some

[9] In Uganda, refugees were initially unable to register SIM cards in their own names due to identity management processes and informality in relation to SIM card registration. Ugandans are permitted to have up to six SIM cards registered to one name, therefore, refugees engaged nationals as a quick fix solution to acquire their own SIM cards. Likewise, Ugandans who do not possess national ID cards use their acquaintance to achieve the same objective. In 2020, UNHCR, the Office of the Prime Minister (OPM), and the Uganda Communications Commission (UCC) formally agreed to issue SIM cards to refugees bearing Refugee ID Cards. However, while OPM has issued Refugee and Asylum Seeker Attestation documents (a printed paper) to 100% of refugee and asylum seekers, the coverage of official ID cards was limited. OPM has since produced a new ID card for refugees and asylum seekers that has security features including a QR Code. The new ID card is being provided as part of the ongoing countrywide Refugee Verification and Individual Profiling Exercise that is verifying and enhancing data on 1.5 million refugees (expected to conclude by December 2022).

months before these OSCs were functionally established but more survivors are likely to benefit from these centres in the long run. The number of GBV prevention campaigns were also affected by the COVID-19 lockdown restrictions and most of the planned campaigns were more appropriately schedule to take place during 16 Days of Activism that followed immediately after the reporting period. However, the number of GBV survivors accessing safe houses for protection was higher due to the strengthened and increased capacity of the partners to respond to the survivors' needs.

Since all these activities were achieved without additional financial cost burden to the CERF-UFE funding, the CERF Secretariat was not consulted for these modifications. Moreover, the achievement in these activities was slightly higher than the target and there were no unspent funds.

Although the directly reached were reportedly less for Protection and Child Protection sector, more were reached through the GBV sector. More focus was on the GBV sector as required and envisioned by the project title "Urgent Response to the Impact of COVID-19 on the protection of refugees,
particularly women and children in Uganda." Needless to say, GBV was on the rise due to the COVID-19 pandemic lockdown measures. The adopted measures as directed by the government health guidelines created challenges in the field to reach out to more persons directly as initially planned. The schools in Uganda were locked down for about 2 years and they were not open during the project cycle. Children were mostly homebound. It is also likely that some of the children that attended the child-friendly spaces in the community were not captured by the community structures.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Protection									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	4,213	4,213	4,212	4,212	**16,850**	3,263	875	2,094	753	**6,985**
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	125	125	125	125	**500**	0	0	0	0	**0**
Total	**4,338**	**4,338**	**4,337**	**4,337**	**17,350**	3,724	240	4,820	3,630	**12414**
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	**39**	**9**	**13**	**9**	**70**

Sector/cluster	Protection - Gender-Based Violence									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	1,161	129	189	21	**1,500**	2,573	164	0	0	**2,737**
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	**1,161**	**129**	**189**	**21**	**1,500**	2,7243	164	0	0	**2,737**
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.

	232	6	38	14	**290**	**368**	**52**	**47**	**0**	**467**

Sector/cluster	Protection - Child Protection									
	Planned					**Reached**				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	3,000	2,000	3,320	2,480	**10,800**	**0**	**0**	**4,820**	**3,630**	**8,450**
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	**3,000**	**2,000**	**3,320**	**2,480**	**10,800**	**0**	**0**	**4,820**	**3,630**	**8,450**
People with disabilities (PwD) out of the tota										
	90	80	186	124	**480**	**0**	**0**	**338**	**507**	**845**

* 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

20% (160,000) of an estimated 800,000 refugee population [mainly South Sudanese, living in Rhino Camp refugee settlement (with spans Madi Okollo and Terego ddistricts), Bidibidi settlement (Yumbe District), Adjumani settlement (Adjumani District), and Palorinya settlement (Obongi District); and refugees mainly Congolese, living in Kyangwali settlement (Kikuube District) in the Southwest of Uganda] are expected were the direct beneficiaries of the CERF-UFE project. These individuals are 160,000 women of reproductive age living in the targeted settlements. Some of the indirect beneficiaries were the family and relatives of the unrestricted multipurpose cash recipients, and of those undergoing case management and receiving multisectoral response including MHPSS and legal assistance, among others. 162 GBV prevention sessions were conducted in which approximately 100 persons were directly reached in each session. The services rendered directly to the beneficiaries on child protection, GBV and MHPSS also had an impact on their direct family members and relatives. Therefore, the indirect beneficiaries of this project were significnatly higher than the actual number of beneficiaries directly reached. Figures were revised double checked and take into account partner year end reports. Underachievement is due to challenges related to COVID restrictions.

6. CERF Results Framework

Project objective	Enhance the comprehensive protection response by addressing immediate critical protection needs and risks

Output 1	Physical and legal protection improved, and mental health and psychosocial support needs addressed

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

Sector/cluster	Protection			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of refugee community structure members supported (with training, mobile phones and airtime) to adapt their work modalities to observe the COVID-19 mitigation measures.	400	785	Distribution lists, Attendance lists, Partner reports
Indicator 1.2	Number of people benefiting from MHPSS counselling sessions	1,000	1,263 (1,187 females & 76 males)	Attendance sheets, case files, couple counselling minutes, referral notes attendance lists, proGres V4 database and GBV IMS
Indicator 1.3	Number of SGBV/VAC survivors able to access MHPSS services	900	2,698 (2,590 females & 108 males)	GBVIMS Report, Note for files, proGres V4 database
Explanation of output and indicators variance:		More refugee community structures were supported by the partners in the refugee settlements. Therefore, the overall achievement under the Protection sector was slightly higher than the target.		

Activities	**Description**	**Implemented by**
Activity 1.1	Strengthen and empower community structures (i.e., refugee community groups formed under the guidance of the MHPSS partner in Rhino, Bidibidi, Palorinya, Adjumani and Kyangwali) to deliver services in manner that observes COVID-19 mitigation measures, including training, information dissemination, community mobilization identification of cases, referral if necessary, and basic support.	Kyangwali: Alight, TPO Bidibidi: IRC, TPO Palorinya: LWF Adjumani: LWF Rhino: DRC, TPO

Activity 1.2	Establishment of a specialized Mental Health and Psychosocial (MHPSS) service provision partner in locations where it is not in existence in an environment with movement restrictions. Increase and enhance the capacity of MHPSS service delivery actors in the targeted settlements and install specialized MHPSS partners in locations where they are not currently present. This shall include services provided in the three top levels of the IASC MHPSS pyramid including: Specialized MH intervention, Specialized counselling, and non-specialized counselling.	Kyangwali: Alight, TPO Bidibidi: IRC, TPO Palorinya: LWF Adjumani: LWF Rhino: DRC, TPO
Activity 1.3	Expansion of MHPSS services to address the increased number of SGBV/VAC and suicide incidences since the onset of COVID-19 and 30% food ration cut, and expansion of services where MHPSS partners have a minimal presence (in an environment with movement restrictions)	Kyangwali: Alight, TPO Bidibidi: IRC, TPO Palorinya: LWF Adjumani: LWF Rhino: DRC, TPO
Activity 1.4	Recruitment of additional specialized staff, trained and deployed (100 community counsellors and 20 social workers)	Kyangwali: TPO Bidibidi: TPO Palorinya: LWF Adjumani: LWF Rhino: TPO

Output 2	Prevention and response to sexual and gender-based violence (SGBV)			
Was the planned output changed through a reprogramming after the application stage?		Yes ☐	No ☒	
Sector/cluster	Protection - Gender-Based Violence			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Number of one stop centers offering multi-sectoral services in a central location established and running in the refugee settlements	4	8	Distribution reports, Partner reports, One Stop Centres (OSC) physical verification
Indicator 2.2	Number of survivors able to access the one stop centers for multi-sectoral SGBV intervention	1,500 (10% men)	551 (all females)	OSC trackers, referral notes, partner reports
Indicator 2.3	Number of SGBV survivors receiving quality individual case management services	1,500	2,737 (2,573 females & 164 males)	Case files, case conferencing minutes, GBVIMS, proGres V4 database
Indicator 2.4	Number of SGBV survivors accessing unrestricted multi-purpose cash grants for material support	1,500	1,500 (1,427 GBV survivors & 73 women at risk)	Approved list of beneficiaries, post distribution report.
Indicator 2.5	Number of SGBV survivors accessing basic financial literacy training	1,500	1,500 (1,427 GBV survivors & 73 women at risk)	Training reports, Attendance list for sessions
Indicator 2.6	Number of SGBV survivors accessing MHPSS services	1,500	1,289 (1,212 females & 77 males)	Case files, attendance list, GBVIMS, proGres V4

Indicator 2.7	Number of SGBV survivors receiving legal services and redress	525	604 (568 females & 36 males)	GBVIMS, case files, Attendance lists for legal aid service provision
Indicator 2.8	Number of SGBV survivors accessing safe houses for protection	60	91 (83 females & 8 males)	Protection house database, partner reports
Indicator 2.9	Number of SGBV prevention campaigns conducted	300	162	Partner reports on prevention campaigns and attendance lists
Explanation of output and indicators variance:		UNHCR established more One Stop Centres (OSCs) (8 against a target set at 4) within the CERF-UFE budget than initially planned. However, the number of survivors accessing the OSCs was fewer than anticipated as some survivors continued accessing GBV caseworkers via the sites where they had been accessing caseworkers prior to the establishment of the OSCs. This also relates to the fact that the OSCs were operationalized mid-way through the project period. The number of GBV survivors who received unrestricted multipurpose cash (1,427) is slightly lower than the target of 1,500 as women at risk of GBV (73) were also provided with cash support to avoid stigma. Achievement of the targeted number of GBV prevention campaigns was affected by the COVID-19 restrictions and lockdown.		

Activities	**Description**	**Implemented by**
Activity 2.1	Establishment of one-stop SGBV drop-in centers in select health facilities.	Alight, LWF
Activity 2.2	Recruitment of 18 additional SGBV case managers as a crucial part of safeguarding refugees at high risk against SGBV; Support to case management staffing; equipping case workers with laptops and internet connectivity to ensure cases are well documented and data is properly managed in the online data and case management tool (ProGres v.4). This will ensure immediate access to basic necessities (food, shelter, clothing, cash/basic needs) and also ease case follow-up.	Alight, LWF, DRC
Activity 2.3	Provision of immediate unrestricted life-saving multipurpose cash grants (for non-food basic needs) to support GBV survivors, and those at high risk of GBV, those at high risk and PSNs as being the most vulnerable to SGBV in the community. SGBV survivors will be prioritized under the 'women at risk' special needs category. The identification process will be through continuous case management as well as from the already documented cases in the data base from previous and ongoing Persons with Specific Needs identification.	UNHCR under direct implementation (through referrals from ALIGHT, DRC, LWF, IRC)
Activity 2.4	Financial literacy training will be embedded in ongoing case management and counseling for the survivors and Women at Risk identified for Multi-Purpose Cash transfers to ensure that they are able to apply the cash appropriately to the intended purpose and to help mitigate against further SGBV.	ALIGHT, DRC, LWF, IRC, UNHCR

Activity 2.5	All survivors will access MHPSS services to address issues related to trauma.	TPO, LWF
Activity 2.6	Provide speedy access to justice (due process and legal aid) for survivors of SGBV in the settlements as part of managing the backlog of cases caused by the COVID-19 shut-down of most courts, which is contributing to the release of perpetrators on bail who are then a risk for the survivors as they then intimidate and/retaliate.	Alight, DRC, LWF, IRC
Activity 2.7	Support maintenance of existing safe shelters to accommodate increased number of survivors who have to be accommodated at safe houses owing to the release of the perpetrators as courts and jails have not been operating optimally during COVID 19 and as such perpetrators are released on bond and most continue posing a security risk to survivors in the community; This support will entail staffing to man the safe houses as well as food and supplies for the women accommodated in the safe shelters.	Alight, DRC, LWF, IRC
Activity 2.8	Conduct community mobilization through the SASA! Approach, an evidence-based methodology for social norms change already in use in some of the refugee settlements. This will include training and sensitization and awareness campaign on SGBV, child protection and mental health through alternative media (i.e., radio, phone) as well as mobilization of community activists.	Alight, DRC, LWF, IRC

Output 3	Child Protection			
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	# of children receiving individual case management services	800	1,984 (1,035 girls & 949 boys)	Case files, partner reports, child protection case tracker, proGres V4 database
Indicator 3.2	# of additional child protection case workers/managers	16 (8 Rhino; 4 Adjumani; 4 Palorinya)	18	Partner reports
Indicator 3.3	# of Child Protection Committees	52	54	Child Protection Committee monthly reports, partner reports
Indicator 3.4	# of children participating in community-based child protection activities	5,000 (3,000 girls; 2,000 boys)	5,517 (2,836 girls & 2,681boys)	Partner reports
Explanation of output and indicators variance:				

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

Activity 3.1	Recruit 20 additional Child Protection case managers as a crucial part of safeguarding refugee children and supporting individual case management for children in need of care and support as a means of mitigating; Support to case management staffing; equipping case workers to ensure cases are well documented and data is properly managed.	LWF, DRC
Activity 3.2	Provide support to existing community based activities, including child rights clubs, peer to peer support groups as well as other adolescent led activities	LWF, DRC
Activity 3.3	Provide training and material support tor Community-based Child Protection Committees (CPCs) and other relevant community groups fostering child participation and child protection outcomes	LWF, DRC

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[10] 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 addressed through project activities and should highlight the achieved impact wherever possible.**

a. Accountability to Affected People (AAP)[11]:

Accountability to Affected People (AAP) was considered through communication and transparency; feedback and response; participation and inclusion; and learning and adaptation. Women, men, boys and girls of diverse backgrounds were consulted on protection assistance and solutions. Mechanisms were established at all stages. This was done using different engagements like Focus Group Discussions (FGDs) using an Age Gender Diversity (AGD) approach. Significant efforts were made to ensure accessibility for marginalized groups (e.g., minorities and people with disabilities without discrimination). Communication with refugees, asylum seekers and host communities enabled UNHCR and partners to understand the needs and priorities of the beneficiaries and adapt with a tailored response for each individual through protection case management. The inter-agency refugee Feedback Referral and Resolution Mechanism (FRRM), suggestion boxes and Refugee Welfare Committees (RWCs) ensured that appropriate sensitivity and confidentiality was applied and that feedback from the beneficiaries was obtained.

b. AAP Feedback and Complaint Mechanisms:

Formal and informal feedback from persons of concern was systematically received and responded to, and corrective actions were taken as appropriate. This was clearly visible when mobilizing the beneficiaries for SIM card registration and the disbursement of the unrestricted multipurpose cash transfers for GBV survivors and women at risk. Effective feedback systems such as international refugee FRRM toll-free line, suggestion boxes and protection help desks were used to provide persons of concern with access to a two-way communications

[10] 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.

[11] 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.

channel. Feedback from persons of concern is systematically collected, acknowledged, assessed, referred, and responded to in a timely, confidential, and effective manner. Collaboration with partners in feedback, referral and response processes (as appropriate) was established to ensure that there is coordinated activity implementation for UNHCR's persons of concern to receive services in a dignified manner that serve to address their views and concerns.

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

The Inter-Agency PSEA Coordinationn mechanism was led by UNHCR's Senior GBV Officer. Community outreach and awareness raising on SEA is routinely done, and this includes the provision of information to communities on where and how to report SEA allegations. An Inter-Agency PSEA Risk Assessment was conceptualized, and an assessment tool was developed. Networks of trained PSEA focal points comprising of UNHCR and partner staff are in place at settlement level. Communities were engaged to secure their support and raise awareness on SEA and how to report SEA incidents. The trained network of SEA focal points is tasked with receiving individual complaints and providing support to survivors. This network is coordinated across all UNHCR field offices to ensure provision of psychosocial support, legal services, medical assistance and safety and security through the Victims' Assistance Protocol. UNHCR conducts regular risk mapping and safety audits, PSEA awareness and training sessions, community outreach for refugees, manages the FRRM with a toll-free line, disseminates regular messages to all staff reiterating zero-tolerance for SEA, and participates in the United Nations Country Team PSEA Mechanism. Survivors are supported and referred in accordance with the existing GBV referral pathways.

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

Prevention, mitigation, and response to GBV continues to be a prioritized as a life-saving activity. The highest budget among the three components (Protection, GBV and Child Protection) was allocated to GBV to support women at risk and GBV survivors. The financial literacy training and provision of unrestricted multipurpose cash assistance to women at risk and GBV survivors served to help them overcome their hardship and improve their resilience by being able to meet their own basic needs without relying on others. Case management for GBV survivors was strengthened by recruiting additional GBV case workers and establishing the eight (8) one stop centres. GBV awareness-raising was done following the SASA! approach. The delivery of MHPSS was strengthened to respond to the level of needs, to be able to support the GBV survivors to manage the trauma that they experienced. Gender equality and women's empowerment was given high consideration throughout the project cycle.

e. People with disabilities (PwD):

UNHCR and partners ensured inclusion of persons with disabilities in the CERF-UFE activities. Some of UNHCR's partners engaged specialized operational partners like Humanity and Inclusion and TPO for their expertise to train staff, carry out targeted projects on disability inclusion and to collect data on disability. Partners aimed to identify and address the barriers that persons with disabilities face. These barriers can be attitudinal (stigma against discrimination), environmental (infrastructure and built environments) or institutional (prohibitive laws and policies). When identifying these barriers, staff were trained on the intersecting identities of PwD where they may experience multiple barriers and, consequently, be at a heightened risk. Some 47 women with disabilities were prioritized for financial literacy training and multipurpose unrestricted cash assistance.

f. Protection:

UNHCR conducted a countrywide participatory assessment through key informant interviews and FGDs. Data from proGres V4, its individual case management modules, the FRRM, and protection monitoring information was analysed. Protection mainstreaming was done within other sectors of intervention by ensuring that the principle of Do No Harm prevails throughout all interventions through ensuring the safety and dignity of all individuals. Accountability mechanisms serving to maintain Accountability to Affected Populations (AAP) and Prevention of Sexual Exploitation and Abuse (PSEA) were adhered to during planning and implementation of the CERF-UFE project. Key approaches such as survivor centered approach, rights-based approach, Age Gender Diversity (AGD) sensitive approach and community-based protection approach were applied to ensure protection-centric implementation. All activities implemented under the CERF-UFE by UNHCR and partners (e.g., strengthening case management, MHPSS, multipurpose unrestricted cash assistance, etc.) were aimed at enhancing the protection environment of the persons of concern living in the five targeted settlements.

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	1,500

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.

Social protection systems in Uganda are limited to support the elderly or for child nutrition, and access to these systems is limited and only in specific targeted districts. Unrestricted multi-purpose cash assistance was provided to women at risk and GBV survivors based on criteria defined by UNHCR and validated by the SGBV Sub-working Group and the National Protection Working Group. The disbursement amount was based on the non-food Minimum Expenditure Basket (MEB) that was validated and agreed by the Cash Working Group and Inter-sector Working Group. Actually 1,676 beneficiaries were supported with cash assistance, out of which 1,500 individuals were supported with CERF-UFE funding and the surplus 176 beneficiaries were supported with UNHCR's flexible funding from donor contributions against the Global Appeal.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
Activity 2.4	1,500	US$ 531,000	Protection - Gender-Based Violence	Unrestricted

9. Visibility of CERF-funded Activities

Title	Weblink
UNHCR helps women at risk rebuild their lives through cash assistance	https://www.unhcr.org/afr/news/stories/2021/12/61a78ac44/cash-assistance-opens-up-life-changing-opportunities-for-refugee-survivors.html

6.2 Project Report 20-UF-CEF-055

1. Project Information

Agency:	UNICEF	**Country:**	Uganda
Sector/cluster:	Nutrition	**CERF project code:**	20-UF-CEF-055
Project title:	Critical lifesaving response to refugees in Uganda through Nutrition interventions		
Start date:	13/11/2020	**End date:**	12/11/2021
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency: **GUIDANCE**: Figure prepopulated from application document.	**US$ 1,000,000**
Total funding received for agency's sector response to current emergency: **GUIDANCE**: Indicate the total amount received to date against the total indicated above. Should be identical to what is recorded on the Financial Tracking Service (FTS). This should include funding from all donors, including CERF.	**US$ 0**
Amount received from CERF:	**US$ 600,000**
Total CERF funds sub-granted to implementing partners: **GUIDANCE**: Please make sure that the figures reported here are consistent with the ones reported in the annex	**US$ 18,444**
Government Partners	US$ 18,444
International NGOs	US$ [Fill in]
National NGOs	US$ [Fill in]
Red Cross/Crescent Organisation	US$ [Fill in]

2. Project Results Summary/Overall Performance

Through this CERF UFE grant, UNICEF and its partners managed 10,746 malnourished children under five in in-patient and out-patient therapeutic care; trained 30 health workers from Kampala and the catchment facilities supported under Mulago National Referral Hospital in the integrated management of acute malnutrition using the revised training modules. UNICEF procured and distributed 8,231 cartons of Ready to Use Therapeutic Food (RUTF), 369 cartons of F75, 123 cartons of F100 and 15 cartons of ReSoMal in the refugee-hosting districts of Kampala, Adjumani, Lamwo, Yumbe, Obongi, Kikuube, Kamwenge and Kyegegwa.

3. Changes and Amendments

No changes or modifications took place as all the project activities were implemented per the approved proposal

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Nutrition									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	1,426	1,484	**2,910**	**0**	**0**	1,485	2,276	3,761
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	2,648	2,756	**5,404**	**0**	**0**	2,758	4,227	6,985
Other affected people	0	0	0	0	**0**	**0**	**0**	0	0	0
Total	**0**	**0**	**4,240**	**4,074**	**8,314**	**0**	**0**	**4,243**	**6,503**	**10,746**
People with disabilities (PwD) out of the total										
	0	0	160	154	**314**	0	0	160	154	**314**

* 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

A total of 1,363,557 children under five were screened by health workers for malnutrition in the health facilities and additional 348,019 were screened by the village health teams (VHTs) at community level. The caregivers of these children were provided with relevant nutrition education and counseling during the screening sessions. Specifically, 890,623 mothers and pregnant women were counseled on maternal nutrition, and infant feeding in the project focus districts.

6. CERF Results Framework

Project objective	To support the MoH and districts of Kampala, Lamwo, Adjumani, Yumbe, Obongi, Kamwenge, Kikuube, and Kyegegwa with critical inputs and capacity strengthening for management of children under five with Severe Acute Malnutrition.
Output 1	Health facilities in the districts of Kampala, Lamwo, Adjumani, Yumbe, Obongi, Kamwenge, Kikuube, and Kyegegwa have essential nutrition commodities for treatment of children under five years of age with Severe Acute Malnutrition

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

Sector/cluster	Nutrition			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of children aged 6-59 months affected by severe acute malnutrition who are admitted into treatment	8,314	10,746	HMIS/DHIS2
Explanation of output and indicators variance:		The capacity building of health workers on the new IMAM guidelines and the rollout of Family Led MUAC contributed to increased screening and enrolment of malnourished children in in-patient and outpatient therapeutic care. Thus, surpassing the project target of 8,314.		

Activities	**Description**	**Implemented by**
Activity 1.1	Procurement of therapeutic supplies (F-100, Ready to use Therapeutic food, F-75, F-100 and ReSoMal)	UNICEF
Activity 1.2	Last mile distribution of nutrition supplies	UNICEF and National Medical Stores

Output 2	Health providers in health facilities and communities in target district of Kampala, acquire the necessary skills and are supported to provide quality services for management of children with SAM, including the counselling of child caregivers on IYCF.

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

Sector/cluster	Nutrition			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Number of health and nutrition workers trained on the management of management of severe acute malnutrition as per national standards	25	30	IMAM training report
Explanation of output and indicators variance:		There were five additional health workers from Kampala and the catchment facilities supported by Mulago National Referral Hospital because of additional resources obtained from other UNICEF support.		

Activities	Description	Implemented by
Activity 2.1	Training of health workers on the revised protocols for the integrated management of children with malnutrition and Family middle upper arm circumference (MUAC)	UNICEF/Ministry of Health
Activity 2.2	Procurement of Personal Protective Equipment (PPE) for the Government of Uganda and UNICEF personnel involved in the implementation of training, monitoring and support supervision of activities	UNICEF
Activity 2.3	Technical supervision and monitoring by UNICEF personnel	UNICEF

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 addressed through project activities and should highlight the achieved impact wherever possible.**

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

The Ministry of Health's Integrated Management of Acute Malnutrition (IMAM) provides for the targeting of all vulnerable and marginalized individuals and groups in life saving interventions. Hence, UNICEF through CERF promoted the involvement of the vulnerable and marginalized groups including refugees, children under 5, and refugees in West Nile. The project ensured all the vulnerable and marginalized children were screened for malnutrition, and the malnourished enrolled into therapeutic care. Through routine supportive supervision, the district health team, regional referral hospital and MoH representatives interacted with health workers and the representatives of these beneficiaries to get their feedback

b. AAP Feedback and Complaint Mechanisms:

Through the routine meetings with the beneficiaries in the in-patient and outpatient therapeutic care facilities, the health workers sought feedback on the quality of the support provided. Additional feedback was provided through exit interviews from the program and in the regular Food Security and Nutrition Assessment (FSNA) in the refugee hosting districts.

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

UNICEF oriented all its partners including the Ministry of Health, Regional Referral and District Local Government representatives on SEA including the channels for reporting the complaints. Through the supportive supervision to the health facilities and the communities in the project areas, additional guidance was provided to the beneficiaries and the service providers

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

[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.

The IMAM program emphasised the need to support all the beneficiaries including girls and women. Hence, the project through the health facility and community-based health workers screened all boy and girls for malnutrition. Women who are the primary caregivers for the malnourished children managed through the project were empowered with knowledge on how to better care for the children especially girls. The project in close coordination with other partners encouraged male participation so they are sensitised about the issues of malnutrition and gender.

e. People with disabilities (PwD):

The IMAM guidelines provide for special criteria for screening of children with disability for malnutrition, and for caring for them once enrolled into the program. The health workers often followed up with the caregivers of such children to ensure they get the extra care during feeding and play. The community health workers were also encouraged to visit their homes for see to it they were fed per the IMAM protocol

f. Protection:

The leadership of the districts, health facilities, sub counties and communities where the project took place provided oversight of the IMAM program so that all the children in care and their caregivers were not discriminated against neither targeted with any form of violence because of their being in the program. Due to the high level of food insecurity and poverty in the refugee settlements and the host communities, the beneficiaries could easily get targeted for because of the supplies obtained. Hence, these leaders and the service providers continuously sensitised the communities against discriminating or targeting the beneficiary households with violent acts.]

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	Choose an item.	[Fill in]

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.

Whereas CVA is an important element for the prevention and management of undernutrition, UNICEF did not have funding to support this aspect of the programme. Funding allowing, UNICEF will implement CVA in future.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
UNICEF and partners make children suffering from acute malnutrition smile again	https://www.unicef.org/uganda/stories/unicef-and-partners-make-children-suffering-acute-malnutrition-smile-again/
Over 30,000 children in West Nile screened for malnutrition	https://www.unicef.org/uganda/stories/over-30000-children-west-nile-screened-malnutrition

6.3 Project Report 20-UF-WHO-035

1. Project Information

Agency:	WHO	**Country:**	Uganda
Sector/cluster:	Health	**CERF project code:**	20-UF-WHO-035
Project title:	Accelerated response to COVID 19 outbreak in Uganda		
Start date:	16/11/2020	**End date:**	15/11/2021
Project revisions:	No-cost extension ☐ Redeployment of funds ☐	Reprogramming	☐

Funding

Total requirement for agency's sector response to current emergency: **GUIDANCE**: Figure prepopulated from application document.	**US$ 5,256,070**
Total funding received for agency's sector response to current emergency: **GUIDANCE**: Indicate the total amount received to date against the total indicated above. Should be identical to what is recorded on the Financial Tracking Service (FTS). This should include funding from all donors, including CERF.	**US$ 525,607**
Amount received from CERF:	**US$ 499,984**
Total CERF funds sub-granted to implementing partners: **GUIDANCE**: Please make sure that the figures reported here are consistent with the ones reported in the annex.	**US$ Nil**
Government Partners	US$ Nil
International NGOs	US$ Nil
National NGOs	US$ Nil
Red Cross/Crescent Organisation	US$ Nil]

2. Project Results Summary/Overall Performance

Through this CERF UFE grant, WHO made available 30000 tests of COVID 19 kits (10,000 PCR based and 20,000 RDT based), recruited 05 short term skilled staff and followed up 9000 contacts of the confirmed cases.

3. Changes and Amendments

Towards the end of the project period in November 2021, a fast-spreading Cholera outbreak was identified in Nakivale refugee settlement. Nakivale was not identified among the settlements for support. However, in view of the limited alternative funding and the fact that the grant was close to the end date, the emergency deployment budget line under this project was used to expeditiously deliver services to the refugees. This allowed expeditious deployment of surge team from national level as well as covering the local operational costs for Oral Cholera Vaccination exercise in a section of the settlement. Cholera was effectively controlled in Nakivale Refugee settlements over a period of 2 months. A total of 172 cases with no deaths were recorded in the outbreak. A reactive OCV campaign was robustly supported reaching to 76% (11,400 individuals) for dose 1 and 74% for dose 2.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	11,090	9,768	4,753	4,389	**30,000**	11,090	9768	4753	4389	**30000**
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	3,327	2,931	1,426	1,317	**9,001**	3327	2930	1426	1317	**9000**
Other affected people	0	0	0	0	**0**	0	0	0	0	0
Total	**14,417**	**12,699**	**6,179**	**5,706**	**39,001**	**14417**	**12698**	**5706**	**6179**	**39000**
People with disabilities (PwD) out of the total										
	231	120	99	45	**495**	**231**	**120**	**99**	**45**	**477**

* 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

A large population in the districts benefited from the surveillance systems established by the short-term staff. This is estimated at approximately 70,000 individuals.

6. CERF Results Framework

Project objective	Improve operational presence of WHO in the high burden districts for effective response support to the COVID 19
Output 1	Access to COVID 19 testing services among high risk population is increased

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	Number of high-risk persons tested for COVID 19	30,000	30,000	Proof of Delivery report
Indicator 1.2	Test positivity rate	5% (1,500 COVID 19 +ve cases)	5 – 36%	Daily sitrep
Explanation of output and indicators variance:		Delta variant significantly drove positivity rates in project districts because of high transmissibility		

Activities	**Description**	**Implemented by**
Activity 1.1	Procure assorted COVID 19 PCR & RDT based testing kits	WHO
Activity 1.2	Orientation of lab technicians on COVID 19 testing	WHO

Output 2	Identification, reporting and response to COVID 19 cases conducted in a timely manner

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 2.1	Number of deployment missions conducted in high burdened districts	7	03	Field deployment report
Indicator 2.2	Daily contact follow up rates	85% (9,945 contacts)	80% [9000 contacts]	WHO sitrep
Explanation of output and indicators variance:		The 03 missions were extended and additional support had to provide to the district teams to provide sustained response to the emergency. Contact follow up rates was also relatively low because the outbreak became widespread and the contact tracers were outstretched		

Activities	**Description**	**Implemented by**
Activity 2.1	Emergency deployment of surge of health staff to backstop high volume overburdened health facilities	WHO
Activity 2.2	Support supervision/follow up of contact tracing exercises in the field	WHO

Output 3	High burdened districts effectively supported to control the COVID 19 outbreak			
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 3.1	Number of skilled recruited staff deployed	5 staff at NO-B level	05 staff recruited	HR recruitment report
Indicator 3.2	Proportion of hubs providing daily reports to national level	100% (08)	08 (100%)	WHO sitrep
Explanation of output and indicators variance:		Nil		

Activities	**Description**	**Implemented by**
Activity 3.1	Recruit/ support 05 National Professional Officers at NO-B grade	WHO
Activity 3.2	Conduct regular field support missions to districts	Ministry of Health

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[14] 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 addressed through project activities and should highlight the achieved impact wherever possible.**

a. Accountability to Affected People (AAP) [15]:

Refugees and host community were involved in the design of the interventions. At least 05 persons in each of the refugee hosting districts were enrolled and trained to conduct alert management and contact tracing supervision. During the Cholera emergency, work was conducted with Isingiro district and the implementing partners at Nakivale settlement to develop and implement the Oral Cholera Vaccine deployment plan which effectively controlled cholera.

b. AAP Feedback and Complaint Mechanisms:

In all the settlement implementation was conducted through existing structures. Even though implementing partners were not providing funding, a careful evaluation was done to ensure that they included a strong provision for involvement of local structures in the refugee settlements as well as in the host communities. The Ministry of Health at national level was fully involved to supervise the implementation at subnational level. The Village Health Teams were engaged as mobilizers and in identification and monitoring of the contacts. In this

[14] 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.

[15] 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.

way the communities actively participated in determining their health outcomes. A fair representation for both women/girls and other marginalised groups was promoted

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

WHO staff and its implementing partners always used branded attires and vehicles. The beneficiaries were explained the mission of WHO and the zero tolerance to sexual exploitation and harassment and corruption free work. Ministry of Health was informed to declare the support provided to WHO to the districts and stakeholders so that any complaints from the community could easily be addressed independently to WHO by the districts or partner agencies in the settlement. The Village Health Teams accountability was maintained through existing structures.

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

All persons irrespective of gender was targeted in the project if they were identified as exposed or at risk of exposure to infection. The contact identification tools and those used to delivery OCV were clearly disaggregated for gender and analysis and feedback was conducted to ensure that standard outbreak response principles were applied.

e. People with disabilities (PwD):

All responders were instructed to give priority to persons with disabilities in terms of shortening service access time and specifically identifying them as targets during mobilization.

f. Protection:

All the entities engaged in the project, be it through commodity support or as partners in delivery a portion of the packaged were informed of the need to maintain confidentiality and to always protect the beneficiaries. Confidentiality was maintained in the listing of cases, delivery of results and in ensuring the cases and their contacts were provided with care in a dignified manner.

g. Education:

The project did not directly target education but aspects such as health education and other activities of public health in schools were considered during other follow up projects. WHO successfully mobilized resources for this purpose from Embassy of Denmark and Embassy of Ireland to support schools.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

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

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.

Most of the activities were procurements. There was not provision for cash assistance in the project

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

[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities.

Title	Weblink

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-UF-FPA-035	Health	UNFPA	INGO	$398,233
20-UF-FPA-035	Gender-Based Violence	UNFPA	INGO	$48,012
20-UF-CEF-055	Nutrition	UNICEF	GOV	$16,518
20-UF-CEF-055	Nutrition	UNICEF	GOV	$207
20-UF-CEF-055	Nutrition	UNICEF	GOV	$1,719
20-UF-WOM-004	Gender-Based Violence	UN Women	GOV	$210,998
20-UF-WOM-004	Gender-Based Violence	UN Women	INGO	$109,223
20-UF-WOM-004	Gender-Based Violence	UN Women	NNGO	$83,899
20-UF-WOM-004	Gender-Based Violence	UN Women	NNGO	$99,768
20-UF-WOM-004	Gender-Based Violence	UN Women	NNGO	$50,069
20-UF-WOM-004	Gender-Based Violence	UN Women	INGO	$246,385
20-UF-WOM-004	Gender-Based Violence	UN Women	NNGO	$65,449
20-UF-HCR-028	Protection	UNHCR	INGO	$45,972
20-UF-HCR-028	Protection	UNHCR	INGO	$460,000
20-UF-HCR-028	Protection	UNHCR	INGO	$118,500

ANNEX 2: ACRONYMS AND ABBREVIATIONS

AAR	After Action Review
IST	Institute for Social Transformation
AAP	Accountability to Affected People
CBCM	Community-Based Complaint Mechanisms
CERF	Central Emergency Response Fund
CMR	Clinical Management of Rape
CP	Child Protection
CVA	Cash and Voucher Assistance
DRC	Democratic Republic of Congo
ERC	Emergency Relief Coordinator
ERH	Emergency Reproductive Health
FMC	Food Management Committee
FP	Family Planning
FRRM	Feedback Referral and Resolution Mechanism
GBV	Gender Based Violence
HC	Health Centre
HCT	Humanitarian Coordination Team
HIV	Human Immunodeficiency Virus infection
HMIS	Health Management Information System
IASC	Inter-Agency Standing Committee
IEC	Information Education Communication
IMAM	integrated management of acute malnutrition
IP	Implementing Partner
IRC	International Rescue Committee
LWF	Lutheran World Federation
MH	Mental Health
MoH	Ministry of Health
MHPSS	Mental Health and Psychosocial Support
MPC	multi-Purpose Cash
MPDSR	Maternal and Perinatal Death Surveillance and Response
MUAC	Middle Upper Arm Circumference
NGO	Non-Governmental Organizations
NMS	National Medical Stores
OHCHR	Office of the High Commissioner for Human Rights
OPM	Office of the Prime Minister
OSC	One-stop Centre
PSEA	Protection from Sexual Exploitation and Abuse
PwD	People with Disabilities
RC	Resident Coordinator's Office

RCO	Resident Coordinator's Office
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RLP	Refugee Law Project
RT-PCR	Real Time - Polymerase Chain Reaction
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SEA	Sexual Exploitation and Abuse
SGBV	Sexual and/or Gender-Based Violence
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
SRMH	Sexual Reproductive and Maternal Health
STI	Sexually Transmitted Diseases
TPO	Transcultural Psychosocial Organisation
UFE	Under Funded Emergency
UN	United Nations
UNCT	United Nations Country Team
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USD	United States Dollar
VAC	Violence Against Children
VHT	Village Health Teams
VSLA	Village Savings and Loan Association
WG	Working Group
WHO	World Health Organization