

Independent Review of CERF Allocations to the Democratic Republic of Congo

2017 – 2018

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Disclaimer

This is an independent review and the author, Glyn Taylor of Humanitarian Outcomes, assumes responsibility for all opinions herein.

List of Acronyms

AAP	Accountability to Affected Populations
AAR	After-Action Review
CBPFs	Country-Based Pooled Funds
CERF	Central Emergency Response Fund
CLIO	Comités Locaux Inter-organisations
CPIA	Comités Provinciaux Inter Agence
CRIO	Comités Régionaux Inter-Organisations
DRC-HF	Democratic Republic of Congo Humanitarian Fund
DRR	Disaster Risk Reduction
ERC	Emergency Relief Coordinator
ERF	Emergency Response Fund
GBV	Gender-Based Violence
FTS	Financial Tracking Service
HC	Humanitarian Coordinator
HCT	Humanitarian Country Team
HRP	Humanitarian Response Plan
IASC	Inter-Agency Standing Committee
ICCM	Inter-Cluster Coordination Mechanism
ICP	Inter-Cluster at Provincial Level
ICN	Inter-Cluster at National Level
IDP	Internally Displaced Person
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
NCE	No-Cost Extension
NFI	Non-Food Item
NGO	Non-Governmental Organization
NNGO	National Non-Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs (United Nations)
PAF	Performance and Accountability Framework (CERF)
RC/HC	Resident Coordinator/Humanitarian Coordinator
RR	Rapid Response

TOR	Terms of Reference
SRP	Strategic Response Plan
UFE	Underfunded Emergency
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization (United Nations)

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Executive Summary

DRC has been the top recipient of CERF funding since the Fund's inception in 2006 and CERF was the 3rd largest donor¹ to the DRC 2018 HRP². Although every major humanitarian crisis can be characterized as exceptional, DRC can be described as such in a number of ways: in absolute terms (populations in need and funding requirements); the longevity, scale and complexity of the various conflicts, and public health issues within a single country setting.

Another key characteristic of the response in the DRC is its level of underfunding. Although it is possible to describe underfunding as 'chronic' in the sense that it is ongoing, it is also 'acute' in the sense that it is arguably a significant factor in the weakness of the response architecture at sub-national level. Donor-fatigue and global competition for funding are undoubtedly contributing factors. Multiple escalating crises in combination with these levels of underfunding fully justify the use of CERF funding and at the same time create challenges for its use. Specifically, CERF works through coordination structures, particularly at sub-national level which have been functioning severely under-capacity. The imbalance between pooled and 'mainstream' funding in the case of DRC is problematic. Funding which is typically considered as 'gap filling' also requires a critical mass of core or direct funding to enable agencies to undertake their mandated functions (including normative functions.)

This CERF PAF report looks at six allocations: five from CERF's rapid response (RR) window and one from the underfunded emergencies (UFE) window as follows:

- CERF Rapid Response allocation to address conflict-related displacement in the Kasai and Tanganyika Provinces March 2017
- CERF Rapid Response allocation to support conflict-affected people in the Kasais, Tanganyika, Haut-Katanga and South Kivu September/October 2017
- CERF Rapid Response allocation in support of L3 scale up February 2018³
- CERF 2018 Round I Underfunded Emergencies allocation March 2018
- CERF Allocation RR Ebola May 2018 May 2018
- CERF Allocation RR Ebola August 2018 August 2018

These allocations, although made individually (with the exception of allocations 3 and 4 - below) can clearly be seen as a sequence, tracking the rising requirement for humanitarian assistance in light of escalating conflict across the country. The humanitarian operation in Eastern DRC ('the Kivus') had been the major focus for the response in DRC for a number of

¹ The U.S. is the main donor averaging 44% of HRP requirements per year.

² Accounting for 7.4% of total funding (<https://fts.unocha.org/appeals/652/summary>). 2018 update as part of the DRC multi-year 2017-2019 Humanitarian Response Plan (HRP)

³ The UNFPA proposal to support the establishment of an Accountability to Affected Populations (AAP) mechanism funded under this allocation was subsequently submitted mid-March and approved by the ERC in the first part of April

years. Burgeoning crises in the Kasai⁴ and Tanganyika⁵ regions escalated throughout the review period; over and above the most recent Ebola outbreaks in 2018 and a number of distinct issues with refugees or returning refugees from different neighbouring countries. By the latter part of 2017, predictions of needs in the HRP had been severely outstripped. Within the context of this deteriorating humanitarian situation, an IASC system-wide Level 3 (L3) emergency response was activated by IASC Principals in October 2017 for the crises in the Kasais, Tanganyika and South Kivu, drawing additional attention and capacity to these crises. DRC's L3 response strategy outlined key operational priorities and benchmarks in these areas, including seven areas where collective action was required to ensure that the response was fit-for-purpose: greater collective accountability; streamlined humanitarian coordination; strengthened collective analysis and prioritization; improved response capacity at the inter-provincial level; strengthened preparedness and contingency planning; sufficient funding for humanitarian operations; effective humanitarian advocacy around access, protection and accountability to affected populations. The third CERF allocation under review went to support elements of the L3 strengthening, including coordination elements.

- **Review question 1: Did CERF processes achieve key management benchmarks in respect of inclusivity, quality, transparency and adequate monitoring and evaluation? Are there reasonable grounds to believe that CERF operations: strengthen the humanitarian response by empowering the RC/HC and enhancing coordination; facilitate the elimination of gaps; contribute to a timelier response and serve as a catalyst to kick-start humanitarian response?**

Recipient agencies of the conflict related allocations were content with the transparency and inclusivity of the allocation processes; they were also satisfied that the appropriate inputs were sought from assessments, as well as strategy and planning processes at subnational level. UN agencies and OCHA *can* legitimately claim to be following global guidance on inclusivity and transparency, given the use of assessments and information products from subnational coordination structures. Partners *external* to UN operational agencies who participated in these assessments were typically unaware that the products were used as the basis for CERF decision-making. As such, the term 'inclusive' rings a little hollow.

Overall, the sheer scale of the response across multiple sub-national crises, in addition to the relative weakness of sub-national coordination structures, creates a particular dynamic. Unable to fully decentralize decision-making, coordination structures in Kinshasa and UN agencies themselves (at national level) are forced to substitute for detailed, inclusive prioritisation processes at provincial/regional level. As such, while it is possible to describe CERF allocation processes as inclusive, it is also possible to argue that they reinforced centralized decision-making under these circumstances. More than one Kinshasa-based, UN agency

⁴ Kasai Central, Kasai, Kasai Oriental and Lomami (referred to throughout the report as the Kasai crisis)

⁵ Tanganyika, Haut-Katanga and Haut-Lomami (referred to throughout as the Tanganyika crisis)

representative noted that this situation was far from ideal. They described the extraordinary complexity of selecting priority projects given an incomplete picture of prioritised needs and response capacity from each hub, which spanned multiple, complex emergencies and multiple sectors/clusters. UN staff participating in decision-making for both CERF and the DRC Humanitarian Fund (DRC HF) noted that similar challenges applied to both.

Two Ebola allocations took place within the same country context and were provided to some of the agencies who had also previously received conflict-related allocations. The Ebola allocations constitute, however, a very distinct set of processes from those of the conflict-related allocations, with few commonalities. Ebola allocations were knowingly made with the confidence that other sources of funding would be forthcoming. The CERF process was foreshortened and limited to a small number of key partners. In this context, coordination can certainly be deemed to have been supported and strengthened by the CERF funding. This support and strengthening of coordination structures pertains specifically to those structures established for the Ebola response, rather than the broader set of coordination structures in the DRC.

Monitoring and Evaluation (M&E): The DRC context is unusual in that a decision⁶ was made in late 2016 to include the monitoring of CERF projects by OCHA Humanitarian Financing Unit staff. Interviews suggested that neither the capacity of the monitoring teams nor the travel budget was enhanced to include the monitoring of CERF projects. Monitoring of DRC HF projects was prioritised by the DRC HFU staff as it is a contractual obligation for DRC HF projects; only a small number of CERF-funded projects received monitoring visits in 2017, none in 2018. Recipient agencies, however, noted that a significant proportion of CERF-funded projects had been covered in their respective internal monitoring and evaluation processes. When it came to reporting on CERF grant implementation to the CERF secretariat through the RC/HC report, OCHA staff in-country also noted that the quality of reporting from agencies tended to be low. In their opinion, it was treated as an additional burden by agencies and often delegated to interns or junior staff.

OCHA staff responsible for managing the DRC HF expressed frustration at staffing shortages during the L3 and UFE allocations in particular. The frustrations of the OCHA DRC HFU staff, as often identified in CERF PAF country studies, were also based on a perception that CERF should make a visible/direct contribution to staffing. It is impossible, however, for CERF to contribute directly to OCHA staff costs. The management of CERF processes, including applications as well as reporting, is part of OCHA's humanitarian financing function, one of the five core functions of an OCHA country/regional office i.e. irrespective of whether there is a country-based pooled fund.

⁶ Decision by the HCT

Principally, this is an issue for OCHA management in the DRC; capacity to manage CERF allocations is frequently required in the DRC and needs to be incorporated into Terms of References (ToRs), work and cost plans. In addition, CERF and CBPFs are supported by a similar set of core donors. Especially in countries like the DRC where a significant proportion of funding passes through pooled instruments, donors need to ensure that all parts of the pooled funding process, from allocation to monitoring, reporting and risk management are adequately staffed.

Recommendation: OCHA management and key donors: Ensure that the OCHA Humanitarian Financing Unit (as part of the Joint Pooled Fund Unit in DRC) consistently has the capacity to manage all elements of pooled funding processes, for both CERF and the CBPF.

Recommendation: OCHA DRC management: Ensure that adequate staffing for the management of CERF processes, over and above the requirements of the CBPF, are incorporated into ToRs, work and cost plans.

- **Review question 2: How suited is CERF as a mechanism for supporting enabling activities for strengthening response structures like those under the DRC L3 scale-up? Should CERF consider a formal strategy for systematically funding such activities in certain contexts?**

L3 strengthening: Simply put, short-term interventions by CERF in respect of L3 strengthening were well targeted, logical and defensible. Individual programmatic elements funded by CERF, notably IOM's strengthening of IM capacity and the Displacement Tracking Matrix (DTM), were seen as having improved coordination and having the potential to make a significant contribution to the response. Ultimately, however, they were not transformative. In order to galvanize a real step change in coordination and planning, a sustained and system-wide approach, with the full backing of donors, UN agencies and partners would be required. The visit to Kalemie highlighted that strengthening elements notwithstanding, there remained a lack of critical mass of engagement by actors on the ground in coordination. In general, the quality of cluster coordination was perceived as poor.

Recommendation: A decision to use CERF funding on an ongoing basis for enabling activities for strengthening response structures like those under the DRC L3 scale-up should be taken context by context and with rigorous justification.

- **Review question 3: How well did the CERF Underfunded Emergencies allocation model meet the needs of a large-scale protracted emergency like DRC and fit into a multi-year humanitarian planning and funding framework as applied in DRC?**

In keeping with the other 'bigger picture' questions part of the review around the added value of CERF in DRC, the UFE allocation has to be seen in light of funding shortfalls and challenges in provincial level coordination. At the time of the visit to DRC, there were discussions ongoing about the use of multi-year funding in DRC and around the 'new way of working'. In short, however, CERF funding was not seen as directly connected to these discussions. Given the shortfall in funding overall and the short-term nature of the projects, CERF has, by and large, played its traditional gap filling role, filling gaps in the acute response; funding to the cholera response in Kalemie under the UFE is one example. Overall, the picture is one of CERF fulfilling its 'traditional' role as an emergency funding instrument in line with its role and mandate. Other than the L3 strengthening components, allocations to Kasai and Tanganyika were aimed at acute interventions, gap filling and kick-starting emergency operations. Typically, where complementarity with the DRC HF was discussed, the latter was cited as funding the longer-term programmatic components and was more closely associated with holistic support to the HRP.

- **Review question 4: How does CERF compare to other funding mechanisms available for health emergencies? What is CERF's role and niche in responding to disease outbreaks? What are the lessons learned from these allocations for CERF's funding approach to disease outbreaks and CERF's eligibility criteria?**

The two Ebola allocations in DRC under review follow a fairly straightforward model. There is nothing that specifically sets apart the trigger, the Ebola outbreaks, from any rapid onset emergency for which there is a very high sense of urgency and a very high confidence in the availability of follow-on funding from the CERF allocation. Although some of the funding instruments for public health emergencies are somewhat opaque to humanitarian actors, many of the sources which immediately followed CERF were typical (internal agency response mechanisms and mainstream donor funds). As such, CERF played a similarly typical role and there are no obvious lessons for CERF's funding approach.

Section 1: Introduction

This CERF Performance and Accountability (PAF) country review covers allocation decisions made by the ERC between March 2017 and August 2018. It covers five Rapid Response (RR) allocations. Of these, two were specifically made in support of the responses to two separate Ebola outbreaks in 2018. Three allocations were made in support of the response to principally conflict related needs in a number of sub-national⁷ crises across DRC and in support of the IASC L3 activation related to these crises. In addition, the review will look at the allocation from CERF's 2018 Underfunded Emergencies Round I.

1.1 Objectives and Scope of the CERF PAF Review

The Terms of Reference (ToR) for this review (attached in annex A) fully details the objectives and key questions of the review. The review's main purpose is to assess the value added of CERF funding through five allocations during 2017 and 2018 in the DRC; the critical overriding question being: Have CERF allocations to DRC during this period successfully added value to the broader humanitarian endeavor?

The ToR defines CERF's added value under four objectives: (a) fast delivery of assistance to people in need, (b) better response to time-critical needs, (c) improved coordination among the humanitarian community, and (d) leveraging additional resources from other sources. The following indicators from the CERF PAF form the basis for assessment:

1. *CERF processes are achieving key management benchmarks in that:*
 - CERF submissions are based on an inclusive planning process and adhere to established quality criteria.
 - Transparent systems are in place for correct allocation, efficient flow and use of CERF by agencies.
 - Adequate monitoring and evaluation systems are in place at the agency level for measuring and reporting on results.

2. *There are reasonable grounds to believe that CERF operations favour the following results:*
 - CERF strengthens humanitarian response by empowering the RC/HC and enhancing the quality of coordination within the cluster approach and across clusters.
 - CERF facilitates adequate coverage, eliminates gaps and facilitates an effective division of labor among humanitarian actors.
 - CERF contributes to a timelier response to needs.

⁷ The term 'sub-national' crises is used throughout this report as a generic term for the conflicts centred on Kasai, Tangankiya, North and South Kivu and Haut Uele and their respective consequences. Each affects multiple provinces and the terms 'Provincial' or 'Regional' are, arguably more confusing.

- CERF favors the delivery of relevant life-saving actions at critical moments.
- CERF serves as a catalyst to kick-start humanitarian response while other resources are mobilized.

In addition, the following key issues related to the specific allocations will be assessed:

3. *CERF Rapid Response allocation in support of L3 scale up:*
 - How effectively did CERF support L3 scale-up priorities?
 - To what extent did CERF's support to these collective priorities (including analysis, assessment, coordination, logistics, and accountability to affected populations) enable and/or facilitate agencies' delivery of multi-sectoral assistance?
 - How suited is CERF as a mechanism for supporting enabling activities for strengthening response structures like those under the DRC L3 scale-up? Should CERF consider a formal strategy for systematically funding such activities in certain contexts?
4. *CERF 2018 Round I Underfunded Emergencies allocation:*
 - How well does the CERF Underfunded Emergencies allocation model meet the needs of a large-scale protracted emergency like DRC?
 - How does a CERF Underfunded Emergencies allocation fit into a multi-year humanitarian planning and funding framework as applied in DRC?
5. *CERF Rapid Response allocations in response to the two Ebola outbreaks:*
 - How does CERF compare to other funding mechanisms available for health emergencies?
 - What is CERF's role and niche in responding to disease outbreaks?
 - What are the lessons learned from these allocations for CERF's funding approach to disease outbreaks and CERF's eligibility criteria?

1.2 Methodology

The CERF secretariat provided a range of documentation related to the discussions and design of each individual allocation, reports related to each and other supporting material (including internal communications). This material was reviewed in advance of the visit to DRC in November of 2018.

Key informants were pre-selected by OCHA country office staff to offer a representative sample of significant stakeholders; the Humanitarian Coordinator, CERF focal points and senior managers in recipient agencies, national and international NGO partners of recipient agencies, and NGO representatives in the HCT. A total of 40 individuals were interviewed (25 men and 15 women), of which 22 were staff of CERF recipient agencies. Priority was given to staff in

recipient agencies with significant involvement in CERF processes and/or experience with implementing or monitoring activities supported by CERF.

The DRC mission included a visit to Kalemie, from where the OCHA office coordinates the response for Tanganyika and surrounding provinces. CERF country studies typically include visits to CERF funded projects in order to contextualise the allocation decisions and, at a minimum, to see CERF funding in action to better understand the operational context and the constraints faced by partners. Kalemie was chosen by the CERF secretariat in discussion with OCHA DRC, on the basis that it would be possible to visit and discuss projects funded through CERF’s RR and UFE windows, respectively, as well as discuss activities funded in support of the L3 scale-up. Timing allowed for only a short visit to Kalemie, over the middle weekend of the DRC country visit. OCHA, recipient agencies and partners were generous with their time and the mission was able to hold meetings about CERF allocations. It was also possible to visit a small number of CERF funded projects. These included a UNOPS project (implemented by UNMAS) designed to identify and remove ‘explosive remnants of war’ across Tanganyika; a UNICEF project (components from the RR L3 scale-up allocation) to treat cholera and reduce the risk of cholera amongst displaced populations in Kalemie town (implemented in conjunction with the Ministry of Health and the INGO Solidarité.)

Table 1 – Numbers of Key Informants (UN, partners)

OCHA / CERF Secretariat / HC	11
CERF recipient agencies	22
NGOs (International and local)	7
TOTAL	40

1.3 Report Structure

The broad scope of the review covering multiple allocations across multiple geographical areas offers some challenges to the structure of the report. Neither a fully geographical nor chronological organization of the report structure would offer a perfect solution. The main report which follows is in five sections, including this introduction. Section 2 offers a brief summary of the overall context in DRC and the scale of the humanitarian response. In particular, it outlines the evolving context in each of the conflict related sub-crises to which the majority of CERF funding was allocated. It also summarises the conflict-related allocations, in chronological order. Section 3 details the main findings from the conflict related allocations,

Section 2: CERF Allocations in Context

2.1 Overview

This section summarises the overall context in DRC and the scale of the humanitarian response. It goes on to outline each of the sub-national, conflict related crises within the DRC. It also summarises efforts by the Humanitarian Country Team (HCT) in the DRC, with support from the Global Cluster Coordination Group (GCCG), to strengthen the humanitarian response, including its core coordination structures following the declaration of a system-wide level 3 (L3) emergency in DRC in late 2017.

Every major humanitarian crisis has a basis for being characterized as exceptional and it is possible to make that claim for DRC in a number of ways. The humanitarian response in the DRC is extraordinary in absolute terms; the longevity, scale and complexity of the various conflicts and public health issues are enormous. In order to assess the added value of CERF to the humanitarian response in the DRC, it is important to understand the complexities of the crisis; especially those that render the response particularly challenging for the humanitarian system in its typical formulation.

Firstly, the chronic underfunding of the response in DRC throughout the review period is one of its defining characteristics, one which permeates all the findings herein. Donor-fatigue and global competition for funding are undoubtedly contributing factors to the level of underfunding and are key factors that have led to the DRC being the top recipient of CERF funding since the fund's inception in 2006, with a total of \$364,207,472 allocated⁸. CERF was also the 5th largest donor to the 2017 DRC HRP with 5.6% funding (<https://fts.unocha.org/appeals/587/summary>) and 3rd highest donor⁹ to the 2018 HRP with 7.4% funding (<https://fts.unocha.org/appeals/652/summary>).

In addition, the DRC response includes an exceptionally large number of 'sub-crises' within a single country context. UN-led, humanitarian response architecture is hierarchical, with a coordination structure at capital level which is typically replicated at sub-national level, with staff at lower professional grades. The operation in Eastern DRC ('the Kivus') has been the major focus of the response in DRC for a number of years. Relatively new crises in the Kasai¹⁰ region and in Tanganyika¹¹, Haut-Katanga and Haut-Lomami (referred to hereafter as the Tanganyika crisis); the most recent Ebola outbreaks and distinct issues with refugees or returning refugees from different neighbouring countries all constitute major crises in their own right. Arguably, a number of these would justify the attention of a 'country level'

⁸ As of 31 Dec 2018 (https://cerf.un.org/what-we-do/allocation-by-country/total_to_date)

⁹ The U.S. is the main donor averaging 44% of HRP requirements per year.

¹⁰ Kasai Central, Kasai, Kasai Oriental and Lomami (referred to hereafter as the Kasai crisis)

¹¹ Tanganyika, Haut-Katanga and Haut-Lomami (referred to hereafter as the Tanganyika crisis)

coordination structure. Having four or more country level response teams in a single country and in a single country HRP presents extraordinary challenges for resources, both human and financial. The enormous geographical span of DRC, the lack of transport infrastructure and severe access and security challenges are all exacerbating factors. The IASC Level 3 (L3) scale up and the restructuring and strengthening of coordination structures (described below) were undertaken, in part, in recognition of the need to strengthen the whole response architecture to meet the escalating needs. There is documented evidence, backed up by interviews, of ongoing weakness in subnational coordination structures. Efforts to strengthen coordination and the use of CERF funding explicitly towards this end are explored below.

Paradoxically for CERF¹² in DRC, allocations during this period worked through subnational coordination structures and systems which were overtly acknowledged by OCHA staff and a significant range of partners to have less capacity than required to operate effectively in context. One particular focus of CERF's Performance and Accountability Framework (PAF) is whether the use of the fund has the effect of 'enhancing the quality of coordination within the cluster approach and across clusters'. In answering this question, the report will differentiate between national and subnational structures. One reason for doing so is that the reported lack of capacity at subnational level creates quite specific dynamics, which must be taken into consideration.

The following section provides a brief summary of the sub-national crises and a summary of each of the respective CERF allocations in chronological order.

2.2. Sub-national crises in Tanganyika, Kasai, Kivu's, and Ituri and related 2017 CERF allocations

Tanganyika Crisis: In Tanganyika Province, a resurgence of violence in a longstanding inter-community conflict resulted in the displacement of over 322,000 people in late 2016. Conflict had escalated since July and peaked in December of the same year¹³. Given this escalation and the increasing needs of the affected populations, humanitarian actors on the ground faced capacity and response constraints: including inadequate pre-positioned stocks; security and access issues in a fluid conflict setting. Many of the affected, displaced populations were living without shelter or with vulnerable host families. Multi-sectoral needs assessments across the affected areas in early 2017 highlighted the need for NFIs and that children were particularly vulnerable¹⁴. In addition, a shortage of potable clean water and unhygienic conditions exacerbated the risk of communicable disease outbreaks¹⁵.

¹² And equally for the DRC HF

¹³ Spreading to all six territories of Tanganyika Province as well as the neighbouring province of Haut Lomani.

¹⁴ A significant number of children under the age of 5 suffering from diarrhea (49% in Ankoro and 30% in Kalemie health zones). In addition, in Manono health zone, 41% of children between 6-9 months had a MUAC <125mm, while in Kalemie, 7% suffered from severe acute malnutrition.

¹⁵ Population movement had already caused the spread of measles (2415 cases) and cholera (3034 cases) since the beginning of January 2017.

Inter-communal conflict intensified in July 2017 resulting in the displacement of additional thousands of households under an expanded and exaggerated set of conditions. The majority of the newly (or second-time) displaced were located around Kalemie (in Tanganyika) or Pweto (in Haut-Katanga). In August of 2017, however, the provincial government initiated a plan to move IDPs from Kalemie and its immediate surrounds to new sites 26 to 50 km away from the town. By this point in the year, Tanganyika had already registered a significant outbreak of cholera¹⁶ and the movements, coinciding with the upcoming rainy season, raised concerns of the disease spreading further. In addition, the conflict had led to the loss of three seasons worth of agricultural resources, resulting in 358,000 people in three zones in Tanganyika, reporting as IPC level 4 emergency and another 561,000 reporting as IPC level 3.

Toward the end of 2017, a wave of new displacements was caused by ongoing, inter-communal conflicts and new dynamics; notably acts by militias in Maniema and South Kivu. By the end of the year, Tanganyika and neighbouring provinces contained 717,000 IDPs, collectively; 340,000 of whom were newly displaced¹⁷. During this period there were alarming reports of deteriorating food insecurity, with several health zones in phase 3 or 4 and concerns about malnutrition rates exceeding the emergency threshold in some territories.¹⁸ Rapid needs assessments conducted in December 2017 highlighted specific needs for NFIs and access to drinking water. Cholera and measles outbreaks were also identified as significant risks¹⁹. By October 2017, the IASC had declared a system wide, L3 emergency (see below) which included the Tanganyika crisis.

Kasaï crisis: In the Kasaï provinces, conflicts over customary leadership began in August 2016, leading to an escalation in clashes between the local militia and the armed forces of the DRC. Between September 2016 and February 2017, the burgeoning conflict resulted in the displacement of an estimated 216,000 people. As in Tanganyika, these large population movements gave rise to poor living conditions with ill-equipped temporary shelters, little water, sanitation and hygiene infrastructure, food insecurity and a lack of accessible primary health-care services²⁰ in areas of displacement zones. Children and young people, who made up a large part of the Kamuina-Nsapu militia in the Kasaï region were also noted as particularly vulnerable in the region (400 schools were reported as having been attacked and at least 260 destroyed).

¹⁶ 3467 cases and 66 deaths by week 35.

¹⁷ The Malemba-Nkulu territory alone was hosting 105,000 IDPs.

¹⁸ The Kongolo territories and Malemba-Nkulu.

¹⁹ 10,903 cases were reported in 2017 and 234 deaths in these provinces, as well as measles 7,867 cases and 112 deaths were reported in 2017.

²⁰ In Kasaï Province specifically: the malaria mortality rate reached 35% (morbidity 31.2); statistics related to malnutrition and food consumption exceeded thresholds set by the food security and nutrition clusters; an inter-agency mission registered 806 house fires with 24,000 persons in need of assistance (Kasaï Central); a needs assessment conducted by the RRMP outlined concerns in the area of shelter, schooling, water, sanitation and hygiene (Kasaï Oriental).

The ongoing conflict spread and intensified during 2017 and by July and August of 2017, the HCT identified a significant number of households at risk and stated three key concerns:

- the imminent start of the rainy season raised the risks of waterborne illnesses and further limited humanitarian access in certain zones;
- severe deterioration of food security (nine zones across the three Kasai provinces reported IPC level 4);
- reported increases in Gender-Based Violence (GBV) and separated children²¹.

By September, over 1.4 million people²² were estimated to be displaced (60% of whom were reported as being children), out of a total of 1.9 million people in need of assistance across nine provinces. The main causes of displacement were attacks by militias, conflict between these militias and the FARDC and some intercommunal conflict. In addition, there were a significant number of population movements by returnees (1,257,000 since August 2017). Both returnees and IDPs, however, were reported as living precariously; many households having lost their means of subsistence, social infrastructures having been destroyed and access to primary health centres, reproductive health and education being very limited. Significant needs were highlighted in WASH and there were concerns surrounding the spread of cholera²³ and measles²⁴, cases of which had increased throughout 2017. There were also serious concerns around GBV and Child Protection issues²⁵. Furthermore, by November 2017, 23 health zones were on alert because of their nutrition status (an increase from 8 in April 2017).

Crisis in North and South Kivu, Maniema, Ituri and Bas-Uélé: All of these Provinces saw a sharp deterioration in security as a result of action by armed militia groups during 2017 and each saw a respective and significant increase in displacement. By December 2017, 326,000 IDPs were reported in South Kivu and in Maniema. South Kivu also saw an increase in levels of displacement related to the long-standing conflict. An inter-cluster report noted an 80% increase²⁶ in the number of displaced households. By July 2017, over 9,600 households had been displaced to Kimbi-Lulenge. In addition, 6,350 displaced households had arrived from Tanganyika. The violence further diminished access to social services (specifically health services) for IDPs and host communities in an already fragile context. Cholera also posed a particular risk²⁷ and the presence of IDPs in zones of elevated risk for cholera served to increase the level of concern. In North Kivu, 700,000 individuals were displaced over the course of 11 months in 2017, a significant increase which saw almost the entire province designated a

²¹ Reports stated that 5000 children had been separated from their families and close to 900 that had been recruited by armed groups.

²² 26,000 people were displaced in August alone

²³ 1,787 cases in Ngandajika, 433 in Luilu, 250 cases in Ilebo and 198 in Dekese

²⁴ 8,635 cases and 27 deaths

²⁵ 585 children were reported as having used in armed combat/as human shields and 64,456 women were reported as having been victims of GBV.

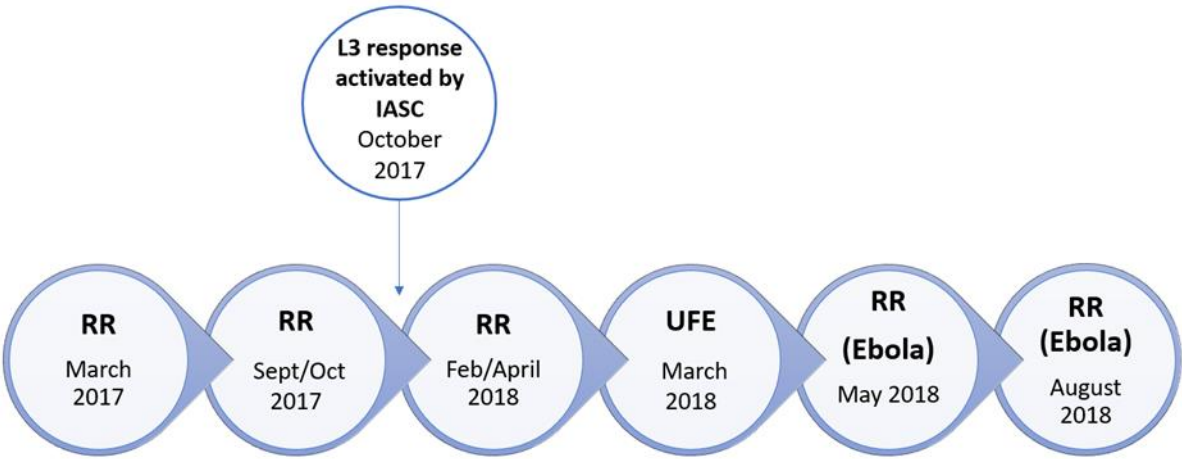
²⁶ The 80% increase figure appears in an inter-cluster report and the time frame is non-specific.

²⁷ Between weeks 1 and 34 (2017), 3739 cases had been reported.

hotspot. Insecurity in North Kivu also caused displacement into Ituri, in addition to localised militia activities.

The region of Bas-Uélé had seen the entry of refugees from the Central African Republic (CAR) since May 2017. While 85% of these refugees were housed by host families, there were significant concerns about living conditions and access to resources²⁸, many of the refugees having arrived without personal effects. Prior to the CERF allocations, a number of rapid needs assessments had been conducted, which identified needs within the sectors of protection, nutrition, education, WASH, and shortcomings in logistics. Data also showed significant food insecurity²⁹ and shortages in access to potable water³⁰ or WASH infrastructure.

CERF allocations 2017: These two RR allocations were provided in support of the responses to the Tanganyika and Kasai crises and the latter to Haut-Katanga and South Kivu in addition. The following section describes the L3 activation; the 2017 RR allocations leading up to the L3 activation; the 2018 RR L3 scale-up allocation; as well as the 2018 UFE allocation provided shortly after in the same areas. Although each allocation is described separately below, they can clearly be seen as a progression, responding in turn to the deterioration of conditions in the context of each sub-national crisis.



²⁸ In fact, in certain regions, the number of refugees surpassed the host population. MSF Belgium had announced in July 2017 that there were 3,000/4,000 refugees for every 800 inhabitants.

²⁹ with 57% of individuals living with insufficient food

³⁰ 90% of the population were reported as having no access to potable water

CERF Rapid Response allocation to address conflict-related displacement in the Kasai and Tanganyika Provinces March 2017 – referred to hereafter as ‘RR March 2017’.

Allocation summary:

Date: March 2017
Window: Rapid Response
Rationale: Conflict-related displacement
Recipient agencies: FAO, UNFPA, UNICEF, WFP, WHO
Allocation total: US\$9,611,948
Grant expiry date: 07 Dec 2017

CERF Rapid Response allocation to support conflict-affected people in the Kasais, Tanganyika, Haut-Katanga and South Kivu September/October 2017 – referred to hereafter as ‘RR October 2017’.

Allocation summary:

Date: October 2017
Window: Rapid Response
Rationale: Conflict-related displacement
Recipient agencies: FAO, IOM, UNFPA, UNHCR, UNICEF, WFP
Allocation total: US\$13,958,355
Grant expiry date: 06 April 2018

2.3 L3 activation, coordination strengthening and CERF allocations 2018

L3 activation: The DRC 2017-2019 Humanitarian Response Plan (HRP) had originally anticipated 7.5 million people in need of humanitarian assistance in 2018, but these numbers increased substantially to 13.1 million in the 2018 update of the HRP. Following the trajectory described above, the multiple humanitarian crises in the DRC had deepened and spread. In total, violent conflict and intercommunal tensions had caused over 1.7 million people to flee their homes and by November 2017, there were 4.1 million IDPs. As of 30 November 2017, there were over half a million refugees spread across affected areas; rising levels of food insecurity³¹, growing crises in public health³² and protection³³.

³¹ 7.7 million people were reported as being affected by phase 3 and 4 food insecurity and more than 255,229 cases of moderate acute malnutrition.

³² 50,000 cases of cholera including 1,070 deaths (increase of 90.3% compared to 2016) and 41,778 (502 deaths) from measles (increase of 134.6% compared to 2016)

³³ The third quarter of 2017 saw 30,953 new cases of protection, 26,418 new cases of sexual violence

Within the context of this deteriorating humanitarian situation, an IASC system-wide emergency response (Level 3 response) was activated by IASC Principals in October 2017 for the crises in the Kasais, Tanganyika and South Kivu, drawing additional attention and capacity to these crises. DRC's L3 response strategy outlined operational priorities in these areas, including seven areas where collective action was required to ensure that the response was fit-for-purpose: greater collective accountability; streamlined humanitarian coordination; strengthened collective analysis and prioritization; improved response capacity at the interprovincial level; strengthened preparedness and contingency planning; sufficient funding for humanitarian operations; effective humanitarian advocacy around access, protection and accountability to affected populations.

Restructuring of coordination architecture in DRC: Recognising challenges with the standing coordination structures and a need to strengthen them in the context of the new sub-national crises and their L3 plan, the HCT 'requested support from the Global Cluster Coordination Group (GCCG) in undertaking a review of the humanitarian coordination architecture in DRC. A GCCG mission was in DRC from the 12-21 November 2017³⁴. The mission found 'clear signs of duplication of work within the coordination system as a result of there being too many mechanisms for the number of operational partners involved' and 'a lack of clarity in the roles and responsibilities of some coordination mechanisms³⁵'. The full narrative of the restructuring is beyond the scope of this review. Some key points are, however, essential to describe the context in which allocation decisions were taken.

Multiple findings of the mission included a number of specific relevance to CERF processes and allocations. There was recognition that delegation of authority to the hubs needed to be strengthened and that low capacity at the level of provincial hubs had had a number of negative effects. These included diminished decision-making capacity; duplication between the provincial coordination level role by national level and overall, a lack of clarity on how mechanisms link and how information flows through the system.

The report also highlighted insufficient coordination and information management (IM) capacity (at national and provincial level with a few exceptions) to effectively and efficiently run a de-centralised coordination system 'across at least four, country-sized, humanitarian responses and, at the same time, maintain a national overview and coherence to the response.' INGOs were also noted as disengaging from the system as the prevailing model did not allow them a voice. The report also highlighted a weakness in how clusters are working together on the substantive elements of the operational response including with regard to the centrality of protection, early recovery and the multi-sectoral approach. In general, the clusters at provincial

³⁴ MISSION REPORT: GCCG SUPPORT MISSION TO DR CONGO ARCHITECTURE REVIEW 12-21 NOVEMBER 2017

³⁵ MISSION REPORT: GCCG SUPPORT MISSION TO DR CONGO ARCHITECTURE REVIEW 12-21 NOVEMBER 2017

level (ICPs) (and at national level (ICN) to a lesser extent) were noted as struggling to implement a multi-sectoral approach.

Recommendations included the strengthening of each cluster (and sub-cluster) and a dedicated, experienced coordinator for each of the clusters in each of the four main hubs for North Kivu, South Kivu, Tanganyika and Kasai. They also include various components of support to the Information Management Working Group (IMWG) in working with OCHA and the clusters to rationalize and lighten reporting and IM requirements. This included consolidation of information at hub level to flow to ICN to support collective operational and gap analysis in the hubs.

In view of the L3 declaration and considering that CERF had released US\$14 million in Rapid Response funding in October 2017 to the Kasais, Tanganyika, Haut-Katanga and South Kivu provinces, the Emergency Relief Coordinator (ERC) agreed in December 2017 to an additional RR allocation based on operational priorities laid out in the L3 benchmarks (October 2017); operational plans (developed shortly afterwards) and a CERF Strategic Priorities³⁶ note, developed in late November. The latter states that the aims of additional CERF funding include: addressing new lifesaving needs in L3 areas and to strengthen key response elements to allow for immediate scale-up and a transformative impact into 2018.

The strengthening of response elements include: (1) supporting L3 benchmarks 2 and 4³⁷ by providing funding for key enabling functions and logistics; (2) delivering urgent, lifesaving assistance linked to the priority needs identified in the L3 priority operational plan; (3) supporting benchmark 7 (AAP) which would cover the capacity and associated costs to establish a response-wide mechanism for engagement with communities, incorporation of feedback into response strategy in place and regular monitoring of people's satisfaction and priorities.

CERF Allocations 2018: Following the ERC's provisional endorsement, the Humanitarian Coordinator and Humanitarian Country Team (HCT) submitted a US\$20 million **rapid response request** on 18 January 2018. Funds for nine approved projects were allocated to agencies in February 2018. A tenth project aimed to reinforce accountability of the humanitarian community in the DRC vis-à-vis the crisis affected people in the L3 areas through the establishment of an inter-agency AAP mechanism was submitted in March, following inter-agency discussions on design, and was approved by the ERC in April. The grants specifically

³⁶ November/December 2017

³⁷ 'Strengthening streamlined, humanitarian coordination' and 'improving response capacity at provincial and interprovincial levels', respectively

focused on activities³⁸ that would have a direct and catalytic impact on the scale-up of the response and operational capacity in the L3 areas to deliver a more coordinated and informed response.

Given the low levels of funding overall (as described above), DRC was one of 10 countries selected by the Emergency Relief Coordinator in December 2017³⁹ for a **UFE allocation** of US\$28 million – the largest amount of the total US\$100m allocation. Recommendations to the ERC⁴⁰ note the ‘surge in violent conflict and intercommunal tensions...bringing the total number of IDPs in DRC to 4.1 million—the highest number of any country on the African continent’; the lack of HRP funding (in absolute terms and against the global average); and the potential for the allocation to highlight the needs in DRC to donors. It also notes the potential synergy with the RR allocation for urgent needs in L3 zones, North Kivu and Ituri.

It is important to look at the RR February 2018 and UFE March 2018 allocations together given their complementary nature. The two allocations were based on the same prioritisation strategy which considered: the unfolding crises in each respective province; the bigger financing picture for the response; ongoing efforts to strengthen the humanitarian coordination architecture and the L3 declaration. Overall, both allocations 2018 are representative of a particular period of transition in the DRC response. The RR October 2017 allocation had focused on the crises in Kasaï, Tanganyika and South Kivu. Other regions, like North Kivu and Ituri received very limited funding. In total in 2017, US\$429M was mobilized for the humanitarian response in the DRC, constituting only 54% of the funds requested through the HRP (US\$812M). This is substantially lower than the 61% global funding average of all HRPs in 2017 (as of 14 Jan 2019): <https://fts.unocha.org/appeals/overview/2017>

[CERF Rapid Response allocation in support of L3 scale up February 2018 – referred to hereafter as RR February 2018.](#)

Allocation summary:

Date:	February 2018
Window:	Rapid Response
Rationale:	L3 Emergency
Recipient agencies:	FAO, IOM, UNFPA, UNICEF, WFP, WHO
Allocation total:	US\$19,981,998
Grant expiry date:	09 Oct 2018

³⁸ Specifically, activities were allocated in support of enhanced coordination and IM capacity; joint analysis and rapid assessments; common logistics services; as well as rapid multi-sectorial assistance within the sectors of Food, WASH, NFIs, Health (including SRH and Cholera prevention/treatment), and protection (child protection, SGBV).

³⁹ DRC UFE 2018 first round infographic:

https://cerf.un.org/sites/default/files/resources/cerf_if_drc_20180216_en.pdf

⁴⁰ CERF UFE 2018-1, Recommendations to the ERC, 1 December 2017

CERF Underfunded Emergencies allocation March 2018 – referred to hereafter as UFE March 2018

Allocation summary:

Date:	March 2018
Window:	Underfunded Emergencies
Rationale:	Conflict-related displacement
Recipient agencies:	IOM, UNFPA, UNHCR, UNICEF, UNOPS, WHO, WFP
Allocation total:	US\$27,840,104
Grant expiry date:	31 Dec 2018

Section 3: Key Findings – Conflict Related Allocations

Findings in this section are organized by key research question, then by allocation and then sub-crisis, where the document review or interviews identify specific findings for each respectively. Where findings are not specific to a specific allocation or a specific sub-national crisis they are organized by research question. Findings are organized in this way as interviewees often did not, or were not able to, distinguish between allocations when describing process. Some responses did, however, clearly distinguish between RR and UFE allocations. Recall was typically (and self-evidently) stronger for the most recent allocations.

3.1 Did CERF processes achieve key management benchmarks in respect of inclusivity, quality, transparency and adequate monitoring and evaluation?

RR March 2017: The RC/HC's report⁴¹ on the implementation of this CERF allocation notes that an initial concept note for the RR March 2017 application was drawn together in January and February 2017 by the National Inter-Cluster group (ICN) with support from OCHA DRC's coordination section and the joint pooled funding unit⁴². For each Provincial component, multiple references are made to provincial level planning. For Tanganyika, a response plan was reportedly⁴³ developed by the Provincial Inter-Agency Committee (CPIA) in late 2016. Reports suggest that the CERF request for Tanganyika was developed through a participatory process that began at the provincial level via the Provincial Inter Cluster⁴⁴. Response planning highlights the need to work equitably with both of the two communities in conflict^{45/46} and references a specific focus on access to life-saving health, nutrition and WASH⁴⁷.

In Kasai, a very similar picture is reported. Initial planning was based on a “multi-sectoral needs assessments conducted by different actors on the ground,” noted as invaluable where no formal humanitarian coordination structures were in place. In Kasai Central and Oriental, the CPIAs were consulted in the development of the Concept Note⁴⁸. Various e-mails make reference to collaboration/complementarity between the DRC Humanitarian Fund (DRC HF)

⁴¹ Rapport Annuel 2017 du Coordonnateur Résident/ Humanitaire sur l'utilisation des subventions du CERF RDC RR DISPLACEMENT 2017, page 10 par. 3)

⁴² l'Unité Conjointe des Financements Humanitaires, the support unit for the DRC Humanitarian Fund (DRC HF).

⁴³ And was being updated in January 2017. Correspondence between Unité Conjointe des Financements Humanitaires – DRC HF & CERF 18-25/01/17

⁴⁴ On 24 January 2017 a meeting of the CPIA was expanded to the Inter-Cluster Provincial (ICP) resulted in the formulation of a short-term rapid response plan for Tanganyika. Rapport Annuel 2017 du Coordonnateur Résident/ Humanitaire sur l'utilisation des subventions du CERF RDC RR DISPLACEMENT 2017, page 10 par. 3

⁴⁵ Rapport Annuel 2017 du Coordonnateur Résident/ Humanitaire sur l'utilisation des subventions du CERF RDC RR DISPLACEMENT 2017, page 8 par. 4

⁴⁶ “it is a highly polarized conflict situation where humanitarian actors and humanitarian assistance have come to be perceived by some as a factor in the conflict. Each side (Twa and Luba) views humanitarians as favouring the other (correspondence between Unité Conjointe des Financements Humanitaires – DRC HF & CERF 25/01/17).

⁴⁷ Correspondence between Unité Conjointe des Financements Humanitaires – DRC HF & CERF 25/01/17)

⁴⁸ Rapport Annuel 2017 du Coordonnateur Résident/ Humanitaire sur l'utilisation des subventions du CERF RDC RR DISPLACEMENT 2017, page 10 par. 3

and CERF in respect of this allocation. Specifically, that the CERF allocation would be used to cover urgent, immediate/short-term activities while the DRC HF would potentially have US\$4-5 million to contribute to the crises and would possibly cover shelter or other sectors and activities requiring longer timeframe⁴⁹. Ultimately the RC/HC's report⁵⁰ notes that the DRC HF supported projects of a longer duration or where NGOs clearly had added value over UN agencies.

RR October 2017: The RC/HC was reported to have launched the CERF grant application process for the RR October 2017 allocation at an HCT meeting on 17 August 2017. A meeting of the Humanitarian Advocacy Group the next day, in which, 'all of the members of the ICN' were present, allowed for the 'sharing of needs and target priorities'. The outline of the application was based on a working meeting of the ICN a few days after. Multiple inter-agency needs assessments (collaborations between UN agencies and INGOs) are cited as being used as the basis for the CERF application. The RC/HC's report highlights the extent to which the allocation was in line with the HRP's three strategic priorities:

- SO1: Improve the living conditions of people affected by crisis, starting with the most vulnerable.
- SO2: Protect the affected population and ensure respect for human rights.
- SO3: Reduce excess mortality and morbidity among the affected population.

The allocation process was also supported by the GBV sub-cluster, which provided support to the review of proposals. Again, there is reference to CERF funds being complemented by allocations from DRC HF and some specific projects are cited in reports.

RR and UFE 2018: An extraordinary meeting of the national inter-cluster was organized very early in January 2018 to discuss the proposal for a complementary funding strategy for the CERF RR and UFE allocations as well as for the DRC HF. Details for the RR February 2018 were discussed the same day in a working session of 'agencies selected by the ICN' and the strategy⁵¹ was reportedly validated in a meeting of the HCT on 10 January.

The UFE allocation strategy was agreed in early February. The principal focus of the allocation was the needs of 485,756 people in L3 areas and surrounding areas (South Kivu, Maniema, Tanganyika, Haut-Katanga, Haut-Lomami, Kasai, and Lomami) and non-Level 3 areas (Ituri and North Kivu). CERF allocations were to support life-saving interventions in the Health, WASH, Nutrition, Food Security, Protection, Shelter/NFIs, Education, and Logistics sectors and to be explicitly complementary to the Rapid Response allocation in support of the L3 scale-up. The process of outlining the strategy for RR February 2018 'indirectly' took the outcomes of discussions in the Provincial Inter-Agency Committees (CPIA) into consideration, since the

⁴⁹ Correspondence between DRC HF & CERF 18-25/01/17

⁵⁰ Rapport Annuel 2017 du Coordonnateur Résident/ Humanitaire sur l'utilisation des subventions du CERF RDC RR DISPLACEMENT 2017, page 10 par. 2

⁵¹ including the basis for UFE allocation

allocation request was based in part on the Operational Plans for the L3 areas drawn up in December 2017 and validated at the provincial level. In keeping with CERF criteria, focus was placed on life-saving activities and on actors⁵² with immediate response capacity⁵³. In addition, a distinct feature of RR February 2018 is that it specifically aimed to support elements of plans to strengthen coordination in light of the L3 declaration and the restructuring of coordination (above). The CERF RR application⁵⁴ also makes it clear that allocation decisions took into consideration other sources of funding (either pending or in place and before and after the L3⁵⁵ declaration), to ensure complementarity.

General findings: For all of the RR allocations, UN agencies stated satisfaction with the inclusive, transparent and structured nature of the prioritisation and allocation processes i.e. they were content that decisions had been made through the appropriate coordination groups in Kinshasa and that inputs had been sought from the appropriate coordination mechanisms at provincial level. Multiple UN agencies made reference to the use of clusters in decision-making processes and in particular for the latter allocations, the use of operational plans at the level of the regional hubs (CPIAs or Comités Régionaux Inter-Organisations/CRIOs) as the overall basis for prioritisation.

Two UN agencies, however, stated that they were effectively excluded from CERF allocations. In part, this was due to the fact that historically/typically they had accessed CERF funding principally through their role as cluster lead. These clusters are inactive in DRC. One noted in an interview that the process was inclusive of all the UN agencies called to take part in the key meetings; i.e. discussions at HCT and/or ICN level, smaller groups of UN agencies would meet to discuss details. With no seat at these tables, the chances of receiving CERF funding were greatly reduced.

Partners external to the UN, however, had a different perspective with regard to inclusivity and transparency. Although a limited number of NGOs were interviewed, they and a majority of OCHA staff, were solidly of the opinion that UN agencies took *key* allocation decisions internally. In their view, agencies engaged in only limited conversations in the relevant coordination groups, rather than truly consulting them, with the possible exception of the initial discussions on overarching priorities forming the basis of the respective CERF applications. This difference in perspective is not atypical in CERF PAF country reviews. Especially with regard to reference to Provincial planning processes and inter-agency assessments; it is likely that these documents and processes were not specifically undertaken as part of the CERF process and were referenced post fact. As such, when RC/HC reporting to CERF refers to collaboration with INGOs for example, the collaboration was genuine and in

⁵² Those sectors and zones that were not integrated into the proposal will have been integrated into the UFE application. CERF RR L3 Application 2018, page 13

⁵³ CERF RR L3 Application 2018, page 13

⁵⁴ CERF RR 2018, page 10

⁵⁵ The HC's report notes that HC notes that after the L3 declaration, an estimated \$418M was required to address the zones affected. Further funding for L3 in early 2018 would have still been uncertain but the response so far had been slow.

support of the whole response i.e. not explicitly linked to CERF allocations in the minds of participants. As such, UN agencies make the claim in reports that decisions were inclusive of partners, while partners, especially those in field locations, claim little or no knowledge of having been involved in CERF application discussions.

Over and above this indirect use of sub-national coordination structures, it is very clear that the strengths of these structures vary greatly from location to location and cluster to cluster. OCHA staff in Kinshasa expressed concerns about the strength of the sub-national coordination hubs, while recognising that they are relatively new.

It was apparent in interviews undertaken in Kalemie that there was little confidence in the ability of the local coordination structures to undertake collective, strategic thinking or prioritization. Essentially, then, the selection of some projects receiving CERF funding in Kalemie at the time of the field visit, did not appear transparent to partners on the ground. Although most partners had played some role in provincial coordination and strategy discussions, none could cite explicit discussions about CERF prioritisation in Kalemie itself. This dynamic is apparent in the case of the projects which were visited and/or around which specific discussions were held. As mentioned above, these projects visited included an UNOPS/UNMAS project designed to map and remove explosive remnants of war; one UNICEF led project to improve cholera treatment and reduce its spread, and a UNHCR project to bolster multi-sectoral needs assessment. In each case, these projects were clearly perceived to be priorities by each individual agency i.e. filling gaps in the portfolio of each respective agency. In the case of the UNHCR project, however, there was no awareness of the project or its potential impact among partners.

In the case of the UNMAS project, it was possible to identify the extent to which the project was perceived as a priority, but impossible to state that it was a priority within the totality of the response. In short, none of the projects were selected as filling priority gaps *through a collective process at regional or local level*. One interviewee also pointed out that CERF projects can only be allocated to a limited number of operational partners, as opposed to DRC HF allocations in which there is a choice of 150 partners who are all headquartered in Kinshasa. “This creates a dynamic whereby, even if prioritization *is* done at local level, it then has to be ‘signed-off’ by the Heads of Agencies who receive the money and if it doesn’t align with the Agency’s own priorities, those local-level can be undone.”

Although the strengthening of coordination was one of the objectives of the RR February 2018 allocation and having seen improvements (below), the Regional and Local Coordination Committees⁵⁶ (known as CRIO and CLIO respectively) and clusters were below an adequate critical mass in terms of the strength of leadership and participation across the board required for collective prioritisation. UN staff in Kalemie said in interviews that they would not

⁵⁶ CRIO and CLIO

recommend greater decentralization of decision-making, given that the capacity at local level was still inadequate.

The lack of transparency around CERF funding caused frustration with NGO partners in Kalemie. One reported having taken part in a data collection exercise, organized by IOM, but using their own funds and staff. The resulting report was branded as ‘funded by CERF’.

Monitoring and Evaluation (M+E): The DRC context is unusual in that a decision⁵⁷ was made in late 2016 to include the monitoring of CERF projects by OCHA Humanitarian Financing Unit staff. Interviews suggested that neither the capacity of the monitoring teams nor the travel budget was enhanced to include the monitoring of CERF projects. Monitoring of DRC HF projects was prioritised by the DRC HFU staff as it is a contractual obligation for DRC HF projects; only a small number of CERF-funded projects received monitoring visits in 2017, none in 2018.

As identified under previous CERF PAF country studies, UN agencies stated that all projects, irrespective of the source of funds, are included in agency specific M+E frameworks. In addition, agencies report directly to CERF at output level and via the RC/HC reports. At the time of writing, the HC’s report of 2017 had the most complete reporting for the first allocation (RR March 2017), simply by virtue of being first chronologically and Agencies having had time to submit full reports. This report noted that 7/9 of the projects funded by this allocation had either completed agency specific evaluations (5/9) or were in the process of conducting evaluations (2/7) when the report was submitted⁵⁸. In the instances where no project evaluation was undertaken, the report⁵⁹ lists the monitoring visits. Again, in keeping with other CERF country studies, OCHA staff in DRC noted that the quality of reporting from Agencies tended to be low i.e. generally treated as an additional burden and often delegated to interns or junior staff.

3.2 Are there reasonable grounds to believe that CERF operations: strengthen the humanitarian response by empowering the RC/HC and enhancing coordination; facilitates adequate coverage and the elimination of gaps; contribute to a timelier response and serve as a catalyst to kick-start humanitarian response while other resources are mobilized?

Among OCHA and UN agencies senior managers, CERF allocations in 2017 and 2018 were seen as invaluable in the context of DRC’s multiple crises and chronic underfunding. Messages from senior management were clear; firstly, that CERF funding was greatly appreciated and had been used to the best ability of the Humanitarian Country Team to fill key gaps and strengthen

⁵⁷ Decision by the HCT

⁵⁸ Rapport Annuel 2017b du Coordonnateur Résident/ Humanitaire sur l’utilisation des subventions du CERF RDC RR DISPLACEMENT 2017

⁵⁹ Rapport Annuel 2017 du Coordonnateur Résident/ Humanitaire sur l’utilisation des subventions du CERF RDC RR DISPLACEMENT 2017, page 52

the overall response. Equally, however, CERF funding could not be expected to address the chronic lack of donor funding and government engagement in the provision of infrastructure and basic public services which exacerbated long standing systemic weakness in collective planning and response. Irrespective of the multiple positive notes around the CERF response, these challenges remained the principle characteristics of the ongoing operation in DRC.

Amongst the positive aspects of CERF's role in kick starting responses, highlights include the facilitating of significant expansion of the operational footprint of UN agencies in the Kasai response, particularly the RR allocation which allowed individual agencies to scale up responses to cholera and new displacement. While a typical element in CERF country studies, the extent to which CERF has served as a catalyst to kick start humanitarian response and leverage additional funds came through very strongly in interviews. In part, this appears linked to the fact that agencies and partners were learning from being on the ground, particularly in the Kasai response i.e. CERF funded projects allowed not just for the establishment of an operational footprint but created the basis for further and more detailed needs assessment.

Interviews and the document review noted a number of specific examples of CERF funding filling gaps and allowing for an expanded response footprint. The CERF grant was seen as vital for GBV programming in the Kasai provinces, where little psychological support was otherwise provided to affected populations.⁶⁰ In addition, at the time of intervention, CERF funds made available to UNHCR filled a gap in NFI and protection needs of the affected populations and returnees⁶¹. As part of the RR allocation, CERF was seen as having filled a critical gap⁶² in funding for the cholera response in Tanganyika and South Kivu in late 2017. The role of CERF funding in cholera in Kalemie is covered below in section 3.3.

In addition to complementarity with the DRC HF, interviews and documentation raised numerous examples of CERF grants leveraging additional funding from major donor governments. UNFPA cited the example of the Japanese Government funding leveraged as a result of an initial CERF grant. This is typical of situations such as Kasai⁶³, where CERF enabled UN agencies with little or no operational presence to launch programmes in new areas.

⁶⁰ Rapport Annuel 2017b du Coordonnateur Résident/ Humanitaire sur l'utilisation des subventions du CERF RDC RR DISPLACEMENT 2017, page 17

⁶¹ Rapport Annuel 2017b du Coordonnateur Résident/ Humanitaire sur l'utilisation des subventions du CERF RDC RR DISPLACEMENT 2017, page 16

⁶² Cholera, the CERF funds arrived at the ideal time. No partners had been positioned in the intervention zone where the cholera had been identified in Tanganyika and South Kivu (400 cases and 790 cases respectively). The CERF grant prevented a catastrophe for these two provinces as well as neighbouring ones. (Rapport Annuel 2017b du Coordonnateur Résident/ Humanitaire sur l'utilisation des subventions du CERF RDC RR DISPLACEMENT 2017, page 16)

⁶³ "In the Kasai provinces, UNICEF developed an integrated education/protection strategy through the CERF funding which was picked up and replicated by USAID." "As a result of information that was funneled by the UNFPA project to its HQ, additional funding was secured for the Kasai region, including from Canada, DFID and the World Bank, as well as Japan." (Rapport Annuel 2017b du Coordonnateur Résident/ Humanitaire sur l'utilisation des subventions du CERF RDC RR DISPLACEMENT 2017, pages 17, 18)

As noted in the sections above outlining the basics of each allocation, especially rapid response, a fair amount of emphasis was placed throughout on the complementarity between CERF and other funding streams. There are multiple references in interviews and documentation^{64/65} to explicit complementarity between CERF and DRC HF. Historically in the DRC, CERF and the DRC HF processes have been closely coordinated. A number of allocations in the past were run jointly, effectively pooling CERF and DRC HF resources, with the understanding that UN agencies would receive CERF funding and that the DRC HF would prioritise funding to NGOs (in accordance with the comparative advantages of each in context).

OCHA staff and donors noted that one simultaneous allocation had been attempted during the review period, ultimately exacerbating capacity shortages in the OCHA Humanitarian Financing Unit. In this instance, CERF allocations had been prioritised, ultimately leading to donor dissatisfaction with the timeliness of the DRC HF allocation.

OCHA staff responsible for managing the DRC HF expressed frustration at staffing shortages during the L3 and UFE allocations in particular. At this juncture, the Humanitarian Financing Unit was already understaffed (with several key positions vacant) and the wider OCHA office was under significant pressure, especially during the L3 scale-up. Typically, if an OCHA office has a CBPF (in 2018 there were 18 such funds), OCHA staff responsible for the CBPF also act as focal points for CERF processes. The frustrations of HFU staff, as is often identified in CERF PAF country reviews, were also based on a perception that CERF should make a visible/direct contribution to staffing. This sense is compounded in the DRC as the cost plan for all HFU staff responsible for managing CERF allocations is paid for via the CBPF and is not included in the broader OCHA cost plan. It is impossible, however, for CERF to contribute directly to OCHA staff costs. The management of CERF processes, including applications as well as reporting, is part of OCHA's humanitarian financing function, one of the five core functions of an OCHA country/regional office, irrespective of whether there is a country-based pooled fund.

Principally, this is an issue for OCHA management in DRC; capacity to manage CERF processes is frequently required in the DRC and needs to be incorporated into ToRs, work and cost plans. Given that some OCHA HFU staff feel overburdened by CERF allocations, however, and that there is an associated perception that CERF should cover additional staffing costs, there is also a communication issue to be addressed. In addition, CERF and CBPFs are supported by a similar set of core donors. Especially in countries like DRC where a significant proportion of funding passes through pooled instruments, donors need to ensure that all parts of the pooled funding process, from allocation to monitoring, reporting and risk management are adequately staffed.

⁶⁴Re: WASH – CERF funding initiated a response in South Kivu that was then followed by DRC HF as well as funding by UNICEF. (Rapport Annuel 2017b du Coordonnateur Résident/ Humanitaire sur l'utilisation des subventions du CERF RDC RR DISPLACEMENT 2017, page 17)

⁶⁵ To complement the CERF allocation, the FH initiated Emergency funding in October 2017 (\$20M). Rapport Annuel 2017b du Coordonnateur Résident/ Humanitaire sur l'utilisation des subventions du CERF RDC RR DISPLACEMENT 2017, page 17.

Recommendation OCHA management and key donors: Ensure that the OCHA Humanitarian Financing Unit (as part of the Joint Pooled Fund Unit in DRC) consistently has the capacity to manage all elements of pooled funding processes, for both CERF and the CBPF.

Recommendation: OCHA DRC management: Ensure that adequate staffing for the management of CERF processes, over and above the requirements of the CBPF, are incorporated into ToRs, work and cost plans.

3.3 CERF support to L3 scale-up and the use of the UFE window in a protracted crisis

In support of the L3 scale-up, how effective was CERF support? Specifically, to what extent did CERF's support to collective priorities enable agencies' delivery of multi-sectoral assistance?

As mentioned above, one principal reason for selecting Tanganyika for a field visit was the opportunity to look at the system strengthening components of the RR February 2018 allocation. This section describes the field visit and findings related to the strengthening components. Other findings, notably from the UFE allocation, are described in other relevant sections.

L3 strengthening components in Tanganyika/Kalemie: At the time of the visit, the capacity of coordination structures in Kalemie, for the Tanganyika crisis, had been 'upgraded' in line with the restructuring described above. Kalemie is host to one of the newly structured coordination hubs, the Kalemie 'CRIO'. Also, in line with the coordination strengthening plan, the OCHA office in Kalemie had a dedicated, international OCHA coordinator for some months.

In addition, Tanganyika was targeted for support under the CERF RR February 2018 in support of the L3 scale-up. The 'chapeau' for the L3 allocation notes the need to strengthen the response in a number of areas across the DRC, some specifically in Tanganyika including the need for additional capacity to engage with national authorities, given ongoing issues related to coordination leading to the denial of access to displaced populations in and around Kalemie; and the need to strengthen emergency telecommunications and, in particular, multi-sectoral needs assessment. The chapeau also acknowledges that some geographical areas of identified need in Tanganyika had not been adequately assessed in recent months. This was the case, for example, for the Kongolo and Kabambare territories, where no assessment had been undertaken. The lack of multi-sectoral assessment was also seen as limiting the capacity of actors to validate population movements (follow-up and analysis of the cycle of displacements). As such, thousands of displaced people were not being represented in needs analysis and in the targeting of the response. The lack of clear data was also seen as undermining the capacity of actors to advocate for resource mobilization.

Given the weaknesses noted in needs assessment and data collection, including the provision of a set of ‘formal’ IDP numbers on which to base discussions with local authorities, an IOM project to support these elements is worthy of note. The CERF application, and the specific IOM proposal requesting CERF funding, list three components: the secondment of IM staff to the regional hubs; the activation of IOM’s Displacement Tracking Matrix (DTM) in each of the hubs; the intention to create and support Joint Assessment Working Group (JAWG) in the same hubs⁶⁶.

At the time of the visit, the IOM secondment had ended, but the IM post remained, filled by an OCHA staff member. In general terms, IM capacity was seen as stronger as a direct result of the secondment, particularly in mapping and tracking the activities of partners across Tanganyika. IOM’s Displacement Tracking Matrix (DTM) was established in Tanganyika at the time of the visit, and assessments of the numbers of displaced populations had begun. Overall, partners and OCHA had mixed perceptions of the success of the DTM, not least because most progress had been made at that time in the relatively accessible populations around Kalemie. The process of compiling numbers for the DTM included a role for local Government authorities and these numbers, although not covering the whole province, had reportedly been used as the basis for discussions. As above, the need for a set of agreed numbers, along with increased capacity to negotiate fulfilled one of the principle areas of strengthening required in the CERF ‘chapeau’ document. The DTM was seen as having the *potential* to provide a useful baseline of data for agencies and partners, but not to have reached an adequate level of frequency or completion to fulfill this function. One partner noted having worked with the DTM in another country context. In their view, the potential of the tool in Tanganyika was not yet apparent to partners, noting that general weaknesses in the energy around coordination were the principal reason. A senior staff member from a UN agency with extensive operations in Tanganyika noted that the benefits of L3 strengthening activities were not immediately apparent outside of Kalemie and its immediate surroundings⁶⁷.

CERF funding was allocated to WFP for the strengthening of emergency communication infrastructure for the humanitarian system, specifically VHF radio repeaters, HF base stations and satellite phones with a view to enabling UN agencies and partners to communicate across the Province and in sub-regional hubs. WFP staff reported that the equipment had been delivered in August of 2018 and was in storage, waiting for installation which required the assistance of MONUSCO, under ongoing negotiation at that time⁶⁸.

⁶⁶ At the level of the Provincial Inter-Cluster (ICP)

⁶⁷ Subsequently to the field visit, IOM reported that the DTM project with CERF funding did allow them to “collect baseline data on displaced population in the whole [of] Tanganyika province”, with regular updates. Since the report arrived some time after the field visit, it was impossible to verify with partners.

⁶⁸ According to the final report submitted by WFP for this project, at the time of writing the report (one year after the project was funded) the installation of this equipment in Kalemie was “being finalized”.

General findings on L3 strengthening: One significant strand of the L3 strengthening component was an ‘accountability to affected populations’ (AAP) project taken on by UNFPA. CERF funding was among other things, allocated for the recruitment of a consultant to implement the AAP approach at inter-agency level to support the establishment of an AAP mechanism. The start of this project had been the subject of significant delay (2.5 to 3 months according to one staff member in an interview), principally due to challenges in hiring a French speaking professional. Although the project was underway at the time of the field visit, UNFPA could not assess its potential impact at this point⁶⁹. One staff member did note in an interview that ‘lessons learned’ from the start-up had identified that 6 months in total was ‘not long enough for a project of such a strategic nature’. One senior OCHA staff member in Kinshasa noted that the L3 uplift had ultimately not been used to maximum effect overall.

How suited is CERF as a mechanism for supporting enabling activities for strengthening response structures like those under the DRC L3 scale-up? Should CERF consider a formal strategy for systematically funding such activities in certain contexts?

As summarized throughout this report, the added value of CERF in DRC needs to be contextualized in light of growing humanitarian needs, the L3 scale up and the decision to restructure coordination structures against a backdrop of chronic underfunding. Within this setting, the strengthening of response structures was agreed as a priority. In this sense, the use of CERF to support the L3 scale-up/benchmarks, including elements supportive of coordination, is entirely in keeping with CERF norms and it is well suited in that respect.

Whether or not CERF should consider a global level strategy to intervene with this type of funding in similar contexts is questionable. First and foremost, the challenges of the strength of sub-national coordination, and particularly inter-cluster coordination are systemic, long standing and have been the subject of multiple reform initiatives. Undoubtedly the scale, in every sense, of the response in the DRC exacerbates these structural issues. The innovative approach taken by CERF to support enabling activities and services for strengthening response structures under the L3 scale-up, as presented above, made sense in context. At the time of the visit, however, it had not initiated a real strengthening of coordination.

Simply put, short term interventions by CERF in respect of L3 strengthening were well targeted, logical and defensible. Ultimately, however, they were not transformative. In order to galvanize a real step change in coordination and planning, a sustained and system wide approach, with the full backing of donors, agencies and partners would be required. The visit

⁶⁹ Sometime subsequent to the field visit, UNFPA reported that the project had enabled the engagement of female headed community organizations into discussions on needs and around the program cycle more broadly. It also improved the use of complaints and feedback mechanisms. As with other projects for which reports were received some time after the field visit, it was impossible to verify these successes with partners, nor to gauge coverage achieved.

to Kalemie highlighted that strengthening elements notwithstanding, there remained a lack of critical mass of engagement in coordination. In general, the quality of cluster coordination was perceived as poor. Given that DRC is somewhat of an 'outlier' in terms of the scale and complexity of the whole response, including its sub-national components, it is arguably ill suited to be taken as a starting point for making a more general case.

Recommendation: A decision to use CERF funding on an ongoing basis for enabling activities for strengthening response structures like those under the DRC L3 scale-up should be taken context by context and with rigorous justification.

How well did the CERF Underfunded Emergencies allocation model meet the needs of a large-scale protracted emergency like DRC and fit into a multi-year humanitarian planning and funding framework as applied in DRC?

In keeping with the other 'bigger picture' questions around CERF use in DRC, the UFE allocation has to be seen in the context of the extraordinarily low level of funding in DRC and the challenges in provincial level coordination. Allocations seem to have been based on the best available information from the provincial (or more recently regional) coordination bodies. The use of this information and discussions at the highest levels of coordination in Kinshasa have provided a reasonable basis for describing the allocations as inclusive, while the ultimate decisions on project selection were made by recipient agencies in Kinshasa. Agency representatives themselves stressed the extraordinary challenge of prioritizing from Kinshasa, faced with multiple competing priorities and the extraordinary challenge of deciding on the relative priorities of different sectors in different sub-crisis.

At the time of the visit to DRC, there were discussions ongoing about the use of multi-year funding in DRC and around the 'new way of working'. In short, however, CERF funding was not seen as directly connected to these discussions. Given the shortfall in funding overall and the short-term nature of the projects, CERF has, by and large, played its traditional gap filling role in the acute response. Funding provided to UNICEF's project to respond to the cholera outbreak in Kalemie is one example.

It is interesting to reflect on the cholera response components in Tanganyika funded under the UFE allocation. In a short (annual) programme cycle, UFE grants might be expected to address/target the most acute, life-saving needs. In the context of a multi-year planning cycle, however, UFE grants might also go to programmes with longer term objectives possibly less attractive to 'pure humanitarian' donors. It is clear in this instance, however, that CERF funds were covering short term, life-saving interventions in line with its mandate and funding criteria. Cholera is endemic in DRC and has long been acknowledged as a cyclical/chronic issue with complex contributing factors, including those related to an overall lack of public health and

WASH infrastructure (including access to potable water sources). The project visited in Kalemie contained lifesaving components which were equal parts essential and rudimentary: on-the-spot chlorination of water collected from the lake in the absence of piped water due to power shortages; staff with megaphones directing the separation of washing (clothes, cars and people); and water collection to the fullest extent possible.

Overall, the picture is one of CERF fulfilling its 'traditional' role as an emergency funding instrument. Other than the L3 strengthening components in support of the HRP, allocations to Kasai and Tanganyika were aimed at acute interventions, gap-filling and kick-starting emergency operations. Typically, where complementarity with the DRC HF was discussed, the UFE allocation was cited as funding the longer-term programmatic components of the HRP.

Section 4: Ebola Allocations

4.1 Ebola Allocations in Context

Ebola outbreak in Equateur province: The provincial health body⁷⁰ notified the Ministry of Health (RDC) of twenty-one cases of hemorrhagic fever, including seventeen deaths in Bikoro health zone, on 3 May 2018. Within a few days of this relatively late notification, a team from the Ministry of Health, supported by the WHO and MSF-Belgium, had already been dispatched to investigate. An official declaration of the outbreak was published by 8 May⁷¹. This was the ninth outbreak in the DRC since 1976 (the last being in 2017) and all had been characterized by high levels of contagion and mortality (total 1,056 cases/764 deaths).

For this particular outbreak, WHO considered the public health risk to be very high at the national level due to the serious nature of the disease, insufficient epidemiological information and the delay in the detection of initial cases, making it difficult to assess the magnitude and geographical extent of the outbreak. However, conditions for a Public Health Emergency of International Concern had not been met (according to IHR Emergency Committee meeting on 18 May). Still, based on the delay in detection, 100-300 cases were expected.

The early stages of the response were challenging, given access constraints and few clear planning parameters. Bikoro health zone contains nineteen health centres and three hospitals; each with limited functionality and frequent stock breaks. Ikoko Impenge, where the three first cases were discovered, is inaccessible by road and falls outside telephone/communication networks⁷². Furthermore, weak virus detection and surveillance mechanisms, in addition to limited training for health professionals, meant that there was a high degree of uncertainty about the extent of the affected area and the possibility of containment. Despite the fact that a number of NGOs (national and international) were present in Equateur, many had a development focus and/or did not have the capacity to respond to this type of crisis.

Numerous priority needs, in addition to the deployment of specialist teams, were identified:

- Multiple types of equipment: protective equipment for health personnel, for case management and the establishment of Ebola Treatment Centers (ETCs); for the safe burial of victims.

⁷⁰ Santé de la Province de l'Equateur

⁷¹ By the time of the declaration, five active cases had been discovered, two in the Bikoro General Hospital, and three in the health centre in Ikoko Impenge. By 15 May, two other health zones reported cases (Iboko and Wangata in the city of Mbandaka, which neighbours the Republic of Congo). By 25 May 2018, a total of 54 cases and 25 deaths had been reported.

⁷² While there was a landing strip 8k from Bikoro, access to other target zones was expected to take between 2-7 hours by boat.

- Water, Hygiene and Sanitation (WASH) activities aimed at reducing the risk of spread at the community level, health centers, schools, churches, markets and all other public places.
- Awareness and communication activities at community level, with a focus on schools.
- Implementation of key activities within the framework of the Protection aimed at reducing the risks of stigmatization, isolation and discrimination of the victims as well as the care of the most vulnerable
- Implementation of psychosocial care activities for victims, their families and support for community reintegration.

CERF Rapid Response allocation in response to the Ebola outbreak in Equateur Province May 2018

Allocation summary:

Date:	May 2018
Window:	Rapid Response
Rationale:	Ebola Outbreak
Recipient agencies:	UNICEF, WFP, WHO
Allocation total:	US\$1,995,504
Grant expiry date:	29 November 2018

This allocation sought to contribute to the control and reduction of Ebola-related mortality and morbidity and prevent the transmission of the disease to other parts of DRC.

The Ministry of Health at the national level, with support from the WHO, was quick to develop a national response plan, as well as country, provincial and local coordination mechanisms. The budgetary requirements of the response, however, were uncertain due to the fact that the true extent of the crisis and how best to address it, remained unclear in the early stages. This was especially true given limited access and the high cost of transportation. In fact, estimates around the budgetary requirements jumped from US\$12M to US\$26M within the first week of the declaration. By 27 May, the requirements had exceeded US\$56M.

At the time of the CERF application, WHO had allocated US\$1M to deploy technical experts and some coverage of costs for a helicopter. As a contingency, UNICEF mobilized US\$600,000 for a WASH response and WFP mobilized logistics teams to evaluate needs. OCHA and WHO, in collaboration with the HCT held meetings with key donors in the humanitarian sector to mobilize resources. The Start Fund announced an allocation of £250,000 for an immediate response (45 days) while DFID, the Wellcome Trust, and Gavi also made pledges; the latter for vaccinations.

Ebola outbreak in North Kivu and Ituri Provinces

The Ministry of Health (DRC) notified the WHO of a case of EVD in the Mabalako health zone in North Kivu on 1 August 2018 and an official declaration of the outbreak was published by the government the same day⁷³. Again, there were delays in detection, in this case as a result of an administrative strike by registered nurses (which had begun on 31 May 2018); the strike had resulted in a suspension of data transmission and vaccination activities and a refusal to receive provincial supervision missions. By 7 August, 17 cases had been confirmed and 27 probable cases were identified (with a total of 36 deaths) in 5 health zones in North Kivu, and one health zone in Ituri. This was the tenth outbreak in DRC since 1976 – and was declared only one week after the end of the outbreak in Equateur (the two however, did not prove to be linked).

Unlike Equateur Province, there were serious concerns about security in the affected areas. Armed militia groups are active in North Kivu and there had been attacks on FARDC positions in early August. This created access problems for the humanitarian/crisis response and increased the potential for the spread of the disease. The health zones affected by the outbreak are characterized by population movements/displacement. North Kivu is one of the most populated provinces in DRC⁷⁴ and a significant proportion of the population is mobile as a result of commercial/ economic activities.

CERF Rapid Response allocation in response to a new Ebola outbreak in North Kivu and Ituri Provinces August 2018:

Allocation summary:

Date:	August 2018
Window:	Rapid Response
Rationale:	Ebola Outbreak
Recipient agencies:	WHO, WFP, UNICEF
Allocation total:	US\$2,808,736
Grant expiry date:	22 February 2019

An RR allocation in August 2018⁷⁵ was provided to respond to an Ebola outbreak in North Kivu and Ituri Provinces. As with the first CERF RR allocation in support of the Ebola response, the aim was to contribute to the control and reduction of Ebola-related mortality and morbidity and prevent the transmission of the disease to other parts of DRC.

⁷⁴ 8 million inhabitants

⁷⁵ CERF Rapid Response allocation in response to a new Ebola outbreak in North Kivu and Ituri Provinces (18-RR-COD-31591, August 2018)

A National Response Plan was developed by the government, in collaboration with the WHO and the World Bank as well as other partners on 9 August 2018. The initial projected budgetary requirements exceeded US\$43M. However, given the experience in Equateur Province, where the projected requirements had jumped from US\$12M to US\$55M, there were expectations that the requirements would increase.

At the time of the CERF application, UNICEF's provisional budget was estimated at US\$20M; the agency was in discussion with the World Bank, DFID, USAID and the Japanese government to mobilize resources (though none were yet available). WHO had a budget estimated at US\$24M and had already mobilized US\$2M through its own emergency funding mechanism. In addition, US\$1.8M was left over from the vaccination campaign as well as US\$2.2M from other activities planned for the response in Equateur and there was potential for this to be reallocated to the response in North Kivu and Ituri following conversations with donors. However, there was not a significant level of visibility on other potential donors and, as a result, the CERF application included minimal analysis of the funding environment.

4.2 Key Findings – Ebola Allocations

Did CERF processes achieve key management benchmarks in respect of inclusivity, quality, transparency and adequate monitoring and evaluation?

RR Ebola May 2018: The CERF application was based on observations/evaluations conducted by several agencies and actors, including WHO, MSF, UNICEF, and the Provincial Health Ministry (DPS)⁷⁶. The final CERF RR application⁷⁷ makes references to a number of coordination meetings to agree on priorities for the CERF application such as ad hoc meetings of the HCT; humanitarian actors working in the health and WASH sectors; the logistics cluster and UNHAS. The application also notes the significance of an inter-cluster strategy meeting⁷⁸ (which included MSF) and outlined the evolution of the outbreak, as well as response activities either planned or already underway, gaps and priority needs. In addition, discussions took place regarding the strategic and complementary interventions that could be supported by CERF. The application states that the RR funding/response purposefully complements actions already underway⁷⁹.

RR Ebola August 2018: Throughout the process, it is clear that much of the application was borrowed directly from the Equateur response, with the addition of considerations for the security and access challenges. Clearly there are many similarities between the two CERF

⁷⁶ CERF RR Application – Final Chapeau 16 May 2018, page 2

⁷⁷ CERF RR Application – Final Chapeau 16 May 2018

⁷⁸ 11 May 2018

⁷⁹ Page 10

funded EVD responses. Large sections of the application are identical to those included in the Equateur outbreak application, with only the numbers/specific case information being changed. The higher level and general strategic elements were similar, however. The August application chapeau was significantly less detailed, specifically in respect of how the CERF allocation would complement other activities. The individual project requests were, however, more detailed and articulated.

Are there reasonable grounds to believe that CERF operations: strengthen the humanitarian response by empowering the RC/HC and enhancing coordination; facilitates adequate coverage and the elimination of gaps; contribute to a timelier response and serve as a catalyst to kick-start humanitarian response while other resources are mobilized?

RR Ebola May 2018: Activities outlined in the application very clearly adhered to CERF's life-saving criteria (the context and trigger make this straightforward), and also explicitly took into consideration logistics and access constraints detailed by the logistics cluster. An analysis of the funding environment, including the amount of funding and the respective areas of focus was included. As with other CERF projects, the Ebola related projects were integrated into the monitoring system of the DRC HF, eligible to be visited by reporting analysts tasked with comparing results with expected statistics/reach. CERF's timeliness data confirms that CERF met its own deadlines for speed of response and was one of the first donors to provide funding to kickstart the response.

RR Ebola August 2018: Identified priority needs for which CERF funding was sought were similar (if not identical) to those which were outlined in the May CERF RR Application for Equateur, with the addition of access to affected communities and the requirement of a MONUSCO military escort. The August CERF application was based on observations/ evaluations conducted by WHO, although several agencies and actors were in the process of completing needs assessments at that time⁸⁰, including WHO, MSF, UNICEF, the Provincial Health Ministry (DPS) as well as ALIMA and OXFAM. The process was launched at a meeting of the HCT on 3 August. A smaller number of UN agencies involved in the response met again on 6 August to outline the details of the CERF request, particularly the strategy/chapeau. Agencies were also asked to prepare individual project proposals. The HCT requested CERF funding on the same day the outbreak was declared, and the first project funding was disbursed within six days⁸¹.

The prioritization/strategy process⁸² outlined recommendations regarding implementation and highlighted the need to prioritise funding for agencies already present on the ground in targeted zones in order to speed up the implementation. Again, activities outlined in the

⁸⁰ CERF RR Application – Final Chapeau August 2018, page 2

⁸¹ CERF data on timeliness

⁸² CERF RR Application – Final Chapeau August 2018, page 10

application very clearly adhered to the life-saving criteria (the context and trigger make the threshold straightforward to clear) and activities were in line with Health in Emergencies/ Logistics activities included in the CERF LSC document. As in Equateur, the application also explicitly considered activities that were already underway through other agencies, including WHO and MSF who had already begun tracking contacts and identifying cases as well as deploying vaccination teams. Again, CERF funds allocated through the CERF RR window were integrated into the monitoring system of the DRC HF, with the possibility of a visit by reporting analysts tasked with comparing results with expected statistics/reach. As above, these visits did not ultimately take place as a result of capacity constraints.

General findings on the Ebola allocations: Interviewees were very clear and consistent regarding the value of CERF in filling gaps in the initial phases of both Ebola outbreaks. In stark contrast to the rest of the response in the DRC, both Ebola outbreaks were well-funded once the responses were properly established⁸³. As such, the need for CERF funding was understood to be time limited, kick starting operations while applications to mainstream donors were pending. In particular for the second outbreak, UN staff noted that the response evolved extremely quickly, a dynamic environment in which it was hard to pin down details or projections for the relatively inflexible systems of other donors. The CERF process was noted as being ‘extremely short and very fast’. In part, this was also seen as being symptomatic of the small number of operational agencies involved at the beginning, making agreement on immediate operational priorities relatively straightforward. Although the number of agencies at the decision-making table was clearly small in relation to the conflict related CERF allocations, there was no sense of frustration or dissatisfaction on the part of those excluded. This can be justified in a number of ways. Firstly, in the recognised trade-off between speed and inclusivity/transparency; speed was clearly very highly valued in this case. In addition, while other sources of funding were slower, they were available in the case of the Ebola outbreak, thereby reducing the sense of competition.

How does CERF compare to other funding mechanisms available for health emergencies? What is CERF’s role and niche in responding to disease outbreaks? What are the lessons learned from these allocations for CERF’s funding approach to disease outbreaks and CERF’s eligibility criteria?

At the time of the visit to the DRC, the response to the second outbreak was in full flow, albeit in a very challenging security environment. Ongoing discussions around funding demonstrated the value of CERF to operational agencies. Although large scale funding (some of it specific to public health emergencies) was understood to be in the pipeline, the procedures for access to

⁸³ At the time of the DRC visit, OCHA was reporting that the first Ebola outbreak had been funded at slightly over 100%, with some funding and equipment carried over to the second response.

these specific sources were unclear to humanitarian actors. For example, a significant tranche of World Bank funding (US\$37.7 Million was being quoted at that time), was understood to be available. However, at a meeting of the Ebola Task Force, humanitarian actors pressed the WB representative for clarity on what was perceived to be a 'non-transparent' application/allocation process. It was unclear as to whether the funding could go straight to partners or had to flow through Government, and if the latter, whether it would be made available as a loan or a grant. Similarly, the timing and exact parameters for a potential GAVI grant for US\$3.3 million for vaccinations were unclear at this point.

In short, the Ebola allocations in DRC follow a fairly typical pattern for RR allocations i.e. although Ebola is a public health emergency, there is nothing specific in this regard that sets it apart from any rapid onset emergency for which there is a very high sense of urgency and a very high confidence in the availability of follow on funding. Although some of the funding instruments for public health emergencies are somewhat unfamiliar / opaque to humanitarian actors, many of the sources which *immediately* followed CERF funding were typical (internal agency response mechanisms and mainstream donor funds). As such, while it is possible to say that CERF is fast in comparison to other funding mechanisms for public health emergencies, CERF played a similarly typical role in the response to the two outbreaks and as such, there are no obvious lessons to be drawn for CERF's funding approach for these two responses.

Annex A

INDEPENDENT REVIEW OF THE ADDED VALUE OF THE CENTRAL EMERGENCY RESPONSE FUND (CERF) IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Terms of Reference

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12 September 2018

1. Background to the CERF and Performance and Accountability Framework

It is widely recognized that the key strengths of CERF lie in its ability to respond quickly and in the relatively high degree of flexibility it affords users compared with other sources of humanitarian funding. Member States and private donors require appropriate assurances that the considerable funds involved are managed appropriately and meaningful results are being achieved. The Emergency Relief Coordinator (ERC) function is charged with a formal fiduciary responsibility over the proper use of CERF funds, and relies upon the CERF secretariat to assist with the proper discharge of these responsibilities. In this context, the development of a Performance and Accountability Framework (PAF) for CERF is regarded as an effective tool.

Paragraph 19 of General Assembly Resolution 60/124 calls for “the establishment of an appropriate reporting and accountability mechanism to ensure that the funds allocated through the Fund are used in the most efficient, effective and transparent manner possible.” Consequently, the CERF Advisory Group at its meeting on 12 October 2006 called for the development of a Performance and Accountability Framework (PAF). In addition, the 2008 CERF Two-Year Evaluation gave as Key Recommendation 4: “The multiple lines of accountability for CERF need to be clarified, in consultation with the UN Controller and the operational agencies, to specify the roles of each actor.” In response, the CERF secretariat developed a PAF, a first draft of which was circulated in 2009. The PAF was formally adopted in 2010.

The CERF PAF proposes, among other things, the introduction of independent reviews to be conducted annually within a sample of three to five countries as determined by the ERC. The CERF Advisory Group supported the inclusion of such an independent country-level mechanism. Following a pilot review conducted in Kenya in early 2010, the CERF Advisory Group met on 1 July 2010 and endorsed the PAF. Since then, the CERF secretariat has aimed to conduct between three and five country-level reviews per year.¹

1 A full list of reviews conducted to date and final reports are available online at <http://unocha.org/cerf/reportsevaluations/evaluations/country-reviews/performance-and-accountability-framework>

2. Scope and Purpose

The main purpose of the present country-level review will be to assess the value added by CERF funding towards the humanitarian response in the Democratic Republic of the Congo (DRC). A major aim of the review will be to provide the ERC with an appropriate level of assurance around the achievement of key performance benchmarks and planned results for the CERF mechanism around the intended inputs, outputs and outcomes as defined by the PAF. In addition, the review will explore certain strategic questions unique to specific allocations. The review will include recommendations aimed at improving operational aspects of CERF and may also identify relevant policy issues which need to be addressed at a global level.

The review will cover the time period from March 2017 until August 2018. Five Rapid Response allocations will be covered: an initial Rapid Response allocation from March 2017 to the Tanganyika, Kasai Oriental and Kasai Central provinces; the Rapid Response allocation in September 2017 just prior to the L3 declaration; and the Rapid Response allocation in support of the L3 scale-up in early 2018 to the same regions as the two prior allocations. The review will also cover two Rapid Response allocations to address humanitarian needs resulting from the Ebola outbreaks in May (Equateur Province) and August (North Kivu and Ituri Provinces) 2018, respectively. In addition, the review will look at the allocation from CERF's 2018 Underfunded Emergencies Round I.

CERF Rapid Response allocation to address conflict-related displacement in the Kasai and Tanganyika Provinces (17-RR-COD-24044, March 2017): CERF provided a Rapid Response allocation of almost US\$10 million to support life-saving activities in Tanganyika, Kasai Oriental and Kasai Central provinces. In Tanganyika, a surge in violence in the longstanding inter-community conflict between the Luba (Bantus) and the Twa (Pygmies) resulted in displacement of 332,000 people, overwhelming response capacity and existing stocks. In the Kasai provinces, clashes between the Kamuina Nsapu militia and the armed forces of the DRC resulted in displacement of an estimated 216,000 people. Over the course of 2017, these situations worsened, eventually contributing to the declaration of the L3 emergency.

CERF Rapid Response allocation to support conflict-affected people in the Kasais, Tanganyika, Haut-Katanga and South Kivu (17-RR-COD-27368, September/October 2017): In September 2017, CERF provided a US\$14 million Rapid Response allocation to address the urgent humanitarian needs arising from the sharp deterioration of the situation in areas affected by violence in the Kasai region, the Bantou-Batwa inter-communal conflict in the East (Tanganyika and Haut-Katanga) and the activities of armed groups in South Kivu. This CERF allocation was approved just prior to the declaration of the L3 emergency and therefore provides important context around the decision-making for the following CERF Rapid Response

allocation in support of the L3 scale up. In addition, it will feed into the assessment of CERF's added value to the humanitarian response in the DRC.

CERF Rapid Response allocation in support of L3 scale up (17-RR-COD-28606, February/April 2018): A system-wide Level 3 emergency was activated by IASC Principals on 20 October 2017. Given that CERF had released US\$14 million in Rapid Response funding one month prior (see above), the ERC agreed that additional funding should support the L3 operational benchmarks and plans. As such, the Humanitarian Coordinator and Humanitarian Country Team (HCT) submitted a US\$20 million request in January 2018 to operationalize priorities laid out in L3 planning documents. In addition to 'traditional' direct assistance, the CERF allocation covered activities in the areas of joint analysis/information management/coordination, accountability to affected populations (AAP), common logistics and rapid multi-sectorial assistance in the Kasai Provinces, Tanganyika Province and South Kivu Province. These collective priorities were established by the HCT in country who also agreed to include a common result with indicators and activities related to joint analysis and rapid assessments. In addition to exploring regular CERF performance indicators, the review will therefore seek to answer a set of higher level strategic questions related to CERF's role in supporting L3 scale up and related strategic priorities and enabling activities, including whether the approach adopted for the DRC L3 scale up allocation could be systematized and replicated.

CERF 2018 Round I Underfunded Emergencies allocation (18-UF-COD-28519, March 2018): CERF provided a US\$28 million Underfunded Emergencies allocation to DRC in March 2018, part of which was used to support humanitarian response under the L3. As one of the longest running humanitarian emergencies and a top recipient of CERF funds (Underfunded Emergencies and Rapid Response) DRC is also a relevant context to explore how to ensure maximum value from CERF Underfunded Emergencies allocations. The review will therefore explore strategic questions surrounding CERF's role in large-scale protracted crises like the DRC. These will include considering how to foster maximum complementarity and strategic alignment between CERF, Country Based Pooled Funds (CBPFs), and other funding channels available to the Resident/Humanitarian Coordinator (RC/HC), and will reflect on multi-year humanitarian response plans and related funding opportunities. This line of enquiry may link to New Way of Working considerations when relevant.

CERF Rapid Response allocation in response to an Ebola outbreak in Equateur Province (18-RR-COD-30550, May 2018): CERF provided a US\$2 million Rapid Response allocation to respond to an Ebola outbreak declared on 3 May in Equateur Province in the DRC. The allocation sought to contribute to the control and reduction of Ebola-related mortality and morbidity and prevent the transmission of the disease. CERF was one of the first donors to provide funding to kickstart the response.

CERF Rapid Response allocation in response to a new Ebola outbreak in North Kivu and Ituri Provinces (18-RR-COD-31591, August 2018): CERF provided a US\$2.8 million Rapid Response allocation to respond to a new Ebola outbreak declared on 1 August in the North Kivu and Ituri Provinces in the DRC. The outbreak was reported 2,500 km away from the outbreak in the Equateur Province in May and confirmed to be unrelated. The HCT requested CERF funding on the same day the outbreak was declared, and the first project funding was disbursed within six days. The allocation sought to contribute to the control and reduction of Ebola-related mortality and morbidity and prevent the transmission of the disease. CERF funds were allocated to support the scaling-up of rapid response activities to the epidemic with immediate priority given to areas directly affected by the virus and with already reported cases of infection. Combined with the CERF allocation in response to the May 2018 outbreak (see above), the review of these two allocations will feed into ongoing efforts to better define CERF's role and niche in responding to disease outbreaks.

3. Key issues

The critical overriding question on which assurance is sought is: **Have CERF operations in the country successfully added value to the broader humanitarian endeavor?** 4

CERF's added value refers to the following four objectives: (a) fast delivery of assistance to people in need, (b) better response to time-critical needs, (c) improved coordination among the humanitarian community, and (d) leveraging additional resources from other sources.

Using the indicators from the CERF PAF, assurances will be sought around the following specific areas of concern:

1. CERF processes are achieving key management benchmarks in that:

- CERF submissions are based on an inclusive planning process and adhere to established quality criteria.
- Transparent systems are in place for correct allocation, efficient flow and use of CERF by agencies.
- Adequate monitoring and evaluation systems are in place at the agency level for measuring and reporting on results.

2. There are reasonable grounds to believe that CERF operations favour the following results:

- CERF strengthens humanitarian response by empowering the RC/HC and enhancing the quality of coordination within the cluster approach and across clusters.
- CERF facilitates adequate coverage, eliminates gaps and facilitates an effective division of labor among humanitarian actors.

- CERF contributes to a timelier response to needs.
- CERF favors the delivery of relevant life-saving actions at critical moments.
- CERF serves as a catalyst to kick-start humanitarian response while other resources are mobilized.

Further key issues specific to this review and to the individual allocations include:

CERF Rapid Response allocation in support of L3 scale up:

- • How effectively did CERF support L3 scale-up priorities?
- • To what extent did CERF’s support to these collective priorities (including analysis, assessment, coordination, logistics, and accountability to affected populations) enable and/or facilitate agencies’ delivery of multi-sectoral assistance?
- • How suited is CERF as a mechanism for supporting enabling activities for strengthening response structures like those under the DRC L3 scale-up? Should CERF consider a formal strategy for systematically funding such activities in certain contexts?

CERF 2018 Round I Underfunded Emergencies allocation:

- • How well does the CERF Underfunded Emergencies allocation model meet the needs of a large-scale protracted emergency like DRC?
- • How does a CERF Underfunded Emergencies allocation fit into a multi-year humanitarian planning and funding framework as applied in DRC?

CERF Rapid Response allocations in response to the two Ebola outbreaks:

- • How does CERF compare to other funding mechanisms available for health emergencies?
- • What is CERF’s role and niche in responding to disease outbreaks?
- • What are the lessons learned from these allocations for CERF’s funding approach to disease outbreaks and CERF’s eligibility criteria?

4. Review Methodology

The formal assessment of agency performance vis-à-vis CERF-funded activities remains the prerogative of recipient agencies via their own internal oversight procedures (internal performance reporting, audit and evaluation etc.). The review approach will therefore be designed in a manner that avoids duplication with such procedures and meets only the immediate assurance needs of the ERC in relation to the PAF.

Recognizing that CERF funds are often co-mingled with other donor funds by agencies and that the in-depth assessment of beneficiary-level impact is formally the charge of recipient agencies, the review will not attempt to link beneficiary-level changes to CERF activity, except

where recipient agencies already have this data. The review mechanism will not seek to provide comprehensive coverage linked to detailed narratives and contextual analysis around how and why results are being achieved. Rather it will focus instead on providing an assurance around issues of the fund's strategic and operational impact.

The review has two main components: (1) an analysis of CERF's added value to the humanitarian response in the DRC; and (2) forward-looking questions on CERF's role (a) in supporting enabling activities for strengthening humanitarian response structures, (b) in addressing underfunded needs in large-scale protracted emergencies, and (c) in responding to health emergencies. For component 1, the review will present its findings and assessment according to the set of criteria outlined in the CERF PAF.

The review will consist of a desk review of relevant documents, remote interviews of stakeholders and a visit to DRC as well as visits to headquarters as required. The country visit will allow meetings and interviews with relevant in-country stakeholders and may include travel to CERF-funded humanitarian projects. The analytical approach will be deliberately kept rapid and light.

Prior to leaving the DRC, the Consultant will brief the RC/HC on the preliminary findings and may leave a short analytical summary of initial observations and potential recommendations in relation to the key assurance issues identified above. The RC/HC, together with the HCT, may subsequently be requested to provide a "management response" to any recommendations in the report once it has been finalized.

5. Data Collection

Desk review: A quantitative analysis will be conducted on the data, reports and files available at the HQ and country level. The desk review includes:

- Remote interviews with key stakeholders,
- If relevant, surveys targeted at key stakeholders,
- Review of relevant studies and evaluations,
- Funding data, including funding from sources other than the CERF (e.g. OCHA's Financial Tracking Service),
- Timelines on sums requested, allocated from CERF database,
- CERF country-level reports on context, needs, status of implementation, activities, results and lessons learned,
 - CERF meeting minutes at HQ and country-level and notifications of application decisions,
 - CERF Project files at HQ and country-level,

- Humanitarian appeals and other humanitarian strategy documents.

Semi-structured interviews at country level may include: RC/HC, OCHA staff, Cluster leads, cluster coordinators at capital level, HCT members, agency CERF focal points, I/NGO partner implementing CERF projects and those without access to CERF funds, affected people, host government, donors. UN Agencies will be asked to provide relevant documents and indicate interview partners to facilitate the review.

Interviews at headquarter and/or regional level may include: Stakeholders at OCHA headquarters in New York and Geneva, relevant agency focal points, and selected donor representatives as relevant. Interviews will also take place with selected CERF secretariat staff to get further background and perspective.

Select project site visits: The consultant may visit sites of CERF-funded projects to help provide some limited anecdotal information regarding the use of funding at the affected population level and can provide a field-level snapshot and some direct contact with affected people and other key informants in field locations.

In-Country working session to review provisional results. This will be used as learning opportunities to discuss, validate and fill key gaps in the findings and recommendations.

6. Proposed Consultant

It is anticipated that one consultant will be required to prepare and conduct the review. The consultant will be independent. She/he should have the following skills:

- Expertise in UN humanitarian action and financing and knowledge of the Humanitarian Programme Cycle
- Expertise and extensive experience in humanitarian evaluation
- Expertise in analyzing financial data in tandem with other types of information
- Expertise in project management and implementation
- Knowledge, including field experience with a broad range of humanitarian actors, such as UN agencies, Red Cross/Red Crescent Movement, local government disaster response structures and systems, and NGOs
- Familiarity with declaration/activation/processes of IASC system-wide emergencies
- Expertise in WHS commitments/agenda for humanity
- Ability to analyze and integrate diverse and complex quantitative and qualitative data from a wide range of sources
- Proven project and programme evaluation skills.
- Fluency in written and spoken English. Knowledge of French is desirable.
- Familiarity with man-made disaster settings

7. Management and Support

The review will be managed by the CERF secretariat, which will identify country-level focal points to support the review mission. Their responsibilities will include:

- Provide necessary administrative, coordination and logistical support to the consultants,
- Facilitate the consultants' access to specific information, key informants and expertise necessary to perform the assessment,
- Monitor and assess the quality of the review and its process,
- Ensure sufficient engagement by the HCT during the mission and in response to the draft and final report,
- Disseminate final report,
- Facilitate relevant management response to the final report and subsequent follow up.

The OCHA country office will support the consultant to liaise with key partners and other stakeholders, make available to the consultant necessary information regarding CERF-funded programmes, projects and activities in the country. Following the preparation of a draft report, the country office will provide factual verifications of the report. The country office will provide the review consultant support in kind (e.g. arranging meetings with project staff, stakeholders and beneficiaries; and assistance for any project site visit).

8. Deliverables

The consultant will be expected to produce the following main outputs:

- (1) Country visit (including final presentation/debrief for RC/HC and OCHA Country Office)
- (2) Draft report (including solicitation of comments from all stakeholders)
- (3) Final report in English to the ERC, through the CERF secretariat, in an electronic version, plus an Executive Summary.

The final report will be structured in the form of short observations and conclusions around the different assurance concerns linked to the review. Country specific analysis and observations will be included in the report in support of the strategic questions outlined above. The report will also include, as appropriate, a set of specific, well-targeted and action-oriented recommendations whose purpose should be to improve the performance of the CERF within the country or raising any policy issues. The annexes will include a brief description of the methods used and the analysis performed and a list of persons interviewed.

9. Process

Phase 1: Preparation

Phase 2: Data collection and analysis

Phase 3: Synthesis, report writing and review

Phase 4: Submission, dissemination and follow up 9

Annex B - CERF Allocation History to the DRC

Year	RR (USD)	UFE (USD)	Total (USD)
2006	\$38,000,000		\$38,000,000
2007	\$5,000,000	\$47,506,578	\$52,506,578
2008	\$3,000,022	\$38,106,996	\$41,107,018
2009	\$19,966,972	\$10,461,001	\$30,427,973
2010	\$5,090,973	\$24,035,653	\$29,126,626
2011	\$4,094,585		\$4,094,585
2012	\$19,715,742	\$11,770,546	\$31,486,288
2013	\$12,057,344		\$12,057,344
2014	\$6,956,312		\$6,956,312
2015	\$6,792,923	\$8,047,670	\$14,840,593
2016	\$5,594,179	\$10,995,505	\$16,589,684
2017	\$26,564,545		\$26,564,545
2018	\$24,786,238	\$27,840,104	\$52,626,342
Total	\$139,619,835	\$216,764,053	\$356,383,888