RESIDENT / HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS
IRAQ
RAPID RESPONSE
DISEASE

RESIDENT/HUMANITARIAN COORDINATOR	Ms. Lise Grande

REPORTING PROCESS AND CONSULTATION SUMMARY

a. Please indicate when the After Action Review (AAR) was conducted and who participated.

The After Action Review convened on 12 February 2015 and conducted by attendants from WHO, UNICEF, and OCHA/UNAMI_ICODHA The AAR report and Success Story for this CERF funded Polio Project are separately available.

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

YES ☒ NO ☐

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

YES ☒ NO ☐

The Report was shared with the HCT prior to the HCT meeting, which then discussed this report on April 16, 2015.

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: US$ 10 million		
Breakdown of total response funding **received by source**	**Source**	**Amount**
	CERF	2,000,000
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*)	0
	OTHER (bilateral/multilateral)	$200,000 from the Republic of Korea for WHO and $4.8 million for UNICEF (Germany and Rotary International
	TOTAL	**7,000,000**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 15-May-14			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	14-RR-CEF-086	Health – Nutrition	1,000,000
WHO	14-RR-WHO-038	Health – Nutrition	1,000,000
TOTAL			**2,000,000**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies/IOM implémentation	1,160,118
Funds forwarded to NGOs for implementation	25,000
Funds forwarded to government partners (expected cost of 4 rounds)	814,882
TOTAL	**2,000,000**

HUMANITARIAN NEEDS

The re-emergence of polio in Syria in October 2013 after 10 years of polio free status resulted in a regional public health emergency. Iraq in general and Anbar governorate in particular become the most vulnerable locations to possible importation and transmission of polio due to proximity with Syrian governorate of Deir El-Zoer where most polio cases detected in Syria originated in addition to the vulnerability aggravated by ongoing conflict, and low coverage rates for routine polio vaccination in Anbar. Polio was imported into Iraq from Syria, and the first case was discovered in February 2014 with a second case coming in April. Sequencing revealed the first case to be most closely related to cases within Syria, while the second case was related to the first in Iraq. Security issues in Anbar since Jan 2014 contributed to poor vaccination coverage which was 48 per cent during March 2014 polio campaign. At the end of January 2014, an estimated population of 30,000 families (equivalent to 180,000 individuals out of a total of about 1.5 million population of Anbar) have been constrained to move from their homes to seek refuge in settlements (school, mosques, public publics) or in settlements hastily erected without the minimum required standards for such settlements. The displaced families were hosted in different locations of Anbar province but also in other such as Erbil, Salah Al-Deen, Baghdad, Kerbala and Babil. A total of about 239,000 children under 5 of age were the direct target for polio vaccination, but the coverage remained low (48 per cent) compared to 98 per cent coverage in the rest of the country.

By the time the project started in May 2014, about 270,050 children under 5 years of age (100,000 IDPs and 170,050 in the host community) were considered as direct beneficiaries, including over 350 Syrian eligible children under five living in Al-Qaim refugee camp or in host community for a total population of Syrian refugees of over 4,500 individuals at that time.

The situation was also compounded by the expansion of territory controlled by Opposition Armed Groups (OAG) in Anbar, Mosul and Salah Addin. However, despite this challenging security situation, the Director Generals (DGs) of the Departments of Health in Ninewa and Anbar governorates remained in their posts and so did their top aides. This has facilitated the process of project implementation as the majority of health staff; especially those in rural areas were encouraged to remain in their posts. Health facilities continued functioning but at a slower pace with little or no interference from OAG. Anbar and Ninewa DGs maintained strong ties with their field staff and the Federal MoH.

Addressing polio challenges in Anbar is also in line with the 2012 World Health Assembly resolution, declaring the completion of polio eradication a programmatic emergency for global public health. It urges all infected countries to declare polio as a national public health emergency.

II. FOCUS AREAS AND PRIORITIZATION

Within Iraq, Anbar governorate represented and continues to represent a unique challenge and a likely site for polio transmission, though since the CERF proposal, the challenges have expanded also. Anbar governorate borders the Syrian province of Dier El Zor, where the Syrian outbreak occurred, making it the likely route of transmission from Syria to Iraq. It remains the site of the huge population displacement in Iraq, both hosting a large number of Syrian refugees and IDPs and being the origin of the displaced population. IOM estimates that over 500,000 persons in Anbar have been displaced within Anbar or to other governorates, particularly Baghdad and the governorates of the Kurdish region. Additionally, the conflict in Anbar increased dramatically in November, causing a new wave of displacement. While conflict engulfed of the center of Iraq (Ninewa, Salah-Al-Din, Diyala, Kirkuk and parts of Baghdad) following June 2014 Mosul crisis, Anbar was already in a state of conflict since January 2014. The ongoing conflict not only created mass displacement but also weakened an already fragile health care system. Routine vaccination coverage for polio in Anbar was the lowest of all governorates in 2013, and since the start of the conflict in January, Anbar has not been reporting on routine coverage to the Ministry of Health, making the area's routine coverage unknown. Additionally, campaigns early in 2014 were reaching less than 50 per cent coverage, though this trend has reversed in recent campaigns and coverage has been above 80 per cent. Taken together, this situation presents an area of concern for polio transmission.

While Anbar was initially identified as the most urgent area of focus for polio programming due to the reasons explained above, conflict, mass displacement and deterioration of the health services has struck much of the country after the start of the conflict in Mosul in June 2014. IOM estimates that almost 2 million persons and 400,000 children under 5 have been displaced due to the conflict to date, though this estimate does not take into account recent developments. This equals 7 per cent of the total population of Iraq, but in conflict-affected zones, it can be up to 40 per cent of the population. Areas in Ninewa, Salah Al-Din, Diyala and Kirkuk have faced similar collapse of health services. On top of this, governorates who have received large numbers of IDPs have had their services stretched and faced shortages in drugs. The three governorates of the Kurdistan region host 47 per cent of the total number of IDPs (along with a largest number of Syrian refugees). Duhok governorate has taken in the largest number of IDPs, over 430,000, and IDPs now account for over 25 per cent of the total population of Duhok. While the proposal initially focused solely on Anbar, the issues that plagued Anbar have spread to a large swath of the country and created the potential large polio reservoir.

III. CERF PROCESS

In response to the polio outbreak in Syria and then Iraq, WHO and UNICEF developed a Polio Emergency Response Plan in close consultation with the Iraqi Ministry of Health, at federal and Kurdistan Region levels. The plan analysed the current gaps and weaknesses in the Polio existing response and showed how to address these gaps and further strengthen the polio program in Iraq. The CERF proposal was developed to bridge the critical gaps in funding. The project proposal jointly developed by WHO and UNICEF was discussed in the Health Cluster and in the inter cluster coordination mechanism (ICCM) meetings and it was agreed that WHO will lead technically the programme while UNICEF will be supporting the process of vaccine procurement and community mobilization efforts. Polio vaccination activities in Anbar were prioritised following series of discussions with technical inputs from WHO/UNICEF Polio Team and the decision to include polio was taken by the HCT in order to allow both agencies to bridge the funding gaps as no funds were available during that time. Polio outbreak in Syria after 10 years of polio free status made Iraq especially Anbar vulnerable due to its proximity to the governorate of Deir-Zur in Syria where several cases of wild polio virus were identified. The escalation of conflict in Ambar in Jan 2014 added to the already increased vulnerability of Anbar to outbreaks. These were the two main reasons as to why the HCT decided that Anbar children should be given priority for immunization as they were more prone to polio outbreak and requested CERF for emergency funding.

During the consultation process, all partners realized that Polio is a different type of emergency than the ones we usually hear about in the news. Its biggest danger is not the current number of cases; the real danger is the resurgence of more polio cases that could kill or disable thousands of children each year if no speed action is taken to stop the poliovirus transmission. This requires a sustained effort and funding.

Placing polio as a priority in Iraq, particularly in Anbar governorate is in line with the 2012 landmark resolution adopted by the World Health Assembly declaring the completion of polio eradication a programmatic emergency for global public health. Member States highlighted the feasibility of eradication but expressed concern at an ongoing funding gap that threatened its success. This Resolution urged all infected countries to declare polio a national public health emergency requiring the implementation of emergency action plans.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR

Total number of individuals affected by the crisis: 270,050

	Cluster/Sector	Female	Male	Total
The estimated total number of individuals directly supported through CERF funding by cluster/sector	Health – Nutrition	134,560	134,559	269,119

BENEFICIARY ESTIMATION

The total direct beneficiary estimation comes from the Iraqi Ministry of Health and Ministry of Planning. This estimation forms the basis for procurement and positioning of vaccines and is based upon micro-plans developed by each primary health center. These micro-plans demarcate each health centre's catchment area and count the population within the area. Additionally, the number is checked against secondary sources. In this instance, the displacement tracking matrix (DTM) that IOM has put in place and is maintaining, in close collaboration with other UNCT/HCT members, in order to trace and quantify the level of population displacement has been extremely useful in assessing continuously their needs and designing response accordingly. In the context of Anbar, updated data regularly shared by IOM has been particularly useful in the response strategy.

The number of reached direct beneficiaries derives from official campaign numbers, which are collected by the vaccinators and compiled and collated by the Iraqi Ministry of Health. The number of Anbar IDPs in other governorates is estimated from combining IOM data with administrative data coverage estimates.

To check the quality of the information, independent monitoring is undertaken by WHO after each round. Since children are given multiple doses of the polio vaccine, the largest number reached by a single campaign is used to estimate the number of children

reached. While using the largest number reached in a single campaign ensures that we are underestimating the actual number of children reached, it is the only accurate method for estimation that reduces the risk of double counting of individuals.

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES DURING NIDs THROUGH CERF FUNDING

Month	June 2014	August 2014	September 2014	October 2014
Total planned	270,050	270,050	270,050	270,050
Total Number of Anbar Children Reached	240,704	253,744	269,119	246,968
Total IDP Reached in Anbar	229,385	222,530	237,567	215,416
Total IDP Children from Anbar Reached in Other Governorates	11,319[1]	31,214	31,552	31,552
Reached Male	120,352	126,872	134,559	123,484
Reached Female	120,352	126,872	134,560	123,484

CERF RESULTS

In April 2014, Anbar vaccination coverage was the lowest coupled with poorest routine immunization coverage in the country. The CERF proposal submitted by WHO and UNICEF aimed at improving the poor immunity profile among Anbar population.

Using funding provided through CERF, WHO and UNICEF, working with Iraqi Ministry of Health, have made a breakthrough by improving the coverage from 48 per cent in April 2014 to over 90 per cent in subsequent four rounds of vaccination. Reaching children with multiple doses of polio vaccine is essential to building the child's immunity and stopping the spread of polio. The largest number of children reached by a single campaign was during the September campaign, where 269,119 were reached: 237,567children in Anbar and 31,552 IDP children from Anbar residing in other governorates were reached with polio vaccination. This is over 99 per cent of the intended target of children under 5. This demonstrates the success of the programme, which sought to increase coverage from below 50 per cent in March 2014 to over 89 per cent in any of the four campaigns.

In addition, CERF funding was instrumental in supporting improvements in polio program operations and raising awareness of the threat of polio among the general population. CERF funding was used to provide 2 million doses of Oral Polio Vaccine (OPV) to fill a vaccine shortfall at a crucial moment. CERF funding supported increasing the sensitivity of the surveillance system in Anbar. Through the support of CERF funding, public awareness campaigns (mass media and social mobilization) were undertaken that raised awareness of the threat of polio and increased acceptance of polio vaccination.

CERF's ADDED VALUE

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

CERF funding allowed fast delivery of assistance to beneficiaries since it allowed the program to purchase vaccines at a critical juncture in the program and allowed UNICEF to start on developing social mobilization and mass media activities and allowed WHO to provide the technical expertise required to the MOH for micro-planning and plan for reaching all eligible population in Anbar including hard to reach areas.

b) Did CERF funds help respond to time critical needs[2]?
YES ☒ PARTIALLY ☐ NO ☐

Due to disagreement amongst various institutions of the state in Iraq, there was an inability to finalise the 2014 budget; consequently, the 2014 budget for the Ministry of Health was not yet approved at the time of submitting the CERF project proposal on polio in Anbar and hence MoH didn't have funds to kick-start the emergency polio vaccination campaign. CERF funds helped in bridging this major funding gap, which was made available at a critical time. WHO and UNICEF were hence able to provide timely support to the MOH and other partners involved in vaccination campaigns. CERF funds also allowed UNICEF to purchase vaccines for campaigns at crucial moments to ensure vaccines were available for the campaigns.

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

CERF allowed UNICEF and WHO to prove that they could access children in very difficult areas, which gave donors confidence that WHO and UNICEF could operate in such conditions.

For WHO, CERF funding for Anbar assisted in drawing the attention of Donors community on the fact that Iraq is the most vulnerable country to polio after Syria and in this context this has assisted WHO at global level to continue advocating for increased funding of the regional polio response plan to which traditional donors have been contributing to but with less contribution during the last few months.

For UNICEF, CERF was the first funding for the polio programming in Iraq. Receiving CERF funding helped to convince the German government ($1 Million) and Rotary international ($3.8 Million) to provide funding for social mobilization and mass media to combat polio in Iraq. Similarly, WHO was also able to leverage additional funding for Iraq amounting to $ 1.2 million from the Republic of Korea out of which $ 200,000 were exclusively allocated for WHO vaccination activities as explicitly requested by the Korea Government.

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

CERF funding allowed UNICEF and WHO to start work in Anbar, which increased our work with OCHA, IOM, the MoH and other agencies in Anbar. Also issues related to polio have been featured in most of Health cluster coordination, UNCT and HCT meetings and regular updates were provided by WHO and UNICEF polio teams. Such updates were necessary and useful for all actors, including other UN agencies, NGOs and diplomatic community in Iraq so that they can inform their respective capitals, given the sheer size of the population displacement that affected Anbar.

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

The two polio confirmed cases in Iraq early 2014 and its genetic links with strains isolated in Syria has shown the vulnerability of the whole region to polio importation and spread and the fact that CERF responded positively has added voice to the global WHO appeal to take the issue of polio more seriously, encouraging member stated to put the necessary means in place for an effective polio eradication programme.

Additionally, CERF funding allowed UNICEF and WHO to take a crucial role in the Polio outbreak in Iraq. Previous to CERF funding, neither WHO nor UNICEF had funding for Polio. With CERF funding we were able to engage with and influence the Iraqi Ministry of Health since we were able to bring resources to the resource-strapped ministry. UNICEF and WHO were able to provide crucial support to the Polio program through vaccines, social mobilization, quality assurance, and technical assistance. Without the funding to support

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

these activities, it is likely that the Iraqi Ministry of Health would not have been as successful in implementing polio campaigns and averting a larger polio outbreak.

Polio program remains remarkable for humanitarian programming in Iraq since it operates in all areas of Iraq, including areas under control of armed opposition groups. Ensuring that vaccines are able to enter into these areas has been one of the greatest successes of the polio program. Using local health staff still within the conflict areas, they have been able to negotiate the transfer of vaccines into these areas. Getting non-political, lifesaving vaccines into the population will be an important example to other humanitarian programming. CERF funding provided the initial fund to start the program and the ability to leverage other funds.

Additionally CERF funding has assisted WHO in ensuring that vaccination programmes remain a high priority agenda in different donors 'briefings. Some of them such as Kuwait and Melinda and Bill Gates Foundation who since then have continued their support to the polio regional response plan which includes Iraq.

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Narrow geographic scope of CERF can be a hindrance to adjusting the response to fast evolving emergency.	The unpredictable nature of complex emergencies made the narrow geographic focus of this CERF funding a hinderance, given the rapid change in situation and the mass displacement of population from Anbar. Loosening up the geographic focus of funding will help it to be more adaptable, especially in rapidly changing situation;	CERF Secretariat
Slow disbursement of funds	Determining mechanisms to accelerate the disbursement of funds will help the program. If disbursement is very slow, the time frame for the programming may need to be refigured to take this into account.	CERF Secretariat

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Implementation, particularly in complex emergencies, must be collaborative with local partners, particularly in insecure environments	The Iraq context presented a lot of challenges to the focus on Anbar and beneficiaries in Anbar, as listed above. This meant that the program needed to work across multiple areas to ensure the population was vaccinated as the situation changed. Working with various partners, including the MoH and the local partners, was the primary way to ensure that program could be implemented in insecure environments.	UNICEF and Implementing partners
Country-specific politics can have an effect on programming and this must be dealt with	The political situation between the Kurdish region and the Central government made implementation more complicated. In this case, the Kurdish region was one of the main areas to accept IDP. With social media and mass media, UNICEF needed to work with both ministries to ensure that the vulnerable population from Anbar are covered. Working across these two ministries was essential to the success of the program,	UNICEF and Implementing partners

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	UNICEF WHO	5. CERF grant period:	01.06.14 – 30.11.14
2. CERF project code:	14-RR-CEF-086 14-RR-WHO-038	6. Status of CERF grant:	☐ Ongoing ☒ Concluded
3. Cluster/Sector:	Health – Nutrition		
4. Project title:	Anbar Polio Outbreak Response		

7.Funding				
	a. Total project budget:	US$ 2,000,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$2,000,000	▪ *NGO partners and Red Cross/Crescent (by WHO)*	US$ 25,000
	c. Amount received from CERF:	UNICEF US$1,000,000 WHO US$1,000,000	▪ *Government Partners* ▪ *Government Partners*	UNICEF US$ 348,957 WHO: US$ 465,925

Results

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

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	135,025	134,560	No significant discrepancy, but this number takes into account both children under 5 in Anbar and IDP children under 5 from Anbar, who reside outside of Anbar governorate. Approximately, 30 per cent of Anbar's population has been displaced within Anbar and 10 per cent outside of Anbar
b. Male	135,025	134,559	
c. Total individuals (female + male):	270,050	269,119	
d. Of total, children under age 5	270,050	269,119	

9. Original project objective from approved CERF proposal

1. Implementation of large scale and repeated Supplementary Immunisation Activities (SIAs) to protect all children under five years of age in Anbar and Baghdad and prevent further spread of WPV (Wild Polio Virus) from infected areas inside country or re-importation from external virus reservoirs.
2. Enhanced reporting and investigation of Acute Flaccid Paralysis (AFP) cases to ensure rapid detection and response to any wild poliovirus transmission.
3. 3. Improved routine immunisation coverage to provide protection and to sustain polio-free status.

10. Original expected outcomes from approved CERF proposal

For WHO and UNICEF:

CERF Project Results Framework		
Outcome statement	To increase the vaccination coverage among <5 children, in Anbar to more than 80 per cent.	
Output 1	4 rounds of polio immunization campaigns conducted in Anbar raising the vaccination coverage from 48 per c to at least 80 per cent	
Output 1 Indicators	Description	Target for Indicator
Indicator 1.1	# of vaccines procured and supplied to Anbar	1.1M vaccines procured & supplied timely to Anbar
Indicator 1.2	# of microplans produced for Anbar district	4 microplans for Anbar in place before November 2014
Indicator 1.3	# of children under 5 vaccinated with OPV in Anbar	220,000 >5children to be vaccinated in every campaig from June to November
Output 1 Activities	Description	Implemented by
Activity 1.1	1.1.1 To procure, supply and deliver Oral Polio Vaccines to the governorate of Anbar	UNICEF/MoH
Activity 1.2	1.2.1 Orient 1,030 vaccinators on correctly delivering potent vaccines in the field and conduct 4 rounds of polio vaccination campaigns.	WHO/MoH
	1.2.2 Orient district and PHC staff on micro-planning and mapping	WHO/MoH
	1.2.3 Orient governorate district and PHC staff on compiling vaccination data and correctly and timely summarizing and reporting them to the next level	WHO/MoH
Activity 1.3	Conduct 4 immunization campaigns in Anbar	WHO/UNICEF/MoH
Output 2	Independent monitoring of each round of immunization campaign performed	WHO/UNICEF/IRCS
Output 2 Indicators	September and October round were monitored PCM data showed >90 per cent coverage. Results for September >90 per cent shared with MoH and DoH	WHO/UNICEF/IRCS
Indicator 2.1	per cent vaccination coverage by district and governorate in each round	>80 per cent vaccination coverage among 270,050 targeted children
Indicator 2.2	# of positive media articles on Anbar polio vaccination	11TV channels, 10 print articles focusing on Anbar polio vaccination during every campaign
Indicator 2.3	# ToTs trained on social mobilization and inter personal communication	10 ToTs trained
Output 2 Activities	Description	Implemented by
Activity 2.1	2.1.1 Training of surveyors in the use and application of mobile information technology for polio post campaign monitoring.	WHO/IRCS/MOH
	2.1.2 Orientation of district and province EPI staff on independent monitoring methodology and field activities	WHO/MOH

Activity 2.2	2.2.1 Conduct 5 meetings with religious leaders/care givers/community elders (One meeting before every campaign)	MoH/UNICEF
	2.2.2 Conduct 5 orientation & advocacy meetings with Journalists (1 meeting prior to every campaign)	MoH/UNICEF
Activity 2.3	2.2.3 Fifty community health workers trained in health promotion methodologies (2 training sessions)	MoH/UNICEF
Output 3	AFP surveillance in Anbar province improved	
Output 3 Indicators	Description	Target for Indicator
Indicator 3.1	per cent NPAFP in 100'000 under 15 population	NPAFP rate increased from 0.7/100,000 <15 population in June to 1.6 by October 2014
Indicator 3.2	per cent AFP cases; correctly & timely; reported and investigated	>80 per cent
Indicator 3.3	per cent AFP stool specimens correctly and timely collected and delivered to NPL	67 per cent stool adequacy
Output 3 Activities	Description	Implemented by
Activity 3.1	Orientation meetings on AFP surveillance and stool collection	WHO/MoH
Activity 3.2	Procurement and delivery of lab reagents and specimen collection kits and specimen carriers	WHO/MoH
Activity 3.3	Conducting independent assessment of AFP surveillance in Anbar	WHO/MoH

11. Actual outcomes achieved with CERF funds

The Iraqi Ministry of Health implemented four rounds of vaccination through the support from UNICEF and WHO with a round in June, August, September and October (Activity 1.3). The primary goal of the program was to boost coverage from 48 per cent in April to over 80 per cent in the succeeding rounds and this was achieved. During each round, over 80 per cent of all Anbar children were covered; the lowest number covered in a single round was **240,704** in June, which covered 89 per cent of all children from Anbar (Indicator 1.3 & 2.1). The independent post campaign monitoring showed a coverage of >95 per cent for each round monitored. To motivate vaccinators and supervisors WHO provided incentives and training as well as hired IRCS to conduct independent monitoring.

Contractor was hired by WHO for the provision of vehicles for the timely investigation of cases and transport of stools of Acute Flaccid Paralysis (AFP) cases to the laboratory. An AFP case is defined as a clinical syndrome characterized by rapid onset of weakness, including (less frequently) weakness of the muscles of respiration and swallowing, progressing to maximum severity within several days to weeks in child of 15 years or below that has had paralysis or the inability to move any appendage in the last 6 months. Detecting AFP cases is essential to finding polio cases and determining when polio transmission has been interrupted. Special incentives were provided for notification and investigation of AFP cases and this lead to improvement of AFP rate/100,000 <15 population from .07/100,000 in July to 1.6/100,000 in October.

To increase vaccination coverage, UNICEF procured and delivered the Iraqi Ministry of Health with 2 million doses of polio vaccine (Indicator 1.1), which allowed the MoHo to cover Anbar's population over multiple rounds at a crucial time. To ensure the quality of the vaccines when the child is vaccinated, UNICEF provided 2,000 refrigerator loggers to improve the quality of the cold chain in Anbar governorate, in coordination with the Iraqi Ministry of Health.

Mass media campaigns were undertaken during the August, September and October round and have been the most successful method in raising awareness of the polio campaigns. CERF directly funded the June, August and September campaigns (both mass media and social mobilization), while funding from Germany was used to support the October round. In each round, 12 to 18 TV stations ran over 400 commercials in the days preceding the campaign that promoted polio vaccination (Indicator 2.2). Newspaper advertisements were run in 4 to 6 newspapers for 4 days, 16 to 24 newspaper articles per campaign (Indicator 2.2). Radio campaigns ran between 235 – 400 commercials across 3 – 5 prominent radio stations.

Utilizing community networks and social mobilization has proven to be an excellent means to reach hard-to-reach populations and

reduce resistance to vaccination among the most vulnerable populations. UNICEF and MoH trained religious and community leaders and journalists to form networks and disseminate accurate information and act as liaisons between the vaccinators and the community. Trainings were done before the June, August, September and October round. Before each of the 4 rounds, 4 trainings were held with 100 participants for a total of 16 trainings (Activity 2.2). UNICEF trained and supported approximately 100 social mobilization workers from the MoH for 3 days for each of the four rounds (Indicator 2.3 and Activity 2.3). These social mobilization workers were tasked to raise awareness of the campaign and the necessity of routine vaccination and reducing rejection of vaccinators and/or vaccines.

UNICEF supported multiple high profile events for each of the four rounds. These events were usually held at Primary Health Centers, parks, cultural sites and malls to engage the public. Events were also held in 5 IDP camps in September and October to ensure that the vulnerable IDP population were aware of and engaged in the campaign. The events included speeches by high profile Ministry officials and multiple activities for children: flash mobs, concerts, drawing contests, etc.
To support and raise the profile of the campaigns, UNICEF provided IEC and polio branding materials. Through CERF funding directly, UNICEF provided 4500 caps and aprons for vaccinators. UNICEF provided over 13,000 posters, 25,000 leaflets (2,500 of which were made with Ramadan messaging), 400 flex banners for events and primary health centers, 3000 pens and 300 cups for events.

As per global standards, each round is independently monitored to determine the quality of implementation and monitor the effects of the mass media, social mobilization and IEC materials. Across the four rounds, an average of 81 per cent of all households (across the whole country) was aware of the campaign before it started. Due to insecurity, Anbar governorate was only monitored during the September and October round. On average, 83 per cent of households in Anbar were aware of the polio campaign before it started. Overall, TV and social mobilization were the most mentioned sources of information: on average, 40 per cent of households listed TV as the source of information and 32 per cent listed social mobilization. While religious leaders were only mentioned as a source of information by 6 per cent of the population, religious leaders played a much greater role in Anbar, where almost 50 per cent of the households reported learning about the vaccination campaign from religious leaders.

WHO trained independent monitors in the use of mobile technology for accurate and timely reporting/notification of cases/situations requiring urgent interventions during the process of independent monitoring.

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

WHO has to devote more resources than what was budgeted in the project. Indeed, the security problems shrunk the ability of vaccination teams to cover the planned 80 children/team each day to below 60 per day. Thus more teams than planned were employed during the 4 rounds of SIAs. The cost of renting of vehicles increased by 50 per cent above what has been panned. At the same time incentives for vaccination teams were increased from $15/day to $20/day.

UNICEF significantly increased spending through the MoH compared with the proposal. The increase was due to a change in implementation modality strategy. Initially, the MoH was to be responsible only for the development of the TV commercials and social mobilization. Instead, the role was broadened to include the implementation of mass media campaigns and development and printing of materials. The role was broadened because the MoH demonstrated capacity to undertake these responsibilities, which enabled the MoH to strengthen the ownership of the program. Overall, the budget implementation was on-track and no divergence was recorded; ultimately, only USD 1,662 is left in the programmable amount.

The program planned to buy 1.1 million doses of polio vaccine, but this needed to be increased to 2 million; the Iraqi Ministry of Health requested this support due to internal budgetary problems that created a gap in vaccines. The original proposal's support to the cold chain was 5 freezers and 25 refrigerators. The MoH requested replacing the freezers and refrigerators with refrigerator loggers that help to improve the quality of the cold chain by monitoring and reporting repeatedly on the refrigerator's operation status.

UNICEF only purchased 4,500 caps and aprons, whereas, there was an initial budget for 25,000. The program initially budgeted for 720,000 leaflets, but the polio program diversified its portfolio of printed materials, thus including posters and flex banners; further, UNICEF held high profile events (which were not initially budgeted for) in coordination with the national counterparts. The program also increased the number of TV channels and commercials, given TV remains as the primary tool to reach large population. Last, the program extended its support to training and supporting community mobilizers and community network leaders (community and religious leaders, journalists, etc.).

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

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

If 'NO' (or if GM score is 1 or 0): All children under 5, regardless of gender, are targeted for vaccination. Independent monitoring has shown across all rounds that there was no difference in vaccination status according to gender. House to house visits is another grantee that children irrespective of gender or being IDP or from the host community will have an equal chance to be vaccinated.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
If evaluation has been carried out, please describe relevant key findings here and attach evaluation reports or provide URL. If evaluation is pending, please inform when evaluation is expected finalized and make sure to submit the report or URL once ready. If no evaluation is carried out or pending, please describe reason for not evaluating project.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/ Sector	Agency	Implementing Partner Name	Sub-grant made under pre-existing partnership agreement	Partner Type	Total CERF Funds Transferred to Partner US$	Date First Installment Transferred	Start Date of CERF Funded Activities By Partner*	Comments/Remarks
14-RR-WHO-038	Health	WHO	MOH Iraq	Yes	GOV	$465,925	20-Jul-14	15-Jun-14	Funds are disbursed only after activities funded are completed
14-RR-WHO-038	Health	WHO	Iraq Red Crescent Society	Yes	RedC	$25,000	25-Jul-14	25-Jun-14	Funds are used for independent monitoring of the SNIDs conducted.
14-RR-CEF-086	Health	UNICEF	Iraqi Ministry of Healt	Yes	GOV	$348,957	24-Jul-14	13-Jun-14	UNICEF significantly increased spending through the MoH compared with the proposal. The increase was due to a change in implementation modality strategy. Initially, the MoH was to be responsible only for the development of the TV commercials and social mobilization. Instead, the role was broadened to include the implementation of mass media campaigns and development and printing of materials. The role was broadened because the MoH demonstrated capacity to undertake these responsibilities and it increased the ownership of the program by our Iraqi Ministry counterparts.

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

AAR	After Action Review
AFP	Acute Flaccid Paralysis
CERF	Central Emergency Response Fund
DGs	Director Generals
DTM	Displacement tracking matrix
Gov	Government
HCT	Humanitarian Country Team
ICCM	Inter cluster coordination mechanism
MoH.	Ministry of Health
ICODHA	Integrated Coordination Office for Development and Humanitarian Affairs
IOM	International Organization for Migration
NIDs	National Immunization Days
OCHA	Office for the Coordination of Humanitarian Affairs
OAG	Opposition Armed Groups
OPV	Oral Polio Vaccine
PHC	Primary Health Care
RC/HC	Resident Coordinator and/or Humanitarian Coordinator
Redc	*Red Cross/Crescent*
SIAs	Supplementary Immunisation Activities
SNIDs	Supplementary National Immunization Days
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPV	Wild Polio Virus
UNCT	United Nations Country Team
WHO	World Health Organization