
# RESIDENT/HUMANITARIAN COORDINATOR REPORT 2012 ON THE USE OF CERF FUNDS DEMOCRATIC REPUBLIC OF THE CONGO

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| **RESIDENT/HUMANITARIAN COORDINATOR** | **Mr. Moustapha Soumare** |

## PART 1: COUNTRY OVERVIEW

## I. SUMMARY OF FUNDING 2012

| TABLE 1: COUNTRY SUMMARY OF ALLOCATIONS (US$) | | |
|---|---|---|
| **Breakdown of total response funding received by source** | CERF | 31,486,288 |
| | COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*) | 88,420,508 |
| | OTHER (Bilateral/Multilateral) | 419,024,315 |
| | **TOTAL** | 538,931,111 |
| **Breakdown of CERF funds received by window and emergency** | **Underfunded Emergencies** | |
| | *First Round* | 0 |
| | *Second Round* | 11,770,546 |
| | **Rapid Response** | |
| | Cholera | 9,098,247 |
| | Ebola | 739,515 |
| | Conflict and Displacement | 9,877,980 |

## II. REPORTING PROCESS AND CONSULTATION SUMMARY

a. Please confirm that the RC/HC Report was discussed in the Humanitarian and/or UN Country Team and by cluster/sector coordinators as outlined in the guidelines.

YES ☒ NO ☐

Reporting requirements, and the need to ensure that all projects adhere to their objectives, and specific reference to the number of no-cost extensions were discussed by HC at the HCT

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

YES ☐ NO ☒

Issues related to the reports were shared at the HCT, and discussed at the Inter cluster meetings, though not the final version, due to late submission of more than a third of the project reports. For both the response to Cholera, and the Ebola outbreak, both recipient agencies were asked to review all comments on results and lessons learned. In summary, the process could have been more consultative, with more specific feedback on the added value of the CERF.

## PART 2: CERF EMERGENCY RESPONSE – CHOLERA (RAPID RESPONSES 2012)

## I. HUMANITARIAN CONTEXT

| TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$) | | |
|---|---|---|
| ***Total amount required for the humanitarian response: 23,600,000*** | | |
| **Breakdown of total response funding received by source** | **Source** | **Amount** |
| | CERF | 9,098,247 |
| | COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*) | 4,854,413 |
| | OTHER (Bilateral/Multilateral) Includes *Agency own funds* | 4,275,299 |
| | **TOTAL** | **18,277,959** |

| TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$) | | | |
|---|---|---|---|
| **Allocation 1 – Date of Official Submission: 10 January 2012** | | | |
| **Agency** | **Project Code** | **Cluster/Sector** | **Amount** |
| **UNICEF** | 12-CEF-001 | Water and Sanitation | 4,405,190 |
| **WHO** | 12-WHO-001 | Health | 4,693,057 |
| Sub-total CERF Allocation | | | 9,098,247 |
| **TOTAL** | | | **9,098,247** |

| TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$) | |
|---|---|
| **Type of Implementation Modality** | **Amount** |
| Direct UN agencies/IOM implementation | 2,794,086 |
| Funds forwarded to NGOs for implementation | 4,742,566 |
| Funds forwarded to government partners | 100,000 |
| **TOTAL** | **9,098,247** |

Cholera is an endemo-epidemic disease often reported in the eastern provinces of DRC, specifically in areas around the lakes. However, in March 2011, in addition to an epidemic in the east, an epidemic was also declared for provinces in the west of the country, where few cases had previously been reported - in Kisangani and surrounding areas. From there, the cholera spread westward along the riverine routes – first to western Province Orientale, then to Bandundu, and by July 2011, cases were reported in Kinshasa.

By the end of 2011, 8,038 cases (with 434 deaths) had been registered in the four provinces along the Congo River (Province Orientale, Bandundu, Equateur and Kinshasa), with a fatality rate of 5 per cent. At the same time, the provinces in the east (North Kivu, South Kivu, Katanga, and the Ituri district in Province Orientale) were in an situation of endemic disease with 13,654 registered cases and 150 deaths by 31 December 2011 (a fatality rate of 1 per cent). By the start of 2012, cholera continued in Kinshasa and Bandundu, and by week 4, a new province – Bas Congo – was struck by the epidemic, bringing the number of cases for the year by 21 February, 2012 to 437, with 13 deaths in the western provinces.

Significant efforts had been made over the six months period ending in December 2011, to curtail the spread of the epidemic and to treat the individuals and communities affected. While these efforts did mitigate the initial impact of the disease, they had been insufficient to fully control the disease, and the epidemic was again reaching new geographic zones, and new cases continued to be reported in new health zones and in areas where previously the epidemic showed signs of decline.

Despite efforts underway by both Health and WASH actors, it quickly became apparent that a new and more robust response was needed, and in a substantive way over a six-month period to stop an already serious situation degrading further. In addition to the fear of cholera becoming endemic in new areas in the west, there was a real threat of spill over of the disease into neighbouring countries (CAR, Angola, and Republic of Congo). Furthermore, the potential arrival of cholera in Kinshasa was of grave concern to the humanitarian community, with the potential of spreading rapidly, and of becoming endemic in a metropolis of some 10 million people, most living in dire sanitary conditions.

Due to the time-critical requirements of responding to the epidemic, and to halt further spread of the disease, CERF funding was requested as a last resort. Other funding opportunities were also sought to address the medium- and longer-term control of the disease, though as the epidemic flared towards the end of the year, most donors had exhausted yearly funds destined for western provinces of DRC, and national health authorities had no additional funding for strengthening cholera response.

## II. FOCUS AREAS AND PRIORITIZATION

The CERF-funded project was planned for roll-out in 32 health zones across the eight affected provinces. By the end of December, 2011, 144 out of 515 health zones reported cases of cholera, with the populations of a further 150 health zones having been at risk. The cases were initially being reported by the Ministry of Health (MoH) and in the eastern provinces – where cholera had become endemic – the health sector and workers were well equipped to investigate cases. However, in the western provinces, local communities were slow to recognize the seriousness of the epidemic, and health structures were less able to put in place protocols to detect cases, report them, or treat the sick effectively. As a result, the epidemic showed high mortality rates from the outset and spread along the course of the Congo River.

TABLE 1 : Epidemiological Situation of cholera in DRC, as of 31 December, 2011

| Province | Cases | Deaths | Fatality rate% |
|---|---|---|---|
| Bandundu | 2323 | 142 | 6% |
| Equateur | 3045 | 165 | 5% |
| Kinshasa | 974 | 42 | 4% |
| P.Orientale(w/o Ituri) | 1631 | 84 | 5% |
| Total | 7973 | 433 | 5% |
| P.Orientale(Ituri) | 20 | 2 | 10% |
| Katanga | 2701 | 44 | 2% |
| Maniema | 220 | 3 | 1% |
| Nord-Kivu | 5093 | 53 | 1% |
| Sud-Kivu | 5527 | 42 | 1% |
| Total | 13561 | 144 | 1% |
| **Country-wide Total** | **21534** | **577** | **3%** |

Assessments were carried by the MoH, and key focus areas and recommendations for interventions regarding the cholera situation in Kinshasa were communicated in the national crisis coordination meeting (CNC) at the MoH on 28 December 2011. For the outbreaks in Kwamouth/Bandundu, a multi-sectorial team was deployed by WHO on 8 January, 2012. Analysis of data and alerts for outbreaks in eastern DRC became available through the North Kivu and South Kivu health clusters, MoH and partners, and were used as the basis for design of interventions.

A major component of the projects to address the cholera epidemic was to put in place improved epidemiological surveillance, such that investigations, confirmation of cases, and collection, compilation, transmission and analysis of data were in place. The daily and weekly evolution of the number of cases was regularly done by WHO in support of the MoH, in collaboration with NGO partners. In the same vein, the analysis and treatment of surveillance data allowed the epidemic to be followed on a daily basis. As such, the needs assessments were being carried out on a regular basis, rather than as a one-off exercise.

In Kinshasa province, from mid-December 2011 until early February 2012, the numbers of cholera cases were increasing more dramatically than in similar time periods previously, with an average of 75 new cases being detected each week. During that time frame, some 1,000 cases were recorded with 42 deaths, giving a fatality rate of 4.3 per cent. Of the 35 health zones in the

province, 33 were affected by cholera, and with high levels of urbanization, and low sanitation levels, there was a real risk of increasing and uncontrolled spread of the disease.

Meanwhile, in the eastern provinces, where cholera has been endemic, the epidemic started to spread beyond initial susceptible areas. Health zones in North Kivu, affected by both the on-going conflict and cholera, saw exceedingly high case fatality rates (Walikale 4.3 per cent, Vuhovi 5.7 per cent).

## III. CERF PROCESS

With the increasing spread of cholera across the DRC, a Task Force was formed in July 2011, initially chaired by OCHA, and then taken over by WHO, and counting on the support of a number of local and international partners. The Task Force became a forum for exchanging information about the developing crisis at the field level, identifying gaps in service delivery, analysing data from the field, and agreeing to a strategic response across several sectors. As such, it was at the level of the Task Force – and in coordination with the Health and WASH Clusters – that the projects for intervention were discussed and prioritized, based on the epidemiological surveillance and the geographical routes of transmission. Through its work in analysing gaps in response at the field level, the Cholera Task Force identified the need for a multi-sectorial approach to addressing cholera focusing on both remedial and preventative measures. The strategy that was developed was undertaken with the objective of also ensuring that the MoH was able to play a leading role in the design and implementation of projects, such that they would be in a better position to respond to future epidemics, and that improved systems for case detections were in place.

In the eastern regions, where cholera is endemic, the response was initially effected through the existing longer-term donor-funded primary health care support programmes, implemented by NGOs and the Red Cross movement supporting the local DRC health systems and structures. As preparedness planning had been part of a longer term strategy for the east, no additional funding was initially sought. Health and WASH actors already active in the east focused some of their activities on cholera. In fact, although not realized fully at the time, some funding sources such as those of the DRC Pooled Fund, which had been used to shore up cholera responses in previous years, were discontinued in 2011 (for example in South Kivu).

## IV. CERF RESULTS AND ADDED VALUE

**TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR**

***Total number of individuals affected by the crisis:*** 2,847,671

| **The estimated total number of individuals directly supported through CERF funding by cluster/sector** | **Cluster/Sector** | **Female** | **Male** | **Total** |
|---|---|---|---|---|
| | Water and Sanitation | 1,452,312 | 1,395,359 | 2,847,671 |
| | Health | 1,452,312 | 1,395,359 | 2,847,671 |

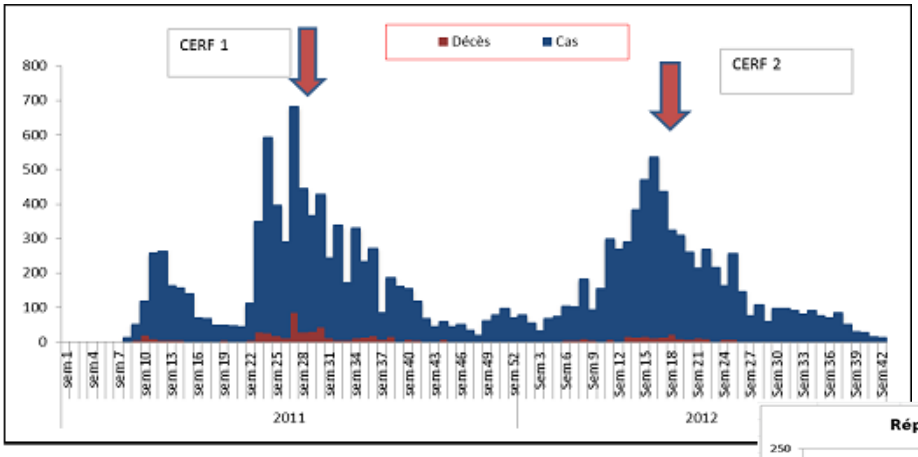
Cholera affects entire communities both directly and indirectly, causing individuals to fall sick suddenly and often fatally, but also destabilizing the resilience of households that are already among the poorest in the world. In DRC it is putting schools, health structures, agricultural and other livelihood activities – all of which barely function in any case – in acute stress. Apart from the direct impact of morbidity and mortality, there is a corollary impact on agricultural and commercial productivity in affected health zones, decrease in school attendance and general quality of life among affected populations. Today as many as 21 million people in DRC nation-wide are at risk of preventable death or of suffering the indirect effects of the epidemic on their livelihoods and communities. In the east, the situation is made worse by the on-going violent conflict, which affects people's ability to reach health centres for treatment, impedes health workers ability to reach clinics, disrupts services, and undermines community action that could prevent or curtail the disease. In the west, urban areas along the great river systems make ideal conditions for the disease where infrastructure for potable water, waste disposal, and good practices of household hygiene are absent.
As such, beneficiary numbers for response purposes were estimated based on positive impact for all populations in the affected health zones. A total of 4,000,000 people were estimated to live in the 40 health zones based on a minimum of 100,000 people per zone. In terms of response, some 2,800,000 people benefitted from direct interventions, and included those most at risk.

| TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING | | |
|---|---|---|
| | **Planned** | **Estimated Reached** |
| **Female** | 1,100,000 | 1,452,312 |
| **Male** | 1,100,000 | 1,395,359 |
| **Total individuals (Female and male)** | 2,200,000 | 2,847,671 |
| **Of total, children under 5** | 400,000 | 512,581 |

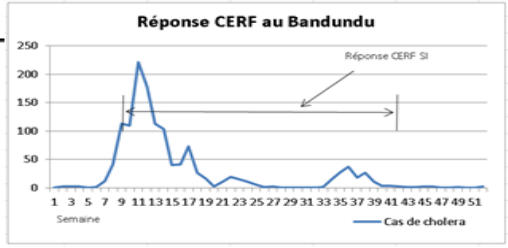
**RESULTS**

The WASH and Health components of the funding defined five common sub-objectives, within the large goal of preventing the deterioration of the situation of cholera, and of reducing the morbidity by 50 per cent. The specific objectives related to:

1. Reducing the mortality in Kinshasa and all provinces by 25 per cent;
2. Reducing morbidity by 50 per cent in the provinces of the west;
3. Ensuring during the first three months, a significant reduction of transmission in affected areas, and by six months the containment of the epidemic in the west;
4. Reducing the epidemic to endemic levels (reducing the morbidity by 50 per cent ) in the east; and
5. Reinforcing the role of the MoH at national and international level.




Overall, there has been a dramatic reduction in the number of cases of cholera, and in line with the roll out of the CERF-funded activities, as can be seen in the graph to the left In 2012, from week 1 until week 36, there were a total of 6,829 cases and 219 deaths identified in the western provinces. However, from that period on, and in line with the project implementation, the next four weeks saw only a total of 217 cases – thus bringing the average down significantly from around 190 cases per week until week 36, to less than 40 cases per week, well above the objective of reducing morbidity by 50 per cent in the west.




The dramatic decrease in transmission rates can be seen from the graph to the right, which shows the evolution of the epidemic in Bandundu.

However, in the eastern provinces, the outcomes have been less than ideal, with the situation exacerbated by the on-going conflict, and the corollary impact on access. As well as the number of cases having risen during the project cycle, the fatality rate has also risen from 1 per cent to around 2 per cent. Overall in the east, the average number of cases per week between Week 1 and Week 36 was at 484, whereas from Week 37 until Week 42 it was at 423 a week. And in Katanga the cases rose significantly over that same time period, notably in the health zones of Kinkondja and Malemba-Nkulu, where the rise in the number of cases occurred at the start of the rainy season, and a new appearance of cholera in the city of Lubumbashi.

Thus, while the CERF-funded projects were able to achieve many successes in carrying out life-saving activities, and rapidly reducing the spread of cholera over the six-month period, the limitations of such projects must be understood from an epidemiological point of view. The goal of the project was to reduce mortality and to stop transmission, and given the time frame,

the limited funds available and the vast size of the country these were certainly achieved. However, the eradication of cholera is a development goal, and one that takes five to ten years to achieve, rather than a rapid response goal.

***WASH Activities***

The main activities supported by this project were the establishment and management of chlorination points, the construction of wells nozzles; distribution of at-home water treatment stocks or cholera kits, the construction of latrines; awareness-raising campaigns and home disinfection.

1. A total of 78 chlorination points were established across the impacted areas. Further, in Bas Congo, REGIDESO (the national water provider), received 240 kilos of chlorine to treat the water, and in Ituri, two mini water treatment stations were established along the river with a capacity for around 40,000 people.
2. The project supported the local production of chlorine in the areas most at risk. In North Kivu, a standard solar power kit for the production of chlorine was distributed, and staff was trained in the use and maintenance of this equipment. Further chlorine production facilities were put in place in South Kivu, in Ituri (two units: in Tchomia and Bunia), in Katanga (two units: Tanganyika and Top Lomani), and in Kinshasa (in N'Sele commune).
3. A total of 34 sources were developed through the project, in the following most affected zones. In the zones most at risk with difficult access to potable water, 33 new wells were built, and a further 10 rehabilitated mostly in Katanga, Bas-Congo, Kinshasa and Bandundu.
4. Distribution of home treatment kits: To curb the spread of cholera while medium-term activities were being carried out, the project distributed 107,372 aquatabs and 51,840 sachets of PUR both of which are used for at-home water treatment.
5. Sanitation is a major problem in the DRC, with over 80 per cent of the population not having access to adequate sanitation. To meet the objective of reducing the spread of cholera, 412 family latrines, 38 emergency public latrines and 145 permanent public latrines were constructed.
6. One the main components of the project were to sensitize the population on methods for stopping the spread of cholera, and good hygiene practices. This was carried out through door-to-door visits, use of the media (radio and leaflet distribution), and with visits to markets, schools and churches. Without taking into account the number of people indirectly reached through the radio, a total of 2,847,671 people were reached through these different campaigns.
7. For affected families, specific WASH kits were distributed to help behaviour change. This included: 34,956 bars of soap; 2,353 jerry cans; 13,300 buckets.
8. A total of 14,920 disinfections were carried out of homes, boats and public space, including 620 homes in Kinshasa.

***Health***

Strengthening case management was a vital component in achieving the health-related objectives. As such, 16 cholera treatment centres were established in the western provinces with 30 cholera kits having been distributed, with the endemic regions of the east already having functioning centres.

To improve coordination of the response, WHO facilitated setting up eight provincial committees to support the MoH. Furthermore, the project rolled out training of health workers on identifying, reporting and managing cases, and establishing early warning systems in the communities, as well as providing necessary medical materials for treating cases in the health establishment.

**ADDED VALUE**

Overall, the rapid distribution of the CERF funds allowed the objectives to be met, with both mortality rates and morbidity rates having been reduced by more than the anticipated percentages of 25 per cent and 50 per cent respectively.

A major outcome was that the project was able to address the whole country in a more strategic manner, specifically including the east, which – due to cholera being endemic there – did not receive the intensive efforts in the first round of interventions in 2011. This holistic approach, and the initial success of the first CERF-funded rapid response intervention in the west, has also resulted in the importance of addressing cholera outbreaks in the east more strategically, and through development initiatives. At the same time, the multi-sectorial approach has been proven to be indispensable in ensuring success in the fight against cholera.

**a) Did CERF funds lead to a fast delivery of assistance to beneficiaries?**

YES ☒ PARTIALLY ☐ NO ☐

With partners already in place in many areas, and projects already either underway (but stopped due to lack of funds) or in the pipeline, the CERF funding enabled rapid response in critical areas. The flexibility of the CERF project was particularly of use in responding to the changing spread of the epidemic in the west, and doing so more rapidly.

**b) Did CERF funds help respond to time critical needs[1]?**
YES ☒ PARTIALLY ☐ NO ☐

Without the CERF funding, the cholera epidemic would have spread further, resulting in a higher fatality rate, and causing more areas of the country to become endemo-epidemic, thus leading to future severe epidemics. This is particular relevant for the western provinces where cholera had not been seen for nearly a decade, leading to slow reactions by the national health authorities, and thus requiring an more immediate an robust intervention strategy.

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

At the time of requesting funds from the CERF for the rapid response to cholera, a two-phased strategy had been developed by actors in the Health and WASH sectors. Namely, the immediate life-saving activities covered the first six months, and to curtail the further spread of the disease. This was ably achieved through the CERF-funded projects. A second phase of 12 months was to consist of medium-term actions to (continue) support for the various ministries concerned so that the cholera situation was completely addressed. Unfortunately, as of this time, there has not been the necessary support of the donors, and more efforts need to be made in advocating for longer-term strategies to eradicate the epidemic, and to keep cholera high on the agenda of the donors. For WASH activities however, there have been some positive outcomes achieved in collaboration with two partners in Bas Congo and in Ituri. This collaboration has allowed continuation of the interventions after the end of the CERF funding through Common Humanitarian Funds (Pooled Funding) projects. Moreover, in the east, ECHO will fund a project following the WASH Cluster community-based strategy for combatting cholera, and advocacy with development donors for complementary projects will continue. From 2013 tp 2017, the DRC Government together with DFID, UNICEF and Japanese funds will implement a safe drinking water project in 97 of the 171 health zones impacted by cholera. This will allow some health zones that benefited from CERF project to transition to longer-term interventions.

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

One of the important results of the CERF funding was the strengthened coordination among the WASH and the Health cluster actors, as well as specifically coordination with the relevant government branches. The initial coordination efforts, and the establishment of the Cholera Task Force was carried out by OCHA, and then the Health Cluster developed and facilitated a transition of this coordination, supporting the MoH to set up a subcommittee with a multi-sectorial mandate.

## V. LESSONS LEARNED

**TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT**

| Lessons Learned | Suggestion For Follow-Up/Improvement | Responsible Entity |
|---|---|---|
| The disbursement of funds in different ways for the two projects (Health and WASH) impacted the ability to coordinate effectively. | Whereas the Health project allowed for flexibility to address new affected zones as they were identified through slower disbursement of funds as needed, the WASH project received rapid and definitive disbursements that were assigned very quickly, allowing little flexibility, or for the two projects to continue working side-by-side. Ensure common disbursement systems in consultation with the fund recipients. | CERF Secretariat |

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

| TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS | | |
|---|---|---|
| **Lessons Learned** | **Suggestion For Follow-Up/Improvement** | **Responsible Entity** |
| Rapid response improved through effective coordination between the Health and WASH cluster, and the establishment of a Cholera Task Force. | For all epidemics, ensure a strong collaboration between actors in different sectors, to work in parallel on prevention and management of cases. | All Clusters |
| The more rapid the response, the more 'cost effective' it is and the more lives are saved. | Strengthen the capacity of stakeholders in WASH activities to improve their preparedness for response. Emphasis should be placed on capacity building for local NGOs and the MoH. | WASH Cluster, Humanitarian community (MoH, local NGOs) |
| Speed is a key factor in fighting cholera, as earlier interventions would have stopped the spread down river towards Kinshasa. | The Clusters should have the capacity and contingency funds at their disposal to react rapidly in the first days of a crisis while external funds are sought. | Humanitarian community, Donors, |
| Medium-term interventions need to be designed to control epidemic peaks, rather than just short-term interventions. | Ensure that the Multi-sectorial Strategic Plan for the Elimination of Cholera and Diarrhoeal Diseases 2013-2017 is finalized, validated and disseminated to the Government, the technical and financial partners and the population of DRC. | WASH, Health Clusters, HCT, MoH |
| Without development initiatives, there will be continued cycles of epidemics. | The HC to advocate for governments and donors to consider setting aside part of the emergency funds (Pooled Fund, and others) for development interventions alongside emergencies. | HC, donors |

## VI. PROJECT RESULTS

| TABLE 8: PROJECT RESULTS | | | |
|---|---|---|---|
| **CERF Project Information** | | | |
| 1. Agency: | **UNICEF** | 5. CERF Grant Period: | 1 February, 2012 – 1 August, 2012 |
| 2. CERF Project Code: | 12-CEF-001 | 6. Status of CERF Grant: | ☐On-going |
| 3. Cluster/Sector: | WASH | | ☒Concluded |
| 4. Project Title: | Cholera response for WASH activities, eastern and western DRC, 2012 | | |
| 7. Funding | *a. Total project budget:* | | US$ 23,600,000 |
| | *b. Total funding received for the project:* | | US$ 4,124,295 |
| | *c. Amount received from CERF:* | | US$ 4,405,190 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 1,100,000 | 1,452,312 | Numbers of beneficiaries reached are those in all impacted health zones at risk of cholera, or affected by it, and thus benefitting from awareness-raising campaigns and hygiene activities design to stop transmission. |
| *b. Male* | 1,100,000 | 1,395,359 | |
| *c. Total individuals (female + male):* | 2,200,000 | 2,847,671 | |
| *d. Of total, children under 5* | 400,000 | 512,581 | |

9. Original project objective from approved CERF proposal

Prevent the deterioration of the cholera situation and reduce morbidity by 50 per cent in both the east and the west.

10. Original expected outcomes from approved CERF proposal

- Number of new cases reduced by 50 per cent within six months;
- Mortality rate from cholera across DRC down by 25 per cent;
- No new health zones affected by disease by end of six month period.

11. Actual outcomes achieved with CERF funds

- Overall rates of cases down by over 50 per cent ;
- Mortality rate reduced from 5 per cent to 3 per cent over the course of the project;
- No new health zones affected by disease during project.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

In the western provinces, there was a dramatic decrease in the number of new cases (down by more than 50 per cent), but in the east the number of cases continued unchanged, or in some areas risen. This is attributed to the on-going conflict, lack of access, and the need to invest in infrastructure and find long-term solutions.

| 13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? | YES ☐ NO ☒ |
|---|---|
| **If 'YES', what is the code (0, 1, 2a, 2b):** Due to women's traditional roles in provision of water, and care for the sick, specific considerations taken into account during the project, including ensuring equal access to sensitization campaigns, and siting of water points aimed to also lessen burden on women and girls in collecting water. Men's roles as fishermen also considered when designing health interventions along the river routes. Both men and women were included for training on better hygiene standards<br>**If 'NO' (or if GM score is 1 or 0):** Project was not envisaged in HAG | |
| 14. M&E: Has this project been evaluated? | YES ☒ NO ☐ |
| UNICEF hired a consultant in Kinshasa, and two in the field to monitor implementation of project. The Ministry of Health – through provincial offices – also monitored results supported by chief medical offices in the health zones and found projects to be on track, with no new health zones reporting cases | |

## TABLE 8: PROJECT RESULTS

**CERF Project Information**

| | | | |
|---|---|---|---|
| 1. Agency: | **WHO** | 5. CERF Grant Period: | 1 February, 2012 – 1 August, 2012 |
| 2. CERF Project Code: | 12-WHO-00 | 6. Status of CERF Grant: | ☐Ongoing |
| 3. Cluster/Sector: | Health | | ☒Concluded |
| 4. Project Title: | Cholera response for health activities, eastern and western DRC, 2012 | | |

| 7. Funding | | |
|---|---|---|
| | *a. Total project budget:* | US$ 23,600,000 |
| | *b. Total funding received for the project:* | US$ 4,693,057 |
| | *c. Amount received from CERF:* | US$ 4,693,057 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 1,100,000 | 1,452,312 | |
| *b. Male* | 1,100,000 | 1,395,359 | |
| *c. Total individuals (female + male):* | 2,200,000 | 2,847,671 | |
| *d. Of total, children under 5* | 400,000 | 512,581 | |

9. Original project objective from approved CERF proposal

- Reduce mortality from cholera in Kinshasa and the western and eastern provinces by 25 per cent;
- Prevent deterioration of the cholera situation and reduce morbidity by 50 per cent in western provinces;
- Over the first three months significantly reduce transmission in affected health zone, and within six months stop further transmission in the western provinces;
- Reduce epidemic level to endemic level (reduce morbidity by 50 per cent) in the eastern provinces through improved case management at health centres and health education in communities;
- Strengthen MoH leadership role at national and provincial levels.

10. Original expected outcomes from approved CERF proposal

- Overall rates of cases down by over 50 per cent;
- Mortality rate reduced from 5 per cent to 3 per cent over course of project;
- No new health zones affected by disease during project.

11. Actual outcomes achieved with CERF funds

- Improved case management for those suffering from cholera through training of health personnel in case identification, education on health and hygiene in health centres, and provision of hygiene materials to health centres.
- Provision and stocking of Cholera Treatment Centres (CTC) in Kinshasa (5), Bandundu (2), Equateur (6), Province Orientale (3); with further support to existing CTCs in the east (that were already existing). Total of 38 CTCs supports and provisioned. Total of 30 cholera kits distributed to the CTCs.
- 30,753 patients treated for free in the different CTCs and given essential medicines.
- In Bas Congo, two dispensary tents were available for partners to help manage cases.

- 1000 cholera rapid test kits were given to partners.
- Support to the Ministry of Health partners in investigating cases, and collecting, compiling, analysing and spotting trends in the epidemic.
- Improved coordination through technical support provided to the MoH and health sector partners. Set up of eight provincial committees to update MoH at Kinshasa level.
- Through partnerships, provision of preventative supplies (chlorine, disinfection) to affected communities, public places (schools, markets) and to health centres. Sensitization of over 5,000,000 people in affected health zones through various means.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

In the western provinces, there has been a dramatic decrease in the number of new cases (down by more than 50 per cent), but in the east the number of cases has continued the same, or has in some areas risen. This is attributed to the on-going conflict, lack of access, and the need to invest in infrastructure and find long-term solutions.

| 13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? | YES ☐ NO ☒ |
|---|---|

**If 'YES', what is the code (0, 1, 2a, 2b):**

**If 'NO' (or if GM score is 1 or 0):**In affected communities, measures were taken to reach all sectors of community for sensitization campaigns, Understanding from the start of the epidemic that along the river routes, men were often more affected by cholera, and so special efforts to reach them. Additional measures to assist women in the community understand signs of cholera so that patients/family members could be transferred to treatment centres more rapidly. All epidemiological data was disaggregated by sex at all stages, to help analysed any differential impact based on sex, both in the health zones, and at the national level in Task Force meeting.

| 14. M&E: Has this project been evaluated? | YES ☐ NO ☒ |
|---|---|

Team made up of MoH delegates, WHO and other health patterns supervised case management at the CTCs in three locations. Other monitoring missions were carried out at each of the health structures. Needs assessments and identification of gaps from these missions were constantly carried out, and results noted. MoH also conducted number of monitoring missions to most affected areas, to assess risk factors for cholera.

## PART 2: CERF EMERGENCY RESPONSE – EBOLA (RAPID RESPONSES 2012)

## I. HUMANITARIAN CONTEXT

| TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$) | | |
|---|---|---|
| ***Total amount required for the humanitarian response:*** ***4,200,000*** | | |
| **Breakdown of total response funding received by source** | **Source** | **Amount** |
| | CERF | 739,515 |
| | COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*) | 999,973 |
| | OTHER (Bilateral/Multilateral) | 367,647 |
| | **TOTAL** | **1,739,488** |

| TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$) | | | |
|---|---|---|---|
| **Allocation 1 – Date of Official Submission: 14 September 2012** | | | |
| **Agency** | **Project Code** | **Cluster/Sector** | **Amount** |
| **UNICEF** | 12-CEF-113 | Health | 250,000 |
| **WHO** | 12-WHO-069 | Health | 489,515 |
| Sub-total CERF Allocation | | | 739,515 |
| **TOTAL** | | | **739,515** |

| TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$) | |
|---|---|
| **Type of Implementation Modality** | **Amount** |
| Direct UN agencies/IOM implementation | 653,495 |
| Funds forwarded to NGOs for implementation | |
| Funds forwarded to government partners | 86,020 |
| **TOTAL** | **739,515** |

Haemorrhagic fever Ebola is a highly contagious disease that is characterized by the sudden onset of fever, intense weakness, muscle pain, headache and sore throat. This is often followed by vomiting, diarrhoea, rash, kidney and liver failure and internal and external bleeding. Death occurs in 60-90 per cent of cases. The central location of the DRC at the crossroads of several Central African countries, poses a great risk of such an outbreak spreading to neighbouring countries, if effective action is not carried out in the shortest possible time. By 11 August 2012, neighbouring Uganda had reported 24 probable and confirmed cases of Ebola and 16 deaths - a mortality rate of 67 per cent. Based on this information and having common borders with Uganda, the medical authorities of the DRC considered this area as a very important risk factor for expansion of this epidemic, because of population movements between the two countries. At the same time, suspected cases of Ebola began to be reported

in the health zones of Dungu and Isiro, and which did not have an epidemiological link established with the case of Uganda. Blood samples were analysed at the laboratory in Uganda, and from six samples there were two confirmed cases of the Bundibugyo strain of Ebola. On 17 August 2012, the Minister of Public Health of the DRC, officially declared the outbreak of Ebola haemorrhagic fever (FHVE) in Isiro, in the District of Haut-Uele, approximately 570 kilometres north of Kisangani, capital of Orientale Province.

Furthermore, health personnel were being affected by the disease, with three nurses in Isiro hospital having died. At that stage, once the first cases were confirmed, the DRC Minister of Public Health of the DRC made a formal declaration of FHV Ebola epidemic.

By 4 September 2012, a total of 30 cases were reported with 15 deaths (six probable cases, eight confirmed cases, 185 people considered to be in contact with those affected). Four health zones were affected in northern Province Oriental: Dungu, Viadana, Isiro and Viadana with a case fatality rate of between 30 per cent and 50 per cent. Due to the highly infectious nature of the virus, all people in the affected health zones were considered to be at risk (700,000 people). By 11 October 2012, when the last case was reported, 77 people had been treated, of which 36 cases were confirmed by the laboratory, 17 probable cases and 24 suspected in the isolation and treatment centre installed in Isiro. A total of 797 contacts were followed and 242 samples were examined. Of the 36 confirmed cases, 27 (75 per cent) were from women, and 2 (5.5 per cemt) from children under 14.

There were already some partners in the field, with MSF Suisse, and MSF Belgium, and WHO that provided an epidemiologist, an emergency medical specialist, along with CDC Atlanta providing a mobile laboratory. However, there was a lack of materials and equipment for effective case management and detection, and the need to rapidly mobilise the community and improve communication and transport.

## II. FOCUS AREAS AND PRIORITIZATION

The National Coordination Advisory group (CNC), chaired by the MoH allowed for a strong governmental leadership as well as the analysis and dissemination of epidemiological data on a daily basis. Blood samples of suspected cases were sent to the UVRI laboratory in Uganda. In conformity with International Sanitary Regulation, after the official declaration of the epidemic, the activities were focused on surveillances, case management, information, education of populations, hygiene measures and control of infection in health centres and laboratories, as well as provision of psychosocial support for patients and their families. These regulations would form the basis for the interventions as designed by WHO and UNICEF, in addition to ensuring support for coordination at the provincial and local levels.

The initial evaluation was conducted by the Ministry of Public Health and WHO in Province Orientale, in the four affected health zones following notification of the first cases, in the week prior to the declaration of an epidemic. This assessment constituted the basis of the contingency plan elaborated by the Ministry.

The geographical coverage for the activities was decided based on health zones where cases or suspected cases had been reported, with an understanding that should the HVF Ebola spread beyond these, activities would be in place to address the new trajectory. Based on experience from previous outbreaks, no health zone where there had been an alert could be excluded from response activities until the declaration of the end of the epidemic, that is, 42 days after the last case confirmed by the laboratory (twice the length of the maximum incubation period). As such, health zones with suspected cases were to be included in the response plan.

## III. CERF PROCESS

The capacity to adequately respond to Ebola was hindered by weak health systems in Province Orientale and the four affected health zones in particular, and an absence of technical and financial partners to support the systems. Of particular concern, were the lack of equipment to confirm cases, insufficient surveillance and early warning systems to notify of new cases, lack of means for mobilising the community in the fight against the epidemic, communication and transport constraints to the affected communities, degraded health facilities overall, and few means of controlling infection in health centres and laboratories.

As explained above, the prioritization of activities was done in conformity with the internationally agreed-upon protocol. With the Government's capacity to respond exceeded, UNICEF and WHO initially submitted a $2 million project to the Common Humanitarian Fund to support the Government in its plans (coordination, investigation of cases, case management, infection

control, hygiene-sanitation, laboratory, logistics, communication and psychosocial care). However, the response of the Common Humanitarian Fund donors was that they would only be able to finance 50 per cent of the proposed budget, and as such, the two agencies approached the CERF to ensure a rapid and effective response. Therefore, the CERF-funded project was a vital supplement to the $1 million received from the Common Humanitarian Fund, rather than a separate or follow-on activity. The Pooled Fund allocation allowed for immediate interventions in the prioritized areas, with continuation of these activities under the CERF allocation. Moreover, there were complementary interventions by different partners, which would be supported by the CERF-funded project. The Centre for Disease Control (CDC-Atlanta), MSF-Belgium, MSF-Spain, MSF-Suisse, along with the Congolese Red Cross society were involved in specific areas of the response and in the coordination of the UNICEF-WHO interventions.

The HVF Ebola epidemic affected all sectors of the population, but there was a noted gender bias, with 75per centof confirmed patients being women, potentially as a consequence of women's roles as the main caretaker for sick family members, and as nurses affected in remote health centres. As such, specific attention was paid to ensuring that women and children were particularly targeted in awareness-raising campaigns to prevent transmission, and also to provide psychosocial support for widows and orphans of victims of the virus.

## IV. CERF RESULTS AND ADDED VALUE

| TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR | | | | |
|---|---|---|---|---|
| ***Total number of individuals affected by the crisis:*** 690,929 | | | | |
| **The estimated total number of individuals directly supported through CERF funding by cluster/sector** | **Cluster/Sector** | **Female** | **Male** | **Total** |
| | Health and WASH | 359,283 | 331,646 | 690,929 |

The total number of direct beneficiaries targeted corresponded to the total population of the four epidemic health zones or those at a strong risk of epidemic, with an estimated total of 690,929 people, of which 52 per cent were women.

| TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING | | |
|---|---|---|
| | **Planned** | **Estimated Reached** |
| **Female** | 359,283 | 359,283 |
| **Male** | 331,646 | 331,646 |
| **Total individuals (Female and male)** | 690,929 | 690,929 |
| **Of total, children under 5** | 134,367 | 134,367[2] |

**CERF RESULTS**

The general objectives of the project were to reduce the mortality and morbidity of FHV in the affected health zones, and to stop the further transmission of the epidemic. This was achieved through the specific objectives of: detecting all suspected cases and contacts; strengthening the capacity to treat cases; reducing the risk of transmissions; promoting good individual and collective

[2] Number represents all children under age of 18, as specific

hygiene practices and inducing behaviour change to stop transmission; psychosocial support for patients, care-givers, families. Complementary activities were designed by WHO and UNICEF to achieve each of these specific objectives.

Each of the specific objectives outlined were achieved, and resulted in the end in the epidemic being declared within the project timeframe (the epidemic is officially declared over 42 days following the notification of the last case). All suspected cases received medical treatment, and almost 797 people who had been in contact with potential cases were identified and followed over a 21-day period.

Case management in isolation units was supported in each affected health zones, with a total of 94 patients admitted. A total of 134 health workers were also trained on triage procedures for cases of Ebola, and on controlling the infection. A total of 300 protection and hygiene kits were distributed to hospitals and treatment centres.

The risk of transmission was reduced by: support for secure burials; awareness-raising campaigns for communities and families, with all 83 health zones in Province Orientale being targeted for messaging, and over 130 community workers trained. Social mobilization campaigns reached large sectors of society, with 107 sessions held for women's groups, 79 for youth groups, 194 sessions in schools; as well as door-to-door campaigns targeting 2,000 rural households.

Psychosocial support was offered to patients, care-givers, and their families, with over 400 people trained on psychosocial support, and 1,000 patients and families receiving direct support. In addition, 76 survivors, families and medical personnel received social assistance kits.

Further, the project directly supported the relevant government authorities, specifically in terms of coordination. The targets set by the project were reached with coordination mechanisms at national, provincial and local level in place and functioning.

**ADDED VALUE**

CERF funding allowed the Health and WASH clusters to fill a vital gap in terms of a holistic response to the Ebola epidemic. Without the funding, the response would have been slower, and the fight to contain the epidemic more lengthy, thus affecting more people, and likely leading to more deaths

In addition to control of the epidemic, the responses planned and achieved strengthened the capacities of the affected health zones through targeted trainings on case management, as well as increased understanding by the local communities of their vital role in stopping the transmission. The Ebola epidemic required a strong coordinated approach from a multiplicity of actors, and the funding allowed for this, and reinforced the role of the MoH in leading the coordination and response efforts.

**a) Did CERF funds lead to a fast delivery of assistance to beneficiaries?**

YES ☒ PARTIALLY ☐ NO ☐

Without the CERF-funds, there would have been limited access to medical assistance for suspected cases, and a long delay in being able to follow all those who had been in contact with them, which are vital components for controlling Ebola. Furthermore, social mobilization campaigns were a key success factor in controlling the spread of the virus and with CERF funds these were able to be begun immediately.

**b) Did CERF funds help respond to time critical needs[3]?**

YES ☒ PARTIALLY ☐ NO ☐

As FHV Ebola has such a rapid transmission rate and high fatality rate, the immediate release of CERF funds allowed both components of the project to carry out immediate life-saving activities, including improvement in hygiene standards, case management and awareness-raising campaigns to stop the further spread of the virus. History has shown that the more rapid the response, the more chance there is of containment

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

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

The CERF funding was a supplement to funds of $1 million received from the Common Humanitarian Fund and both sources were required to ensure an effective response. Both UNICEF and WHO were able to start activities due to staff already on the ground, using their own funds. As the project was successful in reaching its stated objectives of controlling the epidemic, no further resources were needed

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

From its inception, the project was jointly devised by WHO and UNICEF as chairs of the Health and WASH Clusters respectively. The specific aim was to support the role and coordination activities of the MoH, and do so successfully through a clear delineation of tasks among these main actors. A good collaboration between UNICEF and MONUSCO also allowed for quick and free transportation of the first lot of stocks (2 vehicles, 10 motorbikes, 80 bicycles, and other essential items [4]) immediately after the launch of the response. The strategy for response was designed in collaboration with a range of partners, including CDC-Atlanta, MSF (Suisse, Spain and Belgium) as well as INRB, USAID and the University of Kinshasa, each of whom played a specific and vital role

## V. LESSONS LEARNED

| TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT | | |
|---|---|---|
| **Lessons Learned** | **Suggestion For Follow-Up/Improvement** | **Responsible Entity** |
| NA | NA | NA |

| TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS | | |
|---|---|---|
| **Lessons Learned** | **Suggestion For Follow-Up/Improvement** | **Responsible Entity** |
| For new practices to be accepted by the community, there needs to be clear leadership. | Involve traditional chiefs and religious leaders under the leadership of the district commissioner when working on changing hygiene behaviour | All WASH actors |
| Preparedness is key to response to these types of epidemics. | Ensure that contingency plans with budgets are in place for specific epidemics in risk areas, and that these serve as framework for response. | All humanitarian actors |
| Without government involvement, a response cannot achieve success. | The role of the MoH and other political-administrative authorities is a key factor for the success of the response and has strengthened their capacity for future interventions. Ensure that appropriate authorities are involved in all key stages of interventions, rather than just substituting for their role | All humanitarian actors |

[4] The vehicles were not procured on CERF funds. One vehicle was purchased by UNICEF on its own resources. The second one was provided by WHO (apparently it was a vehicle from another WHO project, transferred to Isiro to support the Ebola response).

## VI. PROJECT RESULTS

| TABLE 8: PROJECT RESULTS | | | |
|---|---|---|---|
| **CERF Project Information** | | | |
| 1. Agency: | **WHO** | 5. CERF Grant Period: | 1 September, 2012 – 1 March, 2013 |
| 2. CERF Project Code: | 12-WHO-069 | 6. Status of CERF Grant: | ☐Ongoing |
| 3. Cluster/Sector: | Health | | ☒Concluded |
| 4. Project Title: | Response to HFV Ebola in Province Oriental | | |
| 7. Funding | *a. Total project budget:* | | US$ 4,200,000 |
| | *b. Total funding received for the project:* | | US$ 999,039 |
| | *c. Amount received from CERF:* | | US$ 489,515 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 359,283 | 359,283 | |
| *b. Male* | 331,646 | 331,646 | |
| *c. Total individuals (female + male):* | 690,929 | 690,929 | |
| *d. Of total, children under 5* | 134,367 | 134,367[5] | |

9. Original project objective from approved CERF proposal

Contribute to the reduction of mortality and morbidity caused by HFV Ebola.

10. Original expected outcomes from approved CERF proposal

- Detect all suspected cases and of contacts of Ebola in province;
- Register and follow all cases of contacts;
- Reduce the risk of transmission in the community.

11. Actual outcomes achieved with CERF funds

All of the outcomes were met, in that within the project period Ebola was contained, and the epidemic officially declared over by end of October, 2012.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

[5] Number represents all children under age of 18, as specific data for under 5 was not available

| | |
|---|---|
| 13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? | YES ☐ NO ☒ |

**If 'YES', what is the code (0, 1, 2a, 2b):**

**If 'NO' (or if GM score is 1 or 0):** With 75 per cent of confirmed cases being from women, there was a marked gendered component to the response, and measures were taken to ensure that women were especially targeted for awareness-raising campaigns as main caregivers.

| | |
|---|---|
| 14. M&E: Has this project been evaluated? | YES ☒ NO ☐ |

Final evaluations are underway with the project having been completed 14 days prior to reporting deadline. During project implementation, daily meetings were organized at the field level to monitor activities. All financial spending followed WHO standards and procedures.

| TABLE 8: PROJECT RESULTS | | | |
|---|---|---|---|
| **CERF Project Information** | | | |
| 1. Agency: | **UNICEF** | 5. CERF Grant Period: | 1 September, 2012 – 1 March, 2013 |
| 2. CERF Project Code: | 12-CEF-113 | 6. Status of CERF Grant: | ☐Ongoing |
| 3. Cluster/Sector: | WASH | | ☒Concluded |
| 4. Project Title: | Response to HFV Ebola in Province Oriental | | |
| 7. Funding | *a. Total project budget:* | | US$ 4,200,000 |
| | *b. Total funding received for the project:* | | US$ 999,039 |
| | *c. Amount received from CERF:* | | US$ 250,000 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 359,283 | 359,283 | |
| *b. Male* | 331,646 | 331,646 | |
| *c. Total individuals (female + male):* | 690,929 | 690,929 | |
| *d. Of total, children under 5* | 134,367 | 134,367[6] | |

9. Original project objective from approved CERF proposal

Contribute to the reduction of mortality and morbidity caused by HFV Ebola.

10. Original expected outcomes from approved CERF proposal

- Detect all suspected cases and of contacts of Ebola in province;
- Register and follow all cases of contacts;
- Reduce the risk of transmission in the community.

11. Actual outcomes achieved with CERF funds

All of the outcomes were met, in that within project period Ebola was contained, and the epidemic officially declared over by end of October, 2012.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

[6] Number represents all children under age of 18, as specific data for under 5 was not available

| 13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? | YES ☐ NO ☒ |
|---|---|
| **If 'YES', what is the code (0, 1, 2a, 2b):**<br><br>**If 'NO' (or if GM score is 1 or 0):** With 75 per cent of confirmed cases being from women, there was a marked gendered component to the response, and measures were taken to ensure that women were especially targeted for awareness-raising campaigns as main caregivers. | |
| 14. M&E: Has this project been evaluated? | YES ☒ NO ☐ |
| Final evaluations are underway with project having been completed 14 days prior to reporting deadline. During the project implementation, daily meetings were organized at the field level to monitor activities. All financial spending followed UNICEF standards and procedures. | |

## PART 2: CERF EMERGENCY RESPONSE – CONFLICT AND DISPLACEMENT (RAPID RESPONSE 2012)

## I. HUMANITARIAN CONTEXT

| TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$) | | |
|---|---|---|
| ***Total amount required for the humanitarian response:* *63,256,000*[7] | | |
| **Breakdown of total response funding received by source** | **Source** | **Amount** |
| | CERF | 9,877,980 |
| | COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*) | 5,647,709[8] |
| | OTHER (Bilateral/Multilateral) | 54,365,264[9] |
| | **TOTAL** | **69,890,953** |

| TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$) | | | |
|---|---|---|---|
| **Allocation 1 – Date of Official Submission: 2 July 2012** | | | |
| **Agency** | **Project Code** | **Cluster/Sector** | **Amount** |
| **FAO** | 12-FAO-028 | Agriculture | 1,000,000 |
| **UNHCR** | 12-HCR-035 | Protection/Human Rights/Rule of Law | 201,390 |
| **UNICEF** | 12-CEF-076 | Multisector | 2,271,600 |
| **WFP** | 12-WFP-049 | Coordination and Support Services - Logistics | 867,567 |
| **WFP** | 12-WFP-048 | Food | 4,549,794 |
| **WHO** | 12-WHO-047 | Health | 987,629 |
| Sub-total CERF Allocation | | | 9,877,980 |
| **TOTAL** | | | **9,877,980** |

[7] This amount only reflects that for the sectors represented in the rapid response CERF proposals, rather than the entire needs for the east. As the funding was requested to cover emergency needs during a larger crisis, it is not possible to accurately identify total amount required for humanitarian response to the large displacement issue in the east.
[8] CHF Funding for North Kivu emergency
[9] Based on data from FTS of all donations to North Kivu and South Kivu ($21million), plus $34 million received by WFP for specific project in North Kivu with spillover to South Kivu (includes in-kind donations)

| TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$) | |
|---|---|
| **Type of Implementation Modality** | **Amount** |
| Direct UN agencies/IOM implementation | 6,435,602 |
| Funds forwarded to NGOs for implementation | 3,402,378 |
| Funds forwarded to government partners | 40,000 |
| **TOTAL** | **9,877,980** |

Starting in early April 2012, large scale armed clashes between the national army (FARDC) and a newly constituted armed group, the March 23 Movement (M23), resulted in a deteriorating security situation across much of North Kivu, focused around Masisi and Rutshuru territories, and culminating in the taking of the city of Goma in early November.

Meanwhile, the resulting security vacuum with the redeployment of the FARDC to battle M23, saw an escalation of fighting between and among various other armed groups (including FDLR, Mayi-Mayi and APCLS), often along ethnic lines, and focused around Walikale and South Lubero. All of these violent clashes resulted in massive population movements in various territories, including the town of Goma (and the surrounding areas), with a significant spill over into South Kivu territories bordering North Kivu. By the end of March, there were already 595,000 IDPs and in the months of April and May alone, a further 218,000 people became displaced. While a number of the IDPs sought refuge in camps and spontaneous sites, the vast majority were staying with host families, stretching their already limited coping mechanisms to the maximum.

The spill over of the IDPs into South Kivu, especially around Kalehe territory saw more than 8,700 new households displaced, bringing the number of people newly displaced to around 52,000. During the third quarter (July-September) 2012, Kalehe recorded more than 43,300 people representing 57.8 per cent of the displaced in the province of South Kivu. The health zone of Minova hosted the majority of the displaced, 96.7 per cent of whom were living with host families, worsening the already precarious humanitarian situation of the population there. In addition to the huge burden of the IDP population, the two provinces are also endemic to certain diseases, including cholera and measles, leading to further humanitarian concerns. The urgency of the situation was exacerbated by high rates of malnutrition and growing food insecurity, leading to the need for immediate funds to allow humanitarian actors to be life-saving without further delay. Although finances had been given from other sources, the situation called for the injection of emergency funding above that which had been received from the CHF.

## II. FOCUS AREAS AND PRIORITIZATION

A number of sectorial and multi-sectorial assessments were conducted – including through inter-cluster missions, RRMP, and analysis of data on nutritional standards, and on population movements. The priorities for the Inter-cluster were related to urgent needs in shelter, non-food items, health, water and sanitation, food security, nutrition and protection. Five rapid assessments by the health cluster partners in May 2012 showed that 15-20 health centres (serving around 10,000 – 15,000 people) had been pillaged, with health workers also being displaced in many instances in Masisi, Lubero, and Rutshuru, and as a result the health centres had been closed. Cholera cases were also on the rise, with 155 cases recorded in the six-month period to June 2012, and 203 cases of measles. Protection monitoring missions, though limited due to lack of resources and access, also showed an increase in incidents, with 11,219 individual protection incidents committed against the civilian populations, displaced people and returnees. Reports also indicated an increase in sexual violence, recruitment of children into armed groups, and deteriorating relations between ethnic groups. The food security of large numbers of the population was severely impacted by the displacements, with those fleeing losing the crucial harvest season, thus leading to current and future food shortages, and loss of income.

Based on the population movements, the areas identified at the Inter-cluster level and endorsed at the CPIA for intervention in North Kivu were the territories of Rutshuru Lubero, Masisi, and the areas Walikale, Kibua, Itebero and Hombo. For South Kivu, the main concerns were the displaced populations and host families in the northern part of Kalehe territory and Kabare. From these areas of main concern, each cluster identified specific geographical areas for their specific interventions, based on sectorial needs assessments, access constraints, and efficacy of targeted activities. While RRMP targets both of the affected

provinces, its activities in NFI, WASH and nutrition was to be limited to North Kivu based on analysis of the capacity of partners to respond, and to projects already underway. For WHO, the main areas for intervention were those lacking health activities, including Minova and Bunyakiri in South Kivu, and for North Kivu in health zones where there were large concentrations of displaced coupled with lack of functioning health centres, and moreover would be coordinated with other interventions by health partners such as ICRC, MSF and IRC.

## III. CERF PROCESS

During meetings with partners, it became clear that the humanitarian community in North Kivu lacked the capacity to meet the additional needs of many displaced populations in several areas simultaneously. An analysis of the gaps, quickly highlighted the areas in which interventions would be difficult without additional funding. At the CPIA meeting of 23 May, the decision was taken to alert the Humanitarian Coordinator of the need for additional resources, and a subsequent Inter-cluster prioritized the areas for intervention, with critical activities established by each cluster, with the response plan endorsed by the CPIA.

In terms of food security, WFP operations were already under strained, with a $73 million gap, and a rupture in the pipeline in terms of funding. An emergency fund would allow crucial activities to begin, while advocacy was underway to restore and expand the pipeline, with on-going school feeding programmes having been suspended, and a 50 per cent reduction in rations in other activities. With the pipeline issues expected to be resolved by August 2012, it was vital that additional funding be sought to address immediate needs in food before then.

The Rapid Response to Population Movements (RRMP) related to NFI, WASH, nutrition and emergency education was also already stretched to its maximum, with demand far outpacing ability to respond adequately, and to maintain its position as a provider of 'last resort'. By June 2012, five months into the year, 67 per cent of the budget for NFIs had already been spent, with the multitude – and magnitude – of the crises in the east exceeding predicted budget needs as estimated for the 2012 Humanitarian Action Plan (HAP). Discussions with bilateral donors were underway, but immediate funding was needed to cover the essential gaps in the North Kivu.

In terms of protection, in addition to a massive increase in the number of persons displaced, there was a rise in the number of serious human rights violations and abuse. Despite the increasing need for protection activities as highlighted in the 2012 HAP, UNHCR's activities in the field of protection monitoring were in need of further development. The coverage rate for North Kivu in terms of protection monitoring had decreased from 97 per cent in 2011 to 67 per cent in early 2012, with a lack of monitors to cover the urgent monitoring and reporting needs. The urgency of the situation, and to ensure coverage of vital protection concerns, prompted a request for emergency funding.

For logistical support, although Pooled Funding had been received, it was not sufficient to reopen the priority routes that would allow for improved humanitarian access during the crisis. A commitment for funding for the rehabilitation of the roads in the Masisi-Nyabiondo axis had been received, but did not materialize, thus blocking delivery of vital aid. The priority needs were identified at the Cluster level, and based on a provincial intervention strategy, with input by the Department of Agriculture Service Routes (DVDA), the National Road Maintenance Fund (FONER) and the Ministry for Provincial Planning and Reconstruction.

## IV. CERF RESULTS AND ADDED VALUE

**TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR**

***Total number of individuals affected by the crisis:*** 218,000 newly displaced

| | Cluster/Sector | Female | Male | Total |
|---|---|---|---|---|
| **The estimated total number of individuals directly supported through CERF funding by** | Agriculture | 28,560 | 27,440 | 56,000 |
| | Coordination and Support Services - Logistics | NA | NA | NA |
| | Food | 24,000 | 16,000 | 40,000 |

| | | | | |
|---|---|---|---|---|
| **cluster/sector** | Health | 149,000 | 101,000 | 250,000 |
| | Multisector | 147,426 | 98,284 | 248,710 |
| | Protection/Human Rights/Rule of Law | 33,937 | 22,609 | 80,913 |

Based on the total number of people displaced, each of the clusters carried out a review of: location, accessibility, priority needs and capacity to response in estimating the number of beneficiaries for the projects. RRMP evaluation missions put the total number newly displaced from the current crisis at 71,300 households (South Kivu: 17,000 and North Kivu: 54,300). For the Food Security Cluster, the decision on number of beneficiaries was based on standard protocols that state that 25 per cent of the given population would be most vulnerable, and thus initially deemed some 17,000 households to be most at need. However, taking into account the response capacities of actors in the field and pre-positioning of stock, as well as issues of access, the final number to be targeted was set at 8,500 households (however, a total of 11,200 eventually received assistance). Likewise, the WFP emergency food project took into consideration available stock and partner capacities and arrived at the decision that 25 per cent of the population could be targeted for assistance.

For the Protection Cluster, the zones for intervention were defined based on areas where there was less protection monitoring coverage, and thus their beneficiary numbers of 80,000 was derived from the total number of people in the 79 identified localities for intervention. The Health Cluster took as a starting point a review of existing health facilities in the affected areas, and defined that 10 – 15 health centres were unable to serve the needs of the local population, each serving around 10,000 people, and correlated this with the locations of the newly displaced. Of the newly displaced populations of around 218,000 people, RRMP assessed that they would be able to provide assistance in a combination of nutrition, WASH and NFI to around half of that group, and thus planned to target some 100,000 in areas where access was possible, stocks available, and immediate response feasible.

| TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING | | |
|---|---|---|
| | **Planned** | **Estimated Reached** |
| **Female** | 384,055 | 377,649 |
| **Male** | 262,221 | 259,397 |
| **Total individuals (Female and male)** | 467,703 | 616,347 |
| **Of total, children under 5** | 340,941 | 128,467 |

**RESULTS**

Projects faced constraints due to security and access during the implementation, leading to a few shifts in programming, and not all planned areas being reached. In the health sector in:

- North Kivu: 9,300 patients from among the displaced and host communities received medical treatment;
- 100 war wounded were treated; 4,500 cases of cholera were treated; 26,217 children between the ages of six and 23 months were vaccinated against measles;
- South Kivu: 9,126 patients were treated, 4,586 of whom were from the displaced population. The majority of cases were related to malaria and diarrheal diseases; 22 victims of rape received medical care, and 400 births were attended.

WASH Results in North Kivu:

- 55,000 IDPs in Kanyaruchinya, 23,000 people in host communities, and 7,285 in spontaneous sites received potable water of around 15 litres per person per day, due to water trucking, installation of total of 23 public water points, and rehabilitation of a further five.
- 16,592 households had access to sanitation, with construction of 90 emergency latrine blocks, 45 shower blocks; training on maintenance and hygiene standards.

Nutrition results in North Kivu:

- Support to seven health structures, with training of malnutrition case management;
- 17 health workers and 50 community outreach officers trained on identifying and managing cases of acute malnutrition;
- 7,181 people took part in awareness-raising activities to promote improved hygiene standards;
- 1,109 case of severe acute malnutrition were screened and treated, with a 85 per cent recovery rate.
- 5,000 cases of moderate malnutrition received nutritional education.

To improve food security, 11,200 households (around 56,000 people) received vital supplies for both market gardening and home use, including tools, seeds and kits for communal gardens. Stocks were bought in a timely manner, but the distribution was delayed due to security and access issues in the target area, and a no-cost extension was granted for three months, to allow the project to be completed. As the planned target was for 8,500 households, the project has exceeded its target.

Protection concerns were able to be better analysed and addressed through an increase in coverage of protection monitoring activities. The project allowed an increase in monitoring in 79 localities in North Kivu, which had previously only been 67 per cent covered, to 90 per cent coverage thanks to the recruitment of 15 new monitors for a period of six months. This helped to cover areas that were not previously reported on, and to reinforce those that were poorly covered, leading to a more timely response to protection situations in terms of advocacy, referrals and direct response. During the project period, a total of 9,621 protection incidents were reported, and with the project having planned a total of 15,000 for 2012, this resulted in more than 19,000 incidents having been reported, thus well above the target.

**ADDED VALUE**

The CERF-funded projects allowed for immediate assistance to a large new caseload of displaced and vulnerable people that otherwise would not have been possible. Although a number of concerted and sector-specific advocacy measures were underway with different donors, the initial pledges received did not all come to fruition, or were unable to address the crisis in a timely manner, thus leading to further deterioration of the situation. With the capacities of the humanitarian community already stretched, and the sudden and vast scale of the new displacement, additional rapid sources of funding were vital to save lives, while other funding solutions were being sought. However, the continued escalation of violence, culminating with the taking of Goma by M23 in early November and the ensuring of new displacements, have resulted in not all projects being able to be implemented within the six-month time period.

**a) Did CERF funds lead to a fast delivery of assistance to beneficiaries?**

YES ☐ PARTIALLY ☒ NO ☐

Not all of the planned activities were able to be carried out within the intended time frame due to constraints related to access, security, and provision of supplies. While WFP was able to rapidly distribute High-Energy Biscuits (HEB) to the target beneficiaries, a change in the situation meant that they had to re-programme the main emergency food component of the project – with a shift away from cash vouchers, to a blanket distribution due to massive rise in food prices following the M23 taking Goma. Therefore, the project requested (and received) a four-month no-cost extension, and therefore impacted the fast delivery of assistance. The impact on the target population of this delay is not yet clear, and a review will need to be undertaken.

The rehabilitation project for the routes in North Kivu likewise had to be reprogrammed due to the security situation, with a no-cost extension in the pipeline, even though the intended project end date has been reached. This was an issue of concern for the humanitarian community, as it has also had a run-on impact on delivery of vital supplies.

The food security project also faced difficulties in the initial implementation, resulting in a no-cost extension for three month, though the targets were all met, and 56,000 people saw an improvement in their food security.

**b) Did CERF funds help respond to time critical needs[10]?**

YES ☐ PARTIALLY ☒ NO ☐

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

The deteriorating situation in North Kivu required a time-critical response in most sectors, and four of the six projects completed met their planned outcomes. However, the delay in distribution of emergency foods resulted in a vital component for life-saving activities being missed, as did the extension of the road rehabilitation project. Overall though, the timeliness of CERF funds has had a positive impact on saving lives, that was not otherwise available

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

With immediate life-saving activities underway, many agencies were able to focus on increasing funds for medium-term interventions after the CERF-funded projects ended. However, while there were some strong commitments from the donor community, several of these came towards the end of the year and were therefore not able to be used immediately for the crisis (e.g. $20 million in-kind for WFP, arrived in December).

Following the allocation of the CERF grant in the last quarter of 2012, WFP was able to mobilize over USD $25 million. WFP was able to secure timely support for its emergency operation through other donors.

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

The process of prioritizing geographic areas and sectors for intervention was done first in the Inter-cluster and then in the CPIA-level, bringing together various actors. The final request made for CERF funding was therefore the result of a strong collaborative effort. Further, between WASH and Health projects in North Kivu there was a strong coordination, especially in components related to addressing cholera and other diseases. However, information regarding the delays faced in completing three of the projects could have been better communicated at both the provincial and Kinshasa-level, especially given the impact both the logistics and food projects have on the other response. The CPIA and provincial could have been more involved in overall monitoring of implementation.

## V. LESSONS LEARNED

**TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT**

| Lessons Learned | Suggestion For Follow-Up/Improvement | Responsible Entity |
|---|---|---|
| To ensure a much faster response using in-kind food assistance, WFP would like to purchase more quantities through local suppliers. However, the capacity of the local supplier remains week in terms of the quantity and quality that they can produce. | Continue to enhance the capacity of local producers | WFP |

**TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS**

| Lessons Learned | Suggestion For Follow-Up/Improvement | Responsible Entity |
|---|---|---|
| Cholera response cannot be confined only to emergency | With the most effective response to cholera being prevention, durable actions need to be taken immediately in camps and | WASH, Donors, HC |

| | | |
|---|---|---|
| response. | spontaneous sites to control. WASH cluster should have a contingency fund available to immediately intervene in first days of crisis, rather than waiting for funding. | |
| Sexual violence increases at same rate as presence of armed groups. | Protection needs to be integrated into initial first responses to new crises and a 'do harm' approach reinforced when considering any distributions/interventions. | Protection actors, all humanitarian actors |
| Complexity of situation requires better coordination and engagement with government bodies. | To capitalize on resources and efforts and avoid duplication, there is a need to ensure direct collaboration with government actors in all interventions. | All humanitarian actors |

## VI. PROJECT RESULTS

| TABLE 8: PROJECT RESULTS | | | |
|---|---|---|---|
| **CERF Project Information** | | | |
| 1. Agency: | **UNICEF** | 5. CERF Grant Period: | 01 July 2012 – 1 January, 2013 |
| 2. CERF Project Code: | 12-CEF-076 | 6. Status of CERF Grant: | ☐Ongoing |
| 3. Cluster/Sector: | Multisector | | ☒Concluded |
| 4. Project Title: | Rapid response to population movements in the province of North Kivu in terms of NFI, WASH and nutrition | | |

| 7. Funding | | |
|---|---|---|
| | *a. Total project budget:* | US$ 14,000,000 |
| | *b. Total funding received for the project:* | US$ 7,900,000 |
| | *c. Amount received from CERF:* | US$ 2,716,000 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 147,426 | 147,426 | |
| *b. Male* | 98,284 | 98,284 | |
| *c. Total individuals (female + male):* | 245,710 | 245,710 | |
| *d. Of total, children under 5* | 34,270 | 34,270 | |

9. Original project objective from approved CERF proposal

Reduce mortality and morbidity among displaced populations and host communities affected by the conflict, by providing emergency assistance in NFI, WASH and nutrition.

10. Original expected outcomes from approved CERF proposal

NFI: 50,000 people (IDPs, returnees, host families) have access to NFI.
WASH: 17,000 people are assisted with emergency water; 25,000 with durable water; 25,000 with sanitation and 42,000 have changed their behaviour in hygiene matters.
Nutrition: 570 children with severe acute malnutrition are treated; 5,000 children with moderate acute malnutrition are cared for at community level; 60 health workers and 120 community workers are trained.

11. Actual outcomes achieved with CERF funds

- NFI: fair for 50,000. People
- WASH: 7,285 households in spontaneous sites and with host families had access to potable water in Sake-Minova; 55,000 IDPs in Kanyaruchinya and 23,000 in host population had access to drinking water; 16,592 had access to sanitation.
- Nutrition: 1,109 cases of severe acute malnutrition is treated; 5,000 cases of MAM benefitted from nutrition education;

| |
|---|
| 7,181 people took part in information sessions; 17 health workers and 50 community workers are trained. |
| 12. In case of significant discrepancy between planned and actual outcomes, please describe reasons: |
| |
| 13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? YES ☐ NO ☒ |
| **If 'YES', what is the code (0, 1, 2a, 2b):**<br><br>**If 'NO' (or if GM score is 1 or 0):** All RRMP interventions have mainstreamed gender into both project design and implementation, and women and men are differently targeted in some sectors, specifically in nutrition, whereby 80 per cent of those targeted for awareness-raising were women. |
| 14. M&E: Has this project been evaluated? YES ☐ NO ☒ |
| Two implementing partners trained on M&E are carrying out the process, and under RRMP standards reports are due 3 months after end of project (in this case, middle of March, 2013). |

| TABLE 8: PROJECT RESULTS | | | |
|---|---|---|---|
| **CERF Project Information** | | | |
| 1. Agency: | **FAO** | 5. CERF Grant Period: | 1 Sept, 2012 – 2 May 2013 (with NCE) |
| 2. CERF Project Code: | 12-FAO-028 | 6. Status of CERF Grant: | ☐Ongoing |
| 3. Cluster/Sector: | Agriculture | | ☒Concluded |
| 4. Project Title: | Rapid response to food security needs in recently displaced populations in North Kivu | | |
| 7. Funding | *a. Total project budget:* | | US$ 8,556,000 |
| | *b. Total funding received for the project:* | | US$ 850,000 |
| | *c. Amount received from CERF:* | | US$ 1,000,000 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 17,680 | 23,296 | Total number of households reached with agricultural support was 11,200, higher than the 8,500 planned. The accessible cost of inputs has permitted to achieve this number of beneficiaries. |
| *b. Male* | 16,320 | 21,504 | |
| *c. Total individuals (female + male):* | 42,500 | 56,000 | |
| *d. Of total, children under 5* | 8,500 | 11,200 | |

9. Original project objective from approved CERF proposal

Reinforce food security and nutrition of households most affected by the crisis.

10. Original expected outcomes from approved CERF proposal

- Allocation of agricultural stock based on needs and priorities identified by Cluster.
- 8,500 households receive emergency food security stock.
- A method for monitoring key indicators on food security is in place in target zones.

11. Actual outcomes achieved with CERF funds

- 11,200 households received emergency agricultural supplies.
- A strategic stock committee established and protocols signed with partners to assure monitoring of stock over 6 month period that impact 56,000 people.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

Due to on-going security and access issues after M23 taking of Goma in November, 2012, FAO was forced to suspend its activities, and requested a three-month no-cost extension to allow the project to be readapted to the new situation.

13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? YES ☐ NO ☒

| | |
|---|---|
| **If 'YES', what is the code (0, 1, 2a, 2b):**<br>**If 'NO' (or if GM score is 1 or 0):** In both trainings and for distribution of agricultural stock, the target population was at least 50 per | |
| 14. M&E: Has this project been evaluated? | YES ☐ NO ☒ |
| Evaluation is on-going, and no report is currently available. | |

| TABLE 8: PROJECT RESULTS | | | |
|---|---|---|---|
| **CERF Project Information** | | | |
| 1. Agency: | **UNHCR** | 5. CERF Grant Period: | 1 July, 2012 - 1 January, 2013 |
| 2. CERF Project Code: | 12-HCR-035 | 6. Status of CERF Grant: | ☐Ongoing |
| 3. Cluster/Sector: | Protection/Rule of Law | | ☒Concluded |
| 4. Project Title: | Reinforcement of Protection Monitoring | | |
| 7. Funding | *a. Total project budget:* | | US$ 1,000,000 |
| | *b. Total funding received for the project:* | | US$ 201,390 |
| | *c. Amount received from CERF:* | | US$ 201,390 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 33,937 | 33,937 | |
| *b. Male* | 22,609 | 22,609 | |
| *c. Total individuals (female + male):* | 80,913 | 80,913 | |
| *d. Of total, children under 5* | 24,637 | 24,637 | |

9. Original project objective from approved CERF proposal

Ensure that specific needs of vulnerable persons area taken into account in the framework of the overall response.

10. Original expected outcomes from approved CERF proposal

- 100 per cent of accessible priority areas are covered by protection monitoring activities (in 79 localities and 16 *groups*).
- Monthly statistics are gathered, analysed and made available.

11. Actual outcomes achieved with CERF funds

- An increase in protection monitoring coverage from 67 per cent to 90 per cent has been ensured.
- 9,261 incidents have been analysed during the second semester of 2012.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

| 13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? | YES ☐ NO ☒ |
|---|---|

| |
|---|
| **If 'YES', what is the code (0, 1, 2a, 2b):**<br><br>**If 'NO' (or if GM score is 1 or 0):** One of the aims of the project was to have better monitoring of SGBV to improve case follow up. Moreover, there was awareness of particular protection needs of different groups and needs of men, women, girls and boys were taken into account in protection monitoring |

| | |
|---|---|
| 14. M&E: Has this project been evaluated? | YES ☒ NO ☐ |
| Continuous process of evaluation of the quality of protection monitoring reports coming on during project cycle. Total of 9,621 incidents reported. | |

## TABLE 8: PROJECT RESULTS

**CERF Project Information**

| | | | |
|---|---|---|---|
| 1. Agency: | WFP | 5. CERF Grant Period: | June 2012 – June 2013 |
| 2. CERF Project Code: | **12-WFP-048** | 6. Status of CERF Grant: | ☐ Ongoing |
| 3. Cluster/Sector: | **Food** | | ☒ Concluded |
| 4. Project Title: | Emergency food assistance to newly displaced people in North Kivu, and spill over into Spill over into South Kivu | | |

| 7.Funding | | |
|---|---|---|
| | *a. Total project budget:* | US$ 37,000,000 |
| | *b. Total funding received for the project:* | US$ 10.7 million |
| | *c. Amount received from CERF:* | US$ 4,549,794 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 36,012 | 24,000 | WFP reached less beneficiaries than planned because the grant was originally programmed to be used for C&Vs which normally do not include transport/storage and delivery costs. WFP contained costs by procuring food regionally, however, this implies transport, delivery and storage costs which were not planned under C&V, thus the less number of beneficiaries reached. Secondly, the security situation that followed the M23 take-over of Goma did not allow WFP to reach some beneficiaries in some remote areas. |
| *b. Male* | 24,008 | 16,000 | |
| *c. Total individuals (female + male):* | 36,000 | 40,000 | |
| *d. Of total, children under 5* | 12,004 | 8000 | |

9. Original project objective from approved CERF proposal

Provide adequate food consumption for communities and households affected by conflict-related displacement in North Kivu in the priority zones (current new displacements areas in Rutshuru, central and southern Masisi, Kibua and Itebero axes in Walikale, South Lubero), including those having moved across the provincial border of South Kivu (Kalehe and Kabare).

10. Original expected outcomes from approved CERF proposal

The expected outcome is to maintain adequate levels of food consumption among the recently displaced population. The primary indicator for this will be a food consumption score exceeding the threshold value of 28 (poor food consumption), for 80 percent of targeted households.

11. Actual outcomes achieved with CERF funds

Post-distribution monitoring surveys conducted in North Kivu showed that in June 2013 the food security status of the IDPs in the camps and sites in North Kivu had severely deteriorated as compared to the situation in October 2012: with the percentage of people showing a poor food consumption increasing from 7 per cent in October 2012 to 48 per cent in June 2013.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

The underlying causes of this food insecurity are related to security itself, lack of self-reliance opportunities and the use of negative coping mechanisms which influenced food consumption. Insecurity disturbed not only agricultural activities, which are amongst

| | |
|---|---|
| IDPs' most used coping mechanisms, but also affected markets, thus limiting IDPs' access to other sources of food. | |
| 13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? | YES ☐ NO ☒ |
| **If 'YES', what is the code (0, 1, 2a, 2b):**<br><br>**If 'NO' (or if GM score is 1 or 0):** Not part of the HAP | |
| 14. M&E: Has this project been evaluated? | YES ☒ NO ☐ |
| The results of a PDM exercise conducted in the IDP camps and sites in North Kivu in June 2013 depicted quite a serious situation. In spite of food assistance, 85 per cent of the IDPs are still food insecure, of whom 48 per cent with poor FCS, which is a net deterioration since November 2012, when 61 per cent were food insecure. | |

## TABLE 8: PROJECT RESULTS

**CERF Project Information**

| | | | |
|---|---|---|---|
| 1. Agency: | **WHO** | 5. CERF Grant Period: | 1 August, 2012 – 1 February 2013 |
| 2. CERF Project Code: | 12-WHO-047 | 6. Status of CERF Grant: | ☐Ongoing |
| 3. Cluster/Sector: | Health | | ☒Concluded |
| 4. Project Title: | Improving access to health services for displaced populations in North Kivu and South Kivu | | |

| | | |
|---|---|---|
| 7. Funding | *a. Total project budget:* | US$ 2,700,000 |
| | *b. Total funding received for the project:* | US$ 987,629 |
| | *c. Amount received from CERF:* | US$ 987,629 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 149,000 | 149,000 | |
| *b. Male* | 101,000 | 101,000 | |
| *c. Total individuals (female + male):* | 250,000 | 250,000 | |
| *d. Of total, children under 5* | 50,360 | 50,360 | |

9. Original project objective from approved CERF proposal

Ensure emergency access to health care for around 210,000 vulnerable people recently displaced or from the host communities, in 8 health zones in North Kivu, and two health zones in South Kivu.

10. Original expected outcomes from approved CERF proposal

- The capacity for case management of 35 health centres is assured and strengthened.
- The capacity of 30 maternity units for free births is strengthened.
- 600 victims of sexual violence receive treatment and care.
- 15 health centres pillaged/partially destroyed are revitalized.
- Medicine is in place for treatment of 600 cases of sexual violence.

11. Actual outcomes achieved with CERF funds

- Over 10,000 people sought medical car in the supported centres.
- 400 births were attended, and 22 rape survivors received treatment.
- 100 war wounded were treated.
- 4,500 cases of cholera were managed, and 26,217 children between 6 and 23 months were vaccinated against measles.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

| 13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? | YES ☐ NO ☒ |
|---|---|
| **If 'YES', what is the code (0, 1, 2a, 2b):**<br><br>**If 'NO' (or if GM score is 1 or 0):** Particular focus of project was addressing GBV and maternal health care, with rape survivors provided with PEP kit and other medical care. Other gender issues taken into consideration with response to cholera in terms of sensitization for communities. | |
| 14. M&E: Has this project been evaluated? | YES ☐ NO ☒ |
| The project was monitored by WHO, partners, MoH and NGOs, and several missions went to Mugunga II and Kanyaruchinya camps, to spontaneous sites and other health centres on a regular basis. Two evaluation workshops were convened: one at the mid-term and one at the end of the implementation. Final reporting on recommendations and lessons learnt are pending. | |

## PART 2: CERF EMERGENCY RESPONSE – CONFLICT AND DISPLACEMENT (UNDERFUNDED ROUND II 2012)

## I. HUMANITARIAN CONTEXT

| TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$) | | |
|---|---|---|
| ***Total amount required for the humanitarian response*: *12,000,000*** | | |
| **Breakdown of total response funding received by source** | **Source** | **Amount** |
| | CERF | 11,770,546 |
| | COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*) | 0 |
| | OTHER (Bilateral/Multilateral) | 546,742 |
| | **TOTAL** | **$12,317,288** |

| TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$) | | | |
|---|---|---|---|
| **Allocation 1 – Date of Official Submission: 22 August 2012** | | | |
| **Agency** | **Project Code** | **Cluster/Sector** | **Amount** |
| **WFP** | 12-WFP-063 | Coordination and Support Services - Logistics | 499,893 |
| **UNICEF** | 12-CEF-107 | Health-Nutrition | 3,999,986 |
| **UNFPA** | 12-FPA-041 | Health | 643,127 |
| **WHO** | 12-WHO-063 | Health | 200,510 |
| **WHO** | 12-WHO-064 | Health | 1,150,978 |
| **FAO** | 12-FAO-033 | Agriculture | 1,632,018 |
| **WFP** | 12-WFP-064 | Health-Nutrition | 1,966,306 |
| **WFP** | 12-WFP-065 | Food | 1,677,728 |
| Sub-total CERF Allocation | | | 11,770,546 |
| **TOTAL** | | | **11,770,546** |

| TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$) | |
|---|---|
| **Type of Implementation Modality** | **Amount** |
| Direct UN agencies/IOM implementation | 9,576,579 |
| Funds forwarded to NGOs for implementation | 2,100,767 |
| Funds forwarded to government partners | 93,200 |
| **TOTAL** | **11,770,546** |

During the first six months of 2012, both South Kivu and Katanga witnessed a major deterioration in the already precarious humanitarian situation, with huge numbers of people newly displaced, basic infrastructure strained, malnutrition rates reaching alarming portions and protection concerns rising among the civilian population. South Kivu was directly impacted by the fighting in North Kivu, through large numbers of people being displaced into the provinces, straining local resources. At the same time, the province saw an upsurge of armed groups that benefited from the security vacuum left by the suspension of Amani Kamilufu joint operations, with regiments having been deployed to combat the M23 armed group in North Kivu. In South Kivu, the number of people displaced reached 850,000 by July 2012, a 67 per cent increase from January, with 22,900 of those having come from North Kivu.

Meanwhile, in Katanga the resurgence of armed groups affiliated to Mayi-Mayi Gideon resulted in a 307 per cent increase in the number of people displaced over a six-month period, bringing the total to nearly 170,000 IDPs. Security concerns also severely hampered access to services, and the ability of the humanitarian community to provide assistance. Furthermore, the affected areas of Katanga suffer from high levels of malnutrition, difficult access due to poor road infrastructure and insecurity, a lack of health care and outbreaks of measles.

## II. FOCUS AREAS AND PRIORITIZATION

As a regular part of the work of the clusters, a series of evaluations were conducted in both Katanga and South Kivu in the period leading up to the request for CERF funding. These included RRMP assessments, inter-cluster missions and nutrition surveys by the national nutrition programme (PRONANAUT). The results of the needs assessments in Katanga showed a worrying downward trend in humanitarian assistance, a sharp increase in malnutrition, grave concerns over sexual and gender-based violence, and a deteriorating health situation. Based on an interagency mission from 26 to 28 July, 2012, in the first six months of the year, the number of people displaced had risen from 55,400 to 170,000, with 150,000 of those having no access to humanitarian assistance.

The national nutrition programme showed rates of acute and severe acute malnutrition well above the humanitarian threshold. In Manono, the rates for Global Acute Malnutrition (GAM) and Moderate Acute Malnutrition (MAM) were 19.8 per cent and 5.4 per cent respectively, and in Pweto they were 15.4 per cent and 3.6 per cent. In Mitwaba, meanwhile, 24 per cent of the assessed children were in urgent need of care. Maternal and infant mortality rates were also alarming, especially among the displaced population and were higher than the national average with 534 deaths per 100,000, as well as a HIV-zero prevalence rate among pregnant women of 16 per cent. An inter-agency mission from 26-28 July, 2012 to Bunyeka indicated that 86 per cent of the displaced were female headed-households, and more than 50 per cent of the women were visibly pregnant or nursing infants.
The overall health situation was also assessed as being dire in Katanga, with less than 50 per cent of the population having access to health care, coupled with a measles outbreak having confirmed in six health zones (Manono, Ankoro, Kiyambi, Nyemba, Mbulula, and Kabalo) and rising incidents of malaria.

In South Kivu, the sheer number of people newly displaced in the first six months of 2012, along with the results of assessments carried out in all sectors also gave cause for alarm. From January to July 2012, the province witnessed a 67 per cent rise in the number of people displaced, bringing the total to 857,000, some 108,000 of whom were registered in the second quarter of the

year, the majority staying with host families. The province saw a shift in the location of the displacements, with the centre of gravity moving from west to east – from Shabunda to Kalehe, due to rising ethnic tensions.

Malnutrition was a major concern over South Kivu, but specific focus was to be placed on the following health zones: Kalehe where the GAM stood at 4.3 per cent, Shabunda and Kabare at 12 per cent. Meanwhile in several territories, over 60 per cent of the population was deemed to be suffering from food insecurity, with FAO finding that around 73 per cent of the population of Shabunda to be at serious risk of rising rates of malnutrition.

## III. CERF PROCESS

For both South Kivu and Katanga, the priorities for intervention were decided at the individual Cluster levels, with the final strategies endorsed by the CPIA. Through this process, the four strategic zones for response for South Kivu were defined, based on the needs assessments carried out and on the displacement movements: Shabunda Territory, the area bounded by Luhago-Nzibira-Lubimbe, the Territories of Uvira and Fizi, and in Kalahe Territory due to the spill over effect of the conflict in North Kivu. In terms of specific interventions, the following priorities were defined: health, nutrition, food security (strategic stock, and food distribution).

For Katanga, following the analysis of assessments carried out by individual clusters, the CPIA meeting of 7 June, 2012 validated the number of displaced as having reached some 130,000 people, with the main concentration in the triangle between Manono, Mitwaba and Pweto, and thus the areas of highest concern. In line with the priorities defined for the HAP, and based on project funding for the different sectors, the following areas for intervention were defined: health (to address malaria, improve access to obstetric care, measles control, emergency case management); nutrition (treatment of severe acute malnutrition, training on case management, promotion of good nutrition practices); food security (supplies and seeds for both consumption and for small-scale markets for IDPs, returnees and host families; food distribution to mothers and children, and people living with HIV/AIDS); logistics (rehabilitation of the 280 kilometres of road between Nyunzu and Manono).

Each of the projects submitted considered the gendered impact: UNFPA's project in South Kivu aimed to increase the percentage of female community workers, as well as ensuring that women, men, boys and girls were equally targeted in both awareness-raising campaigns on STIs, and on sexual violence. WFP, likewise, in its Integrated Phase Classification analysis of June 2012, noted a clear deterioration of the food security situation in South Kivu, and rolled out its food distribution project with the aim that beneficiary ration cards be allocated preferentially to women, on behalf of the households.

## IV. CERF RESULTS AND ADDED VALUE

| TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR | | | | |
|---|---|---|---|---|
| ***Total number of individuals affected by the crisis:*** | | | | |
| **The estimated total number of individuals directly supported through CERF funding by cluster/sector** | **Cluster/Sector** | **Female** | **Male** | **Total** |
| | Agriculture | 26,000 | 24,000 | 50,000 |
| | Coordination and Support Services - Logistics | NA | NA | NA |
| | Food | 14,177 | 6,076 | 20,253 |
| | Health | 215,063 | 189,715 | 409,949 |
| | Health-Nutrition | **48,395** | **29,780** | **60,990** |

| TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING | | |
|---|---|---|
| | **Planned** | **Estimated Reached** |
| **Female** | 303,635 | 278,956 |
| **Male** | 249,572 | 309,057 |
| **Total individuals (Female and male)** | 541,192 | 431,751 |
| **Of total, children under 5** | 195,867 | 122,074 |

**Nutrition**

With over 21,000 children under five affected by the nutritional crisis in Katanga and 47,595 in 31 health zones in South Kivu, the project aims to reduce the rate of severe acute malnutrition to less than 10 per cent, and child mortality to less than 2 in 10,000 per day. The focus is on treating malnutrition in the existing health centres and improving referrals to specialist centres, in tandem with preventing malnutrition through community outreach on counselling on food and nutrition for young children.

39,456 children or 111 per cent of the initial target of severe acute malnourished children were reached during the implementation of the project including **20,123 girls and 19,333 boys**. These figures suggest that girls and boys suffering from severe acute malnutrition have received equal access to the service. Cases of gender discrimination have not been. UNICEF contributed through (i) its leadership in the nutrition sector, ensuring effective coordination of the response through the Nutrition cluster at both national level and in the two provinces, (ii) its ability to ensure an efficient supply chain and timely delivery of inputs to partners, (iii) the effective field presence through its offices and sub-offices and deployment of consultants who helped provide technical support to implementing partners.

In addition this has been possible thanks to the establishment and / or maintaining, by implementing partners (MDA, ADRA, World Vision) of 352 functional therapeutic nutrition units including 48 intensive treatment units (UNTI) and 304 outpatient treatment units (UNTA). Of the total, 4735 children treated were supported in intensive units / UNTI and 34,721 in outpatient units / UNTA. The performance of the intervention was of very high quality with cure rates of 86 per cent and 95 per cent respectively in South Kivu and Katanga; death rates of respectively 1.9 per cent and 1 per cent, which is consistent with the

treatment goal which is to save lives by ensuring that more than 75 per cent of children are cured and that less than 5 per cent die during treatment.
There has not been a final assessment on the entire intervention but a final nutritional survey conducted in the territory of Mitwaba (Katanga) region showed a very significant reduction of acute malnutrition. The overall rate of acute malnutrition (MUAC < 125mm) decrease from 23.8 per cent (2012) to 13.1 per cent in January 2014 while that of severe acute malnutrition decrease from 3.6 per cent to 2.6 per cent. Considering the WHO standards the rate of global acute malnutrition was 6.6 per cent while that of severe acute malnutrition was 0.6 per cent according to the January 2014 survey.

The security situation in some areas has been a major constraint in the implementation of interventions. The emergency response could not be implemented in the health zone of Kiambi ( Katanga ) because of the insecurity that led to the withdrawal of humanitarian actors, including MSF- Holland, that had initially be selected by the cluster to implement the response. A fighting between Mai Mai and FARDC in Mitwaba also caused displacement of the population in adjacent health zones and inaccessibility of many areas have prevented to set up planned treatment units. To reduce the risk of inaccessibility of the population to services, outreach services, mobile treatment teams and transport mechanisms of severely ill patients to treatment centers have been established.

The second constraint in the implementation was humanitarian access and supply chain. The poor condition of roads was a threat to the regular supply of partners. Pre-positioning of inputs from the start of the project and delivery at once of the rest of the stock has prevented stock-outs in the field. The recruitment of a qualified national consultant, regular monitoring, supervision and coaching of sites and health providers in health centers were also a success factors explaining the achievement of results and the quality of the response.

Despite these interventions the nutritional situation in Katanga remains a concern. Indeed, nutritional surveys in 2013 confirmed that communities like Bukama, Kambove Kasenga Malemba Nkulu Dilolo, Kabalo and Kinda still face nutritional crises. The funding needs to fill the gap response in Katanga are estimated at 3.5 million U.S. dollars.

**Logistics**
The need for the rehabilitation of the road between Nyunzu and Manono was defined based on existing humanitarian information, such as location of displaced populations, nutritional standards, as well as on assessing access constraints. Manono lies at over 400 kilometres from Kalemie with difficult access, and a lack of ferries on the riverine routes from Luvua to Kiambiest. As such, a large majority of the displaced in Manono have been unable to access humanitarian assistance, and this area has been identified as a priority by the humanitarian community. The project was due to start in October, 2012, and be completed by the end of June 2013. However, during the period from intended start of the project, there was an increase in fighting between the national army (FARDC) and armed groups in the targeted area, which has resulted in large populations displaced, which in turn can have a great potential for further violence. Additionally, the area suffered from heavy rains in late October, and caused flooding in both Nyunzu and Manono territories further impacting the implementation of the project. WFP requested a no-cost extension at a time when the project had yet to begin implementation, and just prior to the intended completion date, which was rejected. As such, there are no results to report.

**Health**
The planned activities in support of reproductive health called for interventions in eight health zones in both North Kivu and South Kivu. However, due to sudden and desperate increase in the number of IDPs during the project cycle, following the taking of Goma by M23 in November, the project was reoriented based on requests for urgent assistance in Minova by the humanitarian community. As such, the initially planned health zones of Minembwe, Itombe and Kaniola did not receive interventions, and instead Minova was targeted for assistance.

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

The CERF grant allowed priority needs to be met based on a large influx of displaced within a short period of time, and which had overwhelmed the capacity of the humanitarian community to respond. However, of the seven projects, three sought no-cost extensions despite the nine-month implementation period: this was based partly on the change in the security situation in South Kivu. For food security and nutrition, the CERF funds were life-saving and allowed for rapid intervention in particular, allowing implementing partners to deploy on short notice to critical areas, and thus prevented a further deterioration of the food situation. For WFP, the lag in the supply chain meant that CSB orderd in October 2012 (at the start of the project), only arrived in December, thereby delaying implementation for some three months, which was further exacerbated by the changing security situation.

**b) Did CERF funds help respond to time critical needs[11]?**

YES ☒ PARTIALLY ☐ NO ☐

CERF funds were used to ensure continuous availability of treatment supplies in the health centers and avoiding disruptions that would have negatively affected the cure, death and drop rate. Distances between some villages and the health centers were very important in some areas reaching a two hour walk, the CERF funds helped establish mobile teams to reach populations that were more than five km from the treatment center and would have had no access to care. Moreover, the service offering was increased from 10 health areas financially supported by the Pooled Fund to 27 health areas in Manono through the CERF, which covered 17 additional health areas.

While waiting for the arrival of inputs acquired on CERF funds, and to facilitate the immediate implementation of the response, UNICEF made available an initial stock from its contingency stocks. This resulted in no lag time between approval of CERF funding and of implementation, and is a model that should be followed by other agencies, who will have been able to pre-position their own supplies elsewhere.

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

YES ☐ PARTIALLY ☐ NO ☒

For health interventions, other funds were not raised but there was complementarity between the CERF and the Pooled Fund in the health zone of Manono which has extended the offer of service to all health areas. The UNICEF / ECHO nutrition funds were used to strengthen nutrition surveillance and publish monthly and quarterly newsletters on nutritional status in sentinel sites and issue warnings.

**d) Did CERF improve coordination amongst the humanitarian community?**

YES ☐ PARTIALLY ☒ NO ☐

As the prioritization for the UFE grant was initially discussed at the CPIAs in both South Kivu and Katanga, the development of the projects was done in coordination, and included final decisions for priority sectors at the HCT.

For the nutrition cluster, the project resulted in the strengthening of the nutrition cluster through: (i) mobilizing new partners including international NGOs specialized in nutritional emergencies (ii) increasing nutrition cluster coordination through the transmission of data for analysis and updates of the situation in the sector, (iii) increase field monitoring with the presence of a national consultant in charge of emergencies and of nutrition cluster members including PRONANUT, (iv) improved involvement and collaboration with the Ministry of Public Health in supporting health zones and contribute to sustainability after the withdrawal of humanitarian actors.

However, overall, the final results of the interventions were not discussed in a coordinated manner, nor were there attempts by the recipient agencies to conduct harmonized evaluation or after-action review of the interventions, based on the initial concerns raised at the CPIA. This is an area that the HCT acknowledges requires improvement by all actors.

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

## V. LESSONS LEARNED

| TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT | | |
|---|---|---|
| **Lessons Learned** | **Suggestion For Follow-Up/Improvement** | **Responsible Entity** |
| The prepositioning of stock well in advance of the deployment of partners was a factor in enabling a rapid response certain areas. | Ensure discussions with CERF on the ability for agencies to pre-position stock to allow for flexibility to pre-finance. | UNICEF & CERF |
| Malnutrition needs to be addressed systemically and through provision of contingency stock. Long delays in receiving therapeutic food stocks make a rapid response untenable. | Ensure a strategic review of financing national contingency stocks to respond to acute malnutrition crises. | CERF with UNICEF |
| Emergency interventions treat diseases without addressing the recurring causes linked to the nutrition sector itself, or to health and WASH. Without other interventions in those sectors, emergency responses will have little impact on the long term on reduction of malnutrition | Advocating for integration of structural interventions in health, nutrition or WASH within emergency responses, for a period of at least a year | Humanitarian actors including donors |
| The presence and use of international NGOs allowed a rapid deployment in the field. Unfortunately only a few NGOs are present in Katanga, which limits coordination. | Mobilisation or more resources to bring more implementing oartners in Katanga | Humanitarian actors including donors |
| Access constraints due to security continue to hinder the implementation of projects in northern Katanga. Therefore, projects should be over a longer period of time in conflict affected areas. | More flexibility on the Terminal Disbursement Date to allow completion of the project in conflict affected zones. | CERF Secretariat |
| The quicker the response, the more 'cost effective' it is. Further, a quick response can prevent acute malnutrition and decrease morbidity and | Strengthen the intervention capacity of stakeholders in Nutrition activities to improve their preparedness for response. Emphasis should be placed on capacity building for local NGOs. | Nutrition Cluster, Humanitarian community and, local NGOs |

| | | |
|---|---|---|
| mortality especially among children. | | |
| Rapid response improved through effective coordination between the Nutrition cluster and the other clusters. | A well articulated strategy and collaboration within the nutrition cluster, including with the Government is essential. The strategy developed in Katanga province continues to strengthen analysis and monitoring of nutrition and food insecurity to revise interventions strategies accordingly. | All Clusters |

| TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS | | |
|---|---|---|
| **Lessons Learned** | **Suggestion For Follow-Up/Improvement** | **Responsible Entity** |
| Organising a final evaluation is critical in a responsem to re-evaluate the crises level of health zones supported. | Plan systematically a final evaluation after responses to regularly update nutrition situation and priorities/gaps. | Cluster Nutrition / All implementing partners |
| N/A | N/A | N/A |

## TABLE 8: PROJECT RESULTS

**CERF project information**

| | | | |
|---|---|---|---|
| 1. Agency: | UNICEF | 5. CERF grant period: | 28 Sept. 2012 to 30 June 2013 |
| 2. CERF project code: | 12-CEF-107 | 6. Status of CERF grant: | ☐ Ongoing |
| 3. Cluster/Sector: | Nutrition | | ☒ Concluded |
| 4. Project title: | Prise en charge de la malnutrition aigüe sévère au Katanga et Sud Kivu | | |

| 7.Funding | | |
|---|---|---|
| | *a. Total project budget:* | US$ 3,999,986 |
| | *b. Total funding received for the project:* | US$ 3,999,986 |
| | *c. Amount received from CERF:* | US$ 3,999,986 |
| | *d. CERF funds forwarded to implementing partners:* | NGOs: US$ 1,016,020 Gov. partners US$ 0 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 18,512 | 20,122 | 111 per cent of the target was achieved during the implementation of the project. Several success factors explain the exceeding pf the planned target:<br>- No partner implementation has seen a break of essential inputs.<br>- Opening of more treatment units than planned. In Katanga out of 48 therapeutic feeding units planned, 53 were made functional.<br>- Use of outreach strategies and mobile teams in areas affected by armed conflict, reaching patients in IDP sites.<br>- Active screening by community volunteers and sensitization increased public support in addition to free care.<br>- Supplies purchased on other funding sources were also used to target sites to cover a larger number of children affected than planned. |
| *b. Male* | 17,088 | 19,334 | |
| *c. Total individuals (female + male):* | 35,600 | 39,456 | |
| *d. Of total, children under age 5* | 35,600 | 39,456 | |

9. Original project objective from approved CERF proposal

**Global Objective:**
Contribute to the reduction of the prevalence of acute global malnutrition to less than 10 per cent and of infant mortality for under 5s to < 2/10 000/per day in 8 months.

**Specific Objectives**
OS1: Rapid Assement in 9 territories in Sud Kivu;
OS2: Treatment for at least 31 250 severe acute malnourished children;
OS3: Strengthen the capacity of the community health workers in 6 health zones in Katanga;
OS4: Strengthen the monitoring and evaluation of interventions;
OS5: Responding to hydratic diseases.

10. Original expected outcomes from approved CERF proposal

1. Réaliser un *rapid assement* dans les 9 territoires du Sud Kivu ;
2. 31 250 enfants souffrants de malnutrition aiguë sévère sont dépistés, référés et traités selon le protocole nationale PCIMA dans les unités de traitement les zones de santé ;

3. 250 nouvelles unités de prise en charge sont fonctionnelles (disposent d'intrants, matériels anthropométrique, personnels formés) ;
4. 130 prestataires de soins, 30 membres des équipes cadres de zones de santé et 600 relais sont (i) formés sur la PCIMA, l'ANJE, la prévention et réponse aux épidémies de maladie hydriques ; (ii) dotés d'outils de counseling et de stock de contingence pour la lutte aux maladies hydriques ;
5. Un consultant national est recruté et apporte un appui technique aux partenaires de la mise en œuvre et le suivi sur le terrain au Katanga ;
6. Les zone de santé et les partenaires de mise en œuvre bénéficient sont techniquement assistés mensuellement dans la mise en œuvre ;
7. Des actions sont menées en réponse aux épidémies de maladies hydriques.

11. Résultats obtenus à l'aide du financement CERF

1. There was no Rapid Assessments made in South Kivu.
2. A total of 39.456 children suffering from severe acute malnutrition were treated in South Kivu and Katanga (111 per cent achievement of the target).

***Katanga***

Of a total of 6822 children expected, 9200 were treated in five health zones covered by the response out of the 6 zones initially identified. Only the health zone of Kiambi did not receive emergency interventions, including measles response during the implementation of the project. Performance of interventions was in line with the SPHERES standards with a cure rate of 95 per cent, a death rate of 1 per cent and a 4 per cent drop.

***South Kivu***

Supplies received helped to support treatment of severe acute malnutrition between September 2012 and June 2013. 30,257 new admissions, with a cure rate of 86 per cent, a drop rate of 12.5 per cent (mainly due to displacement caused by insecurity in some targeted zones) and a fatality rate of 1.9 per cent. Out of the expected total of 30,257 children treated, 96 per cent was achieved to date.

1. In total 352 treatment units (140 per cent of original target) were supported by the project, including 53 units in Katanga out of a planned total of 48 (including 5 units treating severe acute malnutrition with medical complications) , and 299 in South Kivu (256 UNTA and 43 UNTI) out of 202 originally planned.
2. 270 providers with 34 members of health zones management teams and 711 community health workers were trained on the IMAM and promotion of optimal infant and young child feeding (IYCF) practices in Katanga.
3. A Nutrition Officer consultant has been recruited and supported by the CERF funding from November 2012 to June 2013 for Kqtqnga, other sources of funding have helped keep the position until February 2014. The presence of the consultant helped to ensure quality implementation and performance in line with the norms and standards.
4. In the follow-up activities by the Nutrition Cluster, joint technical support missions (government and UNICEF) were held monthly at implementation sites. Good performance and compliance with quality standards are attributable to these missions.
5. A support mission was organized in February in the health zone of Pweto in Katanga, overall for the province of Katanga, four fifths of the reports were received.
6. Waterborne diseases: Supplies for the prevention of waterborne diseases in the target health zones have been procured and received between March and August 2013, and made available to NGO partners IRC Hope in Action, ADRA, ALIMA, and Oxfam, as well as government partners (Haut Katanga, Haut Lomani and Tanganyika Health Districts) . These inputs (chlorine, HTH, DPD1, mobile field bacteriological tests, bladders / tanks...) allowed the continued operation and quality control of the water at the taps for more than 180 chlorination sites in health zones with IDPs in Malemba Nkulu, Pweto, Kiyambi , Manono and disinfection of more than 300 contaminated homes.

There was no Rapid Assessments made in South Kivu. The most recent data on the nutritional situation in the province come from territorial surveys validated March-April 2013 conducted by the National Coordination of the National Nutrition Programme (PRONANUT) with financial support from the World Food Programme (WFP). According to these surveys:
• Three areas ( Walungu Kalehe and Fizi ) have a GAM rate of> 13 per cent or SAM > 3 per cent;
• Three areas ( Kabare , Shabunda and Mwenga ) have a GAM rate between 11 per cent and 13 per cent , and a rate of ≥ 2 per cent SAM with aggravating factors such as population movements and outbreaks of measles ;
• Two areas (Idjwi and Uvira) have GAM rate ≤ 10 per cent and SAM <2 per cent.

37,436 indirect beneficiaries including 29,242 women and 8194 men were reached by nutrition promotional activities. Men's

| |
|---|
| participation in outreach activities especially household heads was very low compared to women participation. |
| 12. En cas de différence significative entre les résultats attendus et atteints, merci d'en expliquer les raisons: |
| The exceeded target of children, compared with the initial target is explained by the availability of supplies and implementation of strategies adapted to each security context (opening more treatment units, establishment of mobile treatment units, etc.) as described in paragraph 8 above, at no additional cost.<br>In Katanga for instance, insecurity in the health zone of Mitwaba caused a massive displacement of populations during the implementation of the project, to the adjacent health zone of Mufunga Sampwe, The implementing partner integrated this area to reach more children affected, and 7 additional processing units have been opened without additional costs.<br><br>The inclusion of older units and opening of new units have contributed to more functional units than expected and trained more players at health facilities and at community levels. |

| | |
|---|---|
| 13. Are the CERF funded activities part of a CAP project that applied an IASC Gender Marker code? | YES ☐ NO ☒ |
| For DRC there is no CAP/Flash Appeal but a humanitarian Action Plan (HAP), however emergency nutrition response provided equal free access to girls and boys. | |
| 14. M&E: Has this project been evaluated? | YES ☒ NO ☐ |
| All territories covered by the intervention have not been evaluated; however, a SMART nutritional survey was conducted in the territory of Mitwaba in January 2014 by the implementing partner with the UNICEF and the National nutrition Programme (PRONANUT) technical support. The results show a significant reduction of GAM, from 23.8 per cent (in 2012) to 13.1 per cent in January 2014 while severe acute malnutrition decreases from 3.6 per cent to 2.6 per cent. Considering the WHO standards, GAM is 6.6 per cent while SAM was 0.6 per cent according to the January 2014 survey. Further investigations are planned to be made in the territories of Pweto and Manono in 2014. These surveys will provide information that will help update the nutritional situation in these areas still affected by fighting between Mai Mai and FARDC. | |

## TABLE 8: PROJECT RESULTS

**CERF Project Information**

| | | | |
|---|---|---|---|
| 1. Agency: | WFP | 5. CERF Grant Period: | June 2012 – June 2013 |
| 2. CERF Project Code: | 12.WFP.065 | 6. Status of CERF Grant: | ☐ Ongoing |
| 3. Cluster/Sector: | Food | | ☒ Concluded |
| 4. Project Title: | Emergency food assistance to newly internal displaced people in South Kivu | | |

| | | |
|---|---|---|
| 7.Funding | *a. Total project budget:* | US$ 80 million |
| | *b. Total funding received for the project:* | US$ 12 million |
| | *c. Amount received from CERF:* | US$ 1,677,728 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 14,177 | 14,177 | The food was planned to arrive in mid-December 2012 through local purchae from Goma. However, due to insecurity directly linked to the M23 take over of Goma in November 2012, there were significant delays in delivering the food. Consequently, the the CERF activities have also been delayed. |
| *b. Male* | 6,076 | 6,076 | |
| *c. Total individuals (female + male):* | 20,253 | 20,253 | |
| *d. Of total, children under 5* | 3,747 | 3,747 | |

9. Original project objective from approved CERF proposal

Provide adequate food consumption for internally displaced people in the South Kivu in the priority zones (new displacementin Kalehe, Kabare, Walungu, Uvira and Fizi territories, excluding Minova town where displaced from north Kivu are settled and will receive assistance through the early response grant funded by CERF).

10. Original expected outcomes from approved CERF proposal

The expected outcome is to maintain adequate levels of food consumption among the recently displaced population. The primary indicator was a food consumption score exceeding the threshold value of 28 (poor food consumption), for 80 percent of targeted households.

11. Actual outcomes achieved with CERF funds

1. percentage of households with poor Food consumption Score : 34 per cent
2. percentage of households with bordeline Food consumption Score : 45 per cent
3. percentage of households with acceptable Food consumption Score : 21 per cent

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

N/A

| | |
|---|---|
| 13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? | YES ☐ NO ☒ |

| | |
|---|---|
| **If 'YES', what is the code (0, 1, 2a, 2b):**<br><br>**If 'NO' (or if GM score is 1 or 0):** | |
| 14. M&E: Has this project been evaluated? | YES ☒ NO ☐ |
| Yes the project was evaluated and a third party post distribution moniroting report indicated that 21 per cent of the households had an acceptable food consumption score, 45 per cent of the households had a borderline food consumption score and 34 per cent had a poor food consumption score. | |

## TABLE 8: PROJECT RESULTS

**CERF Project Information**

| | | | |
|---|---|---|---|
| 1. Agency: | **FAO** | 5. CERF Grant Period: | 1 Oct, 2012 – 30 June 2013 (with NCE) |
| 2. CERF Project Code: | 12-FAO-033 | 6. Status of CERF Grant: | ☐ Ongoing |
| 3. Cluster/Sector: | Agriculture | | ☒ Concluded |
| 4. Project Title: | *Réponse stratégique efficace, rapide et appropriée aux besoins des populations les plus vulnérables par la constitution de stocks stratégiques d'intrants agricoles en RDC* | | |

| 7. Funding | | |
|---|---|---|
| | *a. Total project budget:* | US$ 11,568,000 |
| | *b. Total funding received for the project:* | US$ 1,700,000 |
| | *c. Amount received from CERF:* | US$ 1,632,018 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 26,000 | 26,000 | Total number of households reached with agricultural support was 15,241, with 3,541 households in South Kivu and 11,700 households in Katanga. Total number of households planned. |
| *b. Male* | 24,000 | 24,000 | |
| *c. Total individuals (female + male):* | 50,000 | 50,000 | |
| *d. Of total, children under 5* | 12,500 | 12,500 | |

9. Original project objective from approved CERF proposal

Restore production capacity of vulnerable households through the distribution of agricultural inputs (seeds and tools), and allow them to strengthen their capacity to meet their own needs

10. Original expected outcomes from approved CERF proposal

- The integrated intervention strategy (inter-cluster RRMP) is established
- Stocks are allocated via the "Strategic Stocks Committee"
- Inputs are provided to partners and are distributed to beneficiaries by implementing partners
- Technical support is provided through training partners

11. Actual outcomes achieved with CERF funds

- 15,241 households received emergency agricultural supplies.
- A strategic stock committee established and protocols signed with partners to assure monitoring of stock over 6 month period that impact 62,500 people.
- 269 people trained including 218 men and 121 women on improved agricultural production techniques

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? YES ☐ NO ☒

| | |
|---|---|
| **If 'YES', what is the code (0, 1, 2a, 2b):**<br><br>**If 'NO' (or if GM score is 1 or 0):** In both trainings and for distribution of agricultural stock, the target population was at least 50 per cent women, taking into consideration female-headed households | |
| 14. M&E: Has this project been evaluated? | YES ☐ NO ☒ |
| | |

## TABLE 8: PROJECT RESULTS

**CERF Project Information**

| | | | |
|---|---|---|---|
| 1. Agency: | WFP | 5. CERF Grant Period: | 28.09.12 / 30.10.13 |
| 2. CERF Project Code: | 12-WFP-064 | 6. Status of CERF Grant: | ☐ On-going |
| 3. Cluster/Sector: | Food | | ☒ Concluded |
| 4. Project Title: | Blanket Supplementary Feeding | | |

| 7.Funding | | |
|---|---|---|
| | *a. Total project budget:* | US$ 317,964,831 |
| | *b. Total funding received for the project:* | US$ 193,666,767 |
| | *c. Amount received from CERF:* | US$ 1,966,306 |

**Results**

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

| *Direct Beneficiaries* | *Planned* | *Reached* | *In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:* |
|---|---|---|---|
| *a. Female* | 29,883 | 29,780 | |
| *b. Male* | 12,692 | 12,882 | |
| *c. Total individuals (female + male):* | 42,575 | 42,662 | |
| *d. Of total, children under 5* | 25,390 | 25,420 | |

9. Original project objective from approved CERF proposal

- to reduce mortality risk and morbidity
- to prevent an increase in acute malnutrition and related mortality in nutritionally vulnerable groups.

10. Original expected outcomes from approved CERF proposal

For the 3 categories of beneficiaries, the outcome is the highest number of beneficiaries reached per category and tons distributed per commodity.

11. Actual outcomes achieved with CERF funds

More than 25,420 children aged 6-23 moths and 17,242 Pregnant and Lactating Women (PLW) were assisted in Katanga. WFP provided a food basket consisting of veg oil (20 g /day), CSB (200 g /day) and sugar (20 g /day) equivalent to 1100 K/Calories/day to infants from 6 to 23 months. Under the project WFP also assisted pregnant women from the third month of pregnancy and lactating mothers up to 6 months from childbirth with super cereal (250 g /day), veg oil (25 g /day) and sugar (20 g/day), equivalent to 1300 K/Calories/day. This provided them with highly needed proteins, micronutrients and an increased caloric intake.

MCHN (Mother and Child Health Nutrition) program deliver a combination of services :

1. A food supplement providing additional energy (Kcal) and micronutrients to reduce the nutrient gap between an individual's actual consumption and his/her requirement.
2. An incentive or enabler to attract targeted beneficiaries to key health services (increase access) and related opportunities.
3. A contribution towards household food security, thereby facilitating and extending the caring capacity of households in general and mothers in particular.
4.

Two WFP and four PRONANUT staff were trained including the Health Centers (HC) and Cooperating Partners (CPs).

Overall, the planned beneficiaries were reached and there has been a reduction in the number of cases of acute malnutrition and

related mortality among the nutritionally vulnerable groups, in line with the CERF-funded activities in the targeted areas.

Thus, while the CERF-funded project, WFP, was able to achieve considerable results such as reducing mortality morbidity, over the implementation period, despite the very challenging environment including security and impassable road conditions. New cases of malnutrition are still being registered due to the on-going conflict within the Katanga province especially in the northernmost part Manono-Mitwaba-Pweto the so-called "Triangle of Death".

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

| 13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? | YES ☐ **NO** ☒ |
|---|---|

**If 'YES', what is the code (0, 1, 2a, 2b) :** N/A

**If 'NO' (or if GM score is 1 or 0):**

| 14. M&E: Has this project been evaluated? | YES ☒ NO ☐ |
|---|---|

Yes, this project was evaluated. The results of the post screening conducted by ADRA and PRONANUT following WFP's evaluation in September 2013 to the assisted areas shows that the population's nutritional situation has slightly improved following the intervention.

The evaluation team recommended:
Close follow up of malnutrition cases and referral to the respective health centers to minimize mortality and deterioration in individual and population's nutritional status
Maintain nutrition supplements
to the health centers to prevent acute malnutrition;
Increase community sensitization in the health zones to prevent malnutrition;
Improve children immunization coverage.

## ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

| CERF Project Code | Cluster/ Sector | Agency | Partner Name | Partner Type | Total CERF Funds Transferred To Partner US$ | Date First Instalment Transferred | Start Date Of CERF Funded Activities By Partner | Comments/ Remarks |
|---|---|---|---|---|---|---|---|---|
| 12-CEF-001 | WASH | UNICEF | Oxfam GB | INGO | 844,100 | 1/02/12 | 01/02/12 | |
| 12-CEF-001 | WASH | UNICEF | Solidarité International | INGO | 450,844 | 20/02/12 | 21/02/12 | |
| 12-CEF-001 | WASH | UNICEF | La Croix Rouge RDC | LNGO | 219,700 | 20/02/12 | 21/02/12 | |
| 12-CEF-001 | WASH | UNICEF | Eagle House Business | INGO | 199,990 | 13/02/12 | 14/02/13 | |
| 12-CEF-001 | WASH | UNICEF | Action contre la Pauvreté | INGO | 198,806 | 06/02/12 | 06/02/12 | |
| 12-CEF-001 | WASH | UNICEF | CADECCODE | LNGO | 199,131 | 15/01/12 | 18/01/12 | |
| 12-CEF-107 | Nutrition | UNICEF | ADRA | INGO | 307,242 | 11/12/12 | 11/12/12 | |
| 12-CEF-107 | Nutrition | UNICEF | MEDECINS D'AFRIQUE | INGO | 275,000 | 20/12/12 | 20/12/12 | |
| 12-CEF-107 | Nutrition | UNICEF | WORLD VISION INTERNATIONAL | INGO | 202,495 | 20/12/12 | 20/12/12 | |
| 12-CEF-113 | Sante | UNICEF | Programme Elargi de Vaccination, PEV | Government | 156,413 | 12/02/13 | 20/02/13 | |
| 12-CEF-113 | Sante | UNICEF | Inspection Médicale de la Santé | Government | 7,599 | 06/09/12 | 06/09/12 | |
| 12-CEF-113 | Sante | UNICEF | Commission Prise en Charge Psychosociale, du Conseil National de | Government | 37,500 | 09/10/12 | 30/10/12 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Coordination (CNC) du Ministère de la Sante, Cabinet du Ministre de la Santé Publique | | | | | |
| **12-CEF-076** | AME/NFI, Wash, Nutrition | UNICEF | Solidarités International | INGO | 879,141 | 12/09/12 | 12/09/12 | |
| **12-CEF-076** | AME/NFI, Wash, Nutrition | UNICEF | NRC (Norwegian Refugeee Council) | INGO | 507,046 | 01/10/12 | 01/10/12 | |
| **12-CEF-076** | AME/NFI, Wash, Nutrition | UNICEF | Tearfund | INGO | 50,000 | 15/08/12 | 15/08/12 | |
| **12-CEF-076** | AME/NFI, Wash, Nutrition | UNICEF | NCA (Norwegian Church Aid) | INGO | 330,000 | 15/08/12 | 15/08/12 | |
| **12-CEF-076** | AME/NFI, Wash, Nutrition | UNICEF | Oxfam GB | INGO | 120,000 | 12/12/12 | 12/12/12 | |
| **12-CEF-076** | AME/NFI, Wash, Nutrition | UNICEF | Action Sante Femme | INGO | 4,220 | 12/12/12 | 12/12/12 | |
| **12-CEF-076** | AME/NFI, Wash, Nutrition | UNICEF | Caritas Goma | LNGO | 40,000 | 10/11/12 | 15/11/12 | |
| **12-CEF-076** | AME/NFI, Wash, Nutrition | UNICEF | Pronanut | Government | 49,453 | 01/08/12 | 02/08/12 | |
| **12-FAO-028** | SECAL | FAO | PU-AMI | INGO | 96,518,00 | 18/02/13 | 18/02/13 | |
| **12-FAO-028** | SECAL | FAO | DIOBASS | LNGO | 43,563,00 | 18/01/13 | 18/01/13 | |
| **12-FAO-028** | SECAL | FAO | AVSI-Fondation | INGO | 98,335,00 | 28/01/13 | 28/01/13 | |
| **12-FAO-028** | SECAL | FAO | CARE International | INGO | 69,200,00 | 28/01/13 | 28/01/13 | |
| **12-FAO-033** | SECAL | FAO | IPAPEL | Government | 5,656,00 | 08/11/12 | 08/11/12 | |
| **12-FAO-033** | SECAL | FAO | UDI | LNGO | 9,591,00 | 15/11/12 | 15/11/12 | |
| **12-FAO-033** | SECAL | FAO | CPP | LNGO | 9,465,00 | 15/11/12 | 15/11/12 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **12-FAO-033** | SECAL | FAO | CARITAS Diocèse Kilwa | LNGO | 9,188,00 | 29/11/12 | 29/11/12 | |
| **12-FAO-033** | SECAL | FAO | MANIDEV | LNGO | 7,700,00 | 29/11/12 | 29/11/12 | |
| **12-FAO-033** | SECAL | FAO | AVSI-Fondation | INGO | 95,906,00 | 28/01/13 | 28/01/13 | |
| **12-FAO-033** | SECAL | FAO | AIBEF | LNGO | 81,278,00 | 28/01/13 | 28/01/13 | |
| **12-FAO-033** | SECAL | FAO | MALTESER International | INGO | 85,372,00 | 28/01/2013 | 28/01/2013 | |
| **12-HCR-035** | Protection | UNHCR | Grace | LNGO | 187, 292. | 09/07/2012 | 10/07/2012 | |
| **12-WHO-001** | Health | WHO | ALIMA | ONG | $558,495 | 07/03/12 | 07/03/12 | |
| **12-WHO-001** | Health | WHO | ADRA | ONG | $355,000 | 27/02/12 | 05/03/12 | |
| **12-WHO-001** | Health | WHO | COOPI | ONG | $375,000 | 25/02/12 | 28/02/12 | |
| **12-WHO-001** | Health | WHO | CESVI | ONG | $109,000 | 01/04/12 | 10/04/12 | |
| **12-WHO-001** | Health | WHO | CROIX ROUGE RDC | ONG | $200,000 | 20/02/12 | 01/03/12 | |
| **12-WHO-001** | Health | WHO | MDA | ONG | $433,500 | 21/02/12 | 28/02/12 | |
| **12-WHO-001** | Health | WHO | MEMISA Belgique | ONG | $200,000 | 1/03/12 | 15/03/12 | |
| **12-WHO-001** | Health | WHO | Hope In Action | ONG | $200,000 | 21/02/12 | 10/03/12 | |
| **12-WHO-001** | Health | WHO | CARE International | ONG | $200,000 | 22/02/12 | 20/03/12 | |
| **12-WHO-001** | Health | WHO | Provincial health divisions in 8 health zones. | Government | $100,000 | 15/08/12 | 20/08/12 | |
| **12-WFP-065** | Food | WFP | World Vision | INGO | 793,112.82 | 22/01/13 | 24/01/13 | |
| **12-WFP-065** | Food | WFP | CARITAS Uvira | NGO | 102,625.77 | 27/02/13 | 25/02/13 | |
| **12-FPA-041** | Health | UNFPA | Divisions Provinciales de la Santé | Gov't | 43,200 | 1/09/12 | 1/09/12 | |
| **12-FPA-041** | Health | UNFPA | Action contre la pauvrete | NGO | 41,900 | 10/09/12 | 10/09/12 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **12-FPA-041** | Health | UNFPA | Medicine d'Afrique | NGO | 33,900 | 10/09/12 | 21/09/12 | |
| **12-FPA-041** | Health | UNFPA | Hope in Action | NGO | 49,500 | 10/09/12 | 1/10/12 | |
| | | | | | | | | |
| **12-WHO-063** | Health | WHO | Cedi | NGO | 35,000 | 02/10/12 | 05/10/12 | |
| | | | | | | | | |
| **12-WHO-064** | Health | WHO | Provincial Health Centres | Gov't | 50,000 | 15/10/12 | 15/10/12 | |
| **12-WHO-064** | Health | WHO | Help in Action | NGO | 360,500 | 20/10/12 | 20/10/12 | |
| **12-WHO-064** | Health | WHO | IRC | NGO | 87,000 | 20/10/12 | 20/10/12 | |
| **12-WHO-064** | Health | WHO | PU-AMI | NGO | 87,000 | 25/10/12 | 30/10/12 | |
| **12-WFP-049** | Cluster Log / Road | WFP | IEDA Relief | INGO | 250,113 | 21/12/122012 | 21/10/12 | |
| **12-WFP-049** | Cluster Log / Road | WFP | HELPAGE | INGO | 299,600 | 21/12/12 | **07/01/13** | |
| **12-WFP-049** | Cluster Log / Transport | WFP | Various | INGO & UN | 239,990.00 | 07/06/12 | **13/08/13** | |

## ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

| | |
|---|---|
| ADRA | Adventist Development and Relief Agency |
| AIBEF | Association Ivorienne pour le bien etre familial |
| AVSI | Associazione Volontari per il Servizio Internazionale |
| CESVI | Cooperazione e Sviluppo |
| CNC | National crisis coordination at Ministry of Health |
| COOPI | Cooperazione Internazionale |
| FARDC | DRC Armed Forced (national army) |
| GAM | Global acute malnutrition |
| IRC | International Rescue Committee |
| M23 | Movement of March 23 (armed group) |
| MAM | Moderate acute malnutrition |
| MDA | Medecine d'Afrique |
| MSF | Medecines sans Frontiers |
| NCA | Norwegian Church Aid |
| PEV | Programme Elargi de Vaccination |
| PRONANUT | Programme National de Nutrition |
| PU-AMI | Premiere Urgence – Aide Medicale Internationale |
| IMAM | Integrated Management of Acute Malnutrition |
| IYCF | Infant and Young Child Feeding |
| UNICEF | United Nations Children's Fund |
| UNTA | Unite nutritionnelle therapeutique ambulatoire |
| UNTI | Unite nutritionnelle therapeutique intensive |