RESIDENT / HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS MYANMAR RAPID RESPONSE CONFLICT-RELATED DISPLACEMENT

RESIDENT/HUMANITARIAN COORDINATOR	Ms. Renata Lok-Dessallien

REPORTING PROCESS AND CONSULTATION SUMMARY

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

The AAR was conducted during a meeting of the Humanitarian Country Team (HCT) on 19 December 2013. The meeting was chaired by the Humanitarian Coordinator, a.i. and attended by representatives of UNICEF, UNHCR, UNFPA, UNDSS, WFP, INGO Forum, Oxfam, Malteser, WHO, FAO, UNDP, OCHA, and MSF-H.
CERF focal points from each cluster (Shelter, WASH, Health) that received support through the Rapid Response grant briefed about the results achieved, implementation challenges and other noteworthy issues.

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 ☒

While the RC/HC Report was not discussed in a meeting of the HCT or UNCT, all members of the HCT and sectors and clusters were invited to comment on the draft of the RC/HC report and to enter into a virtual discussion by email. Comments and suggestions received have been integrated into the final version of the report. During the After Action Review on 19 December 2013, the HCT determined that the AAR constituted a sufficient review of the results of the CERF grant.

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 final version of the RC/HC Report has been shared with UN humanitarian agencies, the HCT, and the intercluster/sector. Each cluster/sector coordinator has been encouraged to share the report with their cluster/sector members.

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: 8,478,806 for the three sectors covered by the CERF grant (Shelter, WASH, Health), and a total of 17.2 million required for the overall response including food and education.		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	4,999,616
	EMERGENCY RESPONSE FUND	0
	OTHER (bilateral/multilateral)	2,207,014
	TOTAL	**7,206,630**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 17-Apr-13			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	13-CEF-057	Health	199,020
UNICEF	13-CEF-058	Water and sanitation	2,000,044
UNFPA	13-FPA-020	Health	150,099
UNHCR	13-HCR-033	Shelter and non-food items	2,500,000
WHO	13-WHO-026	Health	150,453
TOTAL			**4,999,616**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies/IOM implementation	3,112,789
Funds forwarded to NGOs for implementation	1,755,623
Funds forwarded to government partners	131,204
TOTAL	**4,999,616**

HUMANITARIAN NEEDS

The inter-communal conflict in Rakhine State that started in early June 2012 and resurged in October 2012 has resulted in the displacement of people, loss of lives and livelihood and restriction of movement. Access to basic services such as health and education has been difficult for the displaced and those living in remote areas. Government figures indicate that, by the end of March 2013, the number of people displaced in Rakhine State was over 125,000 across nine townships. By July 2013, when the Rakhine Response Plan was revised, the number of internally displaced people (IDPs) was estimated to be 140,000 across the State in camps and villages, with an additional 36,000 conflict affected people living in isolated villages.

This situation is further compounded by recurrent natural hazards, such as cyclones, floods, and landslides, which have caused monumental damage and loss of lives in Rakhine State over the years. Rakhine State is characterized by a dry season of seven months and a heavy rainy season from May through September. These rains often trigger localized floods. The months of April, May and October to December are considered to be cyclone months, according to historical records.

In April 2013, the monsoon season was fast approaching with the expectation that rains would result in localized floods. Meeting the immediate basic needs of the IDPs living in camps was the top priority of the Humanitarian Country Team (HCT) as the emergency tents or emergency shelter materials provided by the initial emergency response in 2012 would not withstand the heavy monsoon rains. The situation was extremely concerning for some 69,000 IDPs in 13 camps in Sittwe (40,000 people), Pauktaw (20,000 people) and Myebon (3,900 people) who were situated in paddy fields, with an additional 5,000 IDPs in inadequate shelter. With a lack of a durable solution due to tense inter-communal relations and security risks, the Government and the international humanitarian community agreed to construct temporary shelters in sites identified by the Government.

Flooding would endanger the lives of the 69,000 IDPs in these 13 camps, and result in a rapid deterioration of shelter, water and sanitation and health conditions. Shallow emergency pit latrines were likely to overflow, contaminating groundwater - the primary source of drinking water - thereby increasing the risk of water-borne diseases, and likely resulting in an increase in morbidity and mortality. The situation was further compounded by the limited knowledge of hygiene practices in Rakhine State prior to the displacement, with open defecation practiced by the majority of the affected population.

In addition to the dangers posed by the risk of flooding, the affected population's access to health care, already poor prior to the conflict, was severely constrained. Access to healthcare is further compounded by the shortage of qualified health staff and lack of routine health services due to mistrust, fear and security concerns and limited accessibility of health services in remote isolated villages.

II. FOCUS AREAS AND PRIORITIZATION

Because of the extreme risks imposed by the likely flooding of 13 IDP camps in three townships in Sittwe, Pauktaw, and Myebon, the Humanitarian Country Team prioritized the sectors, namely shelter, WASH, and health, which would have the greatest impact in minimizing the effect of flooding on the 69,000 people living in these camps. The heavy monsoon rains were likely to deteriorate emergency shelters, overflow latrines and contaminate the drinking water, thereby increasing the risks of water-borne diseases.

Shelter

With emergency tents and shelters at the end of their expected six-month lifespan, and the approaching heavy rains of the monsoon season, more adequate shelter was required to reduce the risk that IDPs would be exposed to the elements and to maintain an appropriate standard for people to live in safety and dignity while pending durable solution to the situation.

Of the approximately 125,000 IDPs, an estimated 64,000 were living in flood-prone areas. Of the 20 camps in Sittwe, six were in urban areas and 13 were in rural areas. Construction of a seventh urban camp was ongoing at the time of the development of the CERF proposal. There were also several informal settlements in the rural areas. Eight of the rural camps of Sittwe, where over 40,000 IDPs were housed, were located in flooded areas i.e. paddy fields or lowland areas. In addition, three camps hosted 29,000 people where shelter conditions were sub-optimal (old tents, makeshift shelters) that would not withstand even moderate rainfall. Critical shelter intervention was needed for a total of 69,000 people in Sittwe alone. As shelter interventions were ongoing for some 25,000 people, the higher priority caseload for shelter was 44,000 IDPs.

In Myebon, some 3,900 IDPs lived in flood-prone camps. However, temporary shelters were required by over 4,100 people as their existing makeshift shelters/tents in all camp locations would not withstand the rains. Four of the five Pauktaw camps, hosting some 20,000 IDPs, were at risk of flood/tidal wave, and existing shelter conditions were poor. Together, the two townships required critical elevated shelter interventions for some 24,000 people.

WASH
A WASH cluster assessment in early 2013 showed the risk that Pauktaw, Myebon, and Sittwe camps would be flooded during rainy season. In Pauktaw and Myebon, camps would likely become heavily flooded with more than 40 cm of water, especially during high tide. In Sittwe, floodwater would reach 20 to 40 cm. Two IDP camps in Pauktaw (12,000 persons) would be completely flooded by seawater during high tide. Three camps located in paddy fields i.e. two IDP camps in Pauktaw Township (8,000 persons) and a bigger camp in Myebon (3,900 persons) were considered to be a priority to minimize the health risks associated with flooding. The Myanmar Government supported the identification of solutions for land issues and was working to find an immediate solution to ensure these persons could move away from these 13 most dangerous areas.

The WASH assessment found that the latrine pits and shallow hand pumps would get flooded at the 13 at-risk camps unless immediate action was taken, resulting in the ground water, and therefore the drinking water, being contaminated by both floodwater and feces, increasing the risk of water-borne diseases.

Health and Nutrition
During the hot, dry season of 2012-2013, an increase in the number of diarrheal disease cases among IDPs in camps was observed, mainly due to insufficient supply of potable water and poor sanitation conditions. Conditions were expected to worsen during the rainy season as overflowing latrines would likely contaminate the water supply, resulting in an increased risk of water-borne and food-borne diseases, as well as outbreaks of acute diarrhea. During the 2012 rainy season, there was an increase in the number of malaria cases as populations moved from malaria-free areas to endemic areas, and the overcrowding in the camps contributed to malaria transmission. The number of malaria cases was expected to increase as the rainy season commenced, with possible dengue hemorrhagic fever outbreaks due to living conditions that favor breeding grounds for mosquitoes.

Access to health facilities and referrals of patients to hospitals remains challenging and was expected only to worsen when floods restricted access to some areas. Furthermore, there is unmet demand for health services, especially reproductive health services, among the targeted displaced population, due to the unavailability of health staff, restricted access and insufficient referral services. Mobile health teams encounter negative attitudes over the perceived inequitable provision of assistance favouring the Muslim IDPs, posing disruptions and limiting the time in which health services that can be provided.

Nutrition assessments conducted in December 2012 and January 2013 indicated concerning rates of Global Acute Malnutrition (GAM) (14.4%) and alarming rates of Severe Acute Malnutrition (SAM) (4.5 %) per cent) in rural camps in Sittwe. There was a high risk of further deterioration of the nutritional situation in flood-prone camps as a result of increased risk of diseases outbreaks.

III. CERF PROCESS

During March and April 2013, the Humanitarian Country Team (HCT), with the support of the sectors/clusters, developed an Inter-agency Plan for Rakhine to address immediate humanitarian concerns of protracted displacement and the resulting critical humanitarian needs during the upcoming rainy season. The plan was shared with the Government on 6 April 2013 and presented to the donors on 10 April 2013. The HCT Inter-Agency Plan prioritized the requirements for three months to address the critical needs for immediate shelter, WASH, health, nutrition, education and food between April and June 2013. The $17.2 million in requirements for three months included:

- Shelter – $7.7 million for temporary shelter;
- WASH – $2.6 million for interventions covering construction/repair to latrines, water supply and repair to water systems/drainage;
- Health & Nutrition – $1.05 million ($0.75 million for mobile clinics and improving disease surveillance and $0.30 million to cover medicines, malnutrition treatment, surveillance, and other essential requirements);
- Education – $0.45 for temporary schools;
- Food – $5.4 million for three months food supply for 125,000 beneficiaries. Funding was required immediately to ensure a secure food pipeline after August.

The short-term plan was intended to supplement the action described in the existing Rakhine Response Plan. The Rakhine Response plan had been launched in July 2012 and revised in November 2012 and included a request for more than $67.6 million of which $39 million was funded at the time of the development of the CERF proposal, including over $10 million provided through the CERF Rapid Response window during 2012. While the November 2012 revision of the Rakhine Response Plan remained a relevant strategy, additional measures were required to address the conditions of prolonged displacement entering the 2013 monsoon season

The Rakhine Rapid Response CERF request was based on the priority needs identified in the Inter-agency Plan for Rakhine. The HCT agreed to give priority to three sectors: shelter, WASH and Health, sectors which had been activated as clusters in December 2012 to improve coordination and response strategies. Prioritized activities were consistent with activities from the inter-agency contingency plan and would address the immediate and life-saving requirements to respond to the needs of IDPs during the monsoon season in Rakhine.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR

Total number of individuals affected by the crisis: 125,000 IDPs were included in original proposal as the total number of individuals affected by the crisis. The July 2013 revision of the Rakhine Response Plan identified 140,000 IDPs and 36,000 people in isolated villages, for a total affected population of 176,000.

	Cluster/Sector	Female	Male	Total
The estimated total number of individuals directly supported through CERF funding by cluster/sector	Health	53,590	42,868	96,458
	Water and sanitation	49,123	40,192	89,315
	Shelter and non-food items	12,500	12,500	25,000

BENEFICIARY ESTIMATION

Health
According to Government data collected in April 2013, there were 119,860 IDPs in 10 Townships of Rakhine State staying at 67 locations either IDP camps or villages. Of these, 60 per cent of the IDPs were staying in camps near Sittwe. In emergency health responses, it is important for all IDPs to have access to primary health care services. All 69,000 IDPs in the 13 priority camps were targeted for health support through the CERF project, including affected people in surrounding communities and isolated villages. The estimated number of IDPs fluctuated, with a general increase because people from some isolated villages fled from their villages due to security reasons.

WASH
The estimated number of WASH beneficiaries was based on the populations of camps that would be targeted through agreements with Relief International, Solidarités International, and Consortium of Dutch NGOs. The townships of Sittwe, Myebon, and Pauktaw were targeted for CERF funding as they had the largest gaps in the provision of basic WASH services. The total estimated camp population in the priority camps in the targeted areas was 30,000 IDPs, although these figures were revised down to 27,152 IDPs when sub-agreements were reached with the implementing organisations reflecting updated and more detailed counting measures.

Shelter
Shelter Cluster estimated in April 2013 that there were approximately 69,000 persons located in 13 critical and/or vulnerable camps or camp-like settings deemed high priority for temporary shelter. These 13 locations had been identified because they were in situated in flood-prone sites (principally rice paddies), and/or because they had inadequate shelter forcing displaced households to live under tents or in makeshift shelters. These critical sites were located in Sittwe, Myebon and Pauktaw Townships. Nine sites were located in rural areas in Sittwe Township, with the remainder in sites in the rural areas of Myebon and Pauktaw Townships. These 69,000 people consisted of 60 per cent of the total existing displaced population across Rakhine State, known at the time. The CERF funds targeted 25,000 of the total 69,000 people residing in the 13 priority locations.

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING		
	Planned	**Estimated Reached**
Female	34,500	49,123
Male	34,500	40,192
Total individuals (Female and male)	69,000	89,315
Of total, children under age 5	NA	13,397

CERF RESULTS

CERF funding was made available to respond to urgent needs and to fill gaps identified through needs assessments for WASH, shelter, and health and nutrition.

Health

Health sector partners, UNICEF, WHO and UNFPA, targeted 90,000 IDPs in Sittwe, Pauktaw, Kyauktaw, Minbya, and Myebon townships in Rakhine State.

WHO health interventions and UNICEF health and nutrition interventions for IDPs in Sittwe, Pauktaw, Kyauktaw, Minbya and Myebon were implemented in coordination with the Myanmar Health Assistant Association (MHAA) and the Department of Health (DOH). The programmes were designed to reduce morbidity and mortality among IDPs (focusing on women and children under age 5) due to common illnesses such as diarrhoea, ARI/pneumonia, malaria and other illnesses. A total of 96,458 consultations with IDPs and people in affected communities (53,590 female, 42,868 male – of which 12,384 were children under age 5) were reached by preventative and curative health services. The number of reached beneficiary visits is higher than originally planned because the number of people in isolated villages without access to primary health care services was found to be higher than originally assessed. Essential life-saving medicines were provided, including anti-malaria medicines; health education materials were disseminated; and referral services for severely ill patients were supported. Around 5,605 suspected malaria patients were screened for the disease with rapid diagnostic tests (RDT), and 1,214 confirmed malaria cases were treated in accordance with national malaria treatment guidelines. Moreover, 1,647 diarrhoea cases were treated with oral rehydration salts (ORS) and Zinc tablets, more than 7,919 children with common childhood diseases were treated with appropriate antibiotics. More than 75,000 IDPs accessed health education sessions on the prevention of common communicable diseases and other illnesses, and early and correct treatment-seeking behaviour. A total of 79 severely ill patients received support for referral services from IDP camps to Sittwe General Hospital. CERF funding enabled WHO and UNICEF to support partners to provide life-saving medication and timely implementation of preventive and curative measures. As a result of these interventions, there have been no reported outbreaks of communicable diseases such as severe diarrhoea, pneumonia and malaria in Rakhine State. Major outbreaks of disease were avoided during the rainy season, when the likelihood for such outbreaks was highest. Furthermore, CERF funding supported MHAA to deliver aid employing a conflict-sensitive approach by implementing in both IDP communities, as well as host and neighbouring communities to provide assistance to all needy beneficiaries affected by the conflict.

With CERF funds, UNFPA was able to assist its implementing partners and the Ministry of Health to provide critical reproductive health services in Sittwe, Pauktaw, and Myebon. UNFPA's implementing partner, MNMA recruited 10 Midwives and provided midwifery services to IDP population where needs were critical and there was shortage of trained health care providers. With UNFPA emergency Reproductive Health Kits, health partners were able to provide reproductive health services in three townships. In coordination with funding provided by CERF, UNFPA has also use its own funds to engage Myanmar Medical Association to provide reproductive health services through mobile clinics. Myanmar Medical Association used reproductive health kits to provide services in addition to other medical supplies. UNFPA's implementing partner AFXB engaged one professional counsellor to provide training on counselling to stakeholders working in Sittwe, Pauktaw and Myebon. 24 peer educators (selected among IDPs) of AFXB working in IDP camps in Sittwe Township received on the job training to provide counselling at 6 women friendly spaces in IDP camps.

WASH

With CERF funding, a total of 89,315 individuals (49,123 female, 40,192 male – of whom 13,397 were children under age 5) were reached with lifesaving water, sanitation and hygiene services. UNICEF, through implementing partners, reached beneficiaries in Sittwe, Pauktaw, Kyaukphyu, Ramree and Myebon Townships. The original proposal focused on Sittwe, Pauktaw and Myebon townships, but

urgent and demanding needs in Ramree and Kyaukphyu necessitated the expansion of targeted areas. The intervention, in all townships, was designed to improve access to safe drinking and cooking water, provide proper sanitation facilities, and improve hygiene practices – all in an effort to reduce mortality and morbidity of the affected population by decreasing disease risks associated with unsanitary living conditions and unhygienic practices, particularly for vulnerable populations living in the type of poor conditions found in IDP camps.

Through the WASH cluster's coordinated service provision approach, the targeted areas of water, sanitation and hygiene are implemented in tandem (where all three needs are present) through coordinated activities. Therefore, where water access is improved, sanitation facilities are also improved and hygiene promotion sessions are conducted, so that an overall improvement of conditions is realized. Through implementing partners, UNICEF reached 38,859 beneficiaries with this coordinated WASH approach. Water sources were improved through the construction of dug wells, tube wells, ponds and rainwater catchments. Chlorine-treated water tanks and piping systems were installed in Sittwe camps, and in other camps household water treatment was supported through the distribution of water purification items and periodic bacterial testing of untreated water. Access to sanitary toilets and washing areas was improved, school latrines and washing facilities were constructed, and camp management committees were trained in latrine maintenance. Waste disposal mechanisms were also established, and necessary facilities were constructed. Necessary hygiene supplies were provided, and supplemented with training in best hygiene practices. The remaining 50,456 IDPs benefitted from the construction of a network of drainage channels around camps and WASH facilities in Sittwe Township. These were constructed through the government partner Department of Rural Development (DRD) and were established as a responsive and preventive measure to reduce the risk and spread of communicable diseases.

Shelter

CERF's funds assisted in the construction of 211 8-unit shelters, 74 community kitchens, and 91 walkways (each walkway serving a cluster of 5 shelters) for 8,440 displaced persons. The funds also supported 4 shelter-related staff within United Nations High Commissioner for Refugees (UNHCR) and supported transport for staff to and from Sittwe and the IDP sites in Myebon and Pauktaw, which supported shelter efforts for 25,000 IDPs. Without CERF's support, as many as 25,000 IDPs would have been affected by a shortfall in support in shelter during Rakhine State's harsh rainy season. The likelihood of catastrophic situation would have been high with such numbers located in flooded fields receiving a meter of rain each month and with nothing more than a tent, emergency shelter material or makeshift material to offer any protection.

Estimating total Beneficiaries

In order to minimize the incidence of double counting the beneficiaries of this CERF grant, the total number of people estimated to have benefited from the overall CERF grant is equivalent to the total number of beneficiaries reached by the WASH sector response implemented by UNICEF. Because the health sector interventions by WHO and UNICEF, which provided primary health care, count the number of healthcare interventions rather than individuals, many of the beneficiaries were likely to have been counted multiple times. The 25,000 beneficiaries of the shelter response are primarily in camps that have been targeted by WASH interventions. Therefore, the most conservative estimate of the number of beneficiaries reached is at least 89,315 people.

CERF's ADDED VALUE

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

Health

Immediately upon signing of the programme cooperation agreement (PCA) between MHAA and UNICEF, most of the essential drugs and funds were provided in a timely manner. This proactive distribution enabled partner organizations to expediently deliver services and supplies to camps to ensure the provision of quality life-saving healthcare to the affected population.

WHO received CERF allocations in August and November 2012 and received third round of CERF in May 2013 which bridged existing resource gaps to enable WHO to continue to provide medicines and to assist in the provision of primary health care services and early warning and response by deploying additional health staff in the field. UNFPA was able to mobilize 10 midwives from other parts of Myanmar to deploy in Rakhine to address critical shortage of trained healthcare providers.

WASH

Immediately upon receipt of CERF funds, UNICEF was able to support implementing partners to meet critical, urgent WASH needs. At the time of writing the CERF proposal, Myebon had no dedicated WASH actors. CERF funding enabled UNICEF to support the deployment of Relief International to Myebon in order to provide life-saving WASH assistance to the population. CERF funding also enabled UNICEF to support Solidarités International in an immediate response to provide safe drinking water in Pauktaw as a measure

against documented diarrhoea cases in the area. CERF funds also enabled UNICEF to immediately order life-saving WASH supplies to send to partners.

Shelter
Without CERF funds, UNHCR was not in a position to start construction of temporary shelter due to limited budget resources in its budget at the time. To reconfigure priorities within a limited budget or identify a new alternative donor, would have caused delay in the eventual start of the shelter construction.

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

Health
CERF funds helped put in place the timely supply of basic essential drugs to targeted populations for the provision of free health care. It also supported a systematic referral of the most serious cases to Sittwe General Hospital for further treatment during the implementation period. The funds helped to reduce the risk of outbreaks of communicable diseases, particularly malaria, in IDP camps and nearby villages. Because of the project, necessary preventive and curative measures were undertaken, preventing the occurrence of major communicable disease outbreaks in IDP camps and remote villages.

WASH
CERF funds enabled a comprehensive intervention to address critical morbidity and mortality reduction needs in the affected communities. Myebon, where there had not previously been a dedicated WASH intervention, was able to receive critical WASH services as a result of CERF. Additionally, the interplay between an improvement in the overall sanitation environment, combined with improvements in healthcare and preventive and curative health measures, contributed to a timely response to address the urgent needs of the displaced population. The symbiotic relationship between improved access to safe drinking water and sanitation facilities, and preventive and curative measures for disease, enabled the efficacy of environmental and direct lifesaving measures for the displaced community in targeted camps in Rakhine State.

Shelter
By April 2013, critical pressure was building on all shelter actors, including the Government, to implement temporary shelter construction immediately before rains began in May-October. While the international community pressed the Myanmar Government for clarity on the number of shelters it would construct, the Shelter Cluster and UNHCR committed to working to construct shelter for 70,000 of the most vulnerable IDPs living on flood-prone areas and living in inadequate make-shift shelters or tents. CERF's funding was provided with sufficient speed to ensure no further delay was caused when the need for engagement by UNHCR in shelter construction was clearly defined.

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

Health
In addition to CERF funds, UNICEF and MHAA were both able to mobilize core funds for the relief response in Sittwe and four other affected townships in Rakhine State. Most of the CERF funding was used for procurement of life-saving medicines, supporting patient referral and transportation of medicines and supplies from Yangon to IDP camps in the target townships in Rakhine State. UNICEF's core fund was used for procurement of remaining life-saving medicines and operational costs for the PCA with MHAA and outreach health and nutrition services undertaken in IDP camps in Rakhine State.

After receiving CERF funds, WHO was able to attract funding from the South East Asia Regional Health Emergency Fund (SEARHEF) to support the Rakhine emergency response. UNFPA complemented CERF funds with its own core funds in order to meet critical reproductive health needs. UNFPA used its core funds to support Myanmar Medical Association to provide reproductive health services through mobile clinics.

WASH
CERF funds contributed to UNICEF's ability to mobilize core resources (especially in the acquisition of supplies such as Hygiene Kits) to support WASH interventions in Rakhine State. CERF funding addressed major gaps in WASH provision, and through the narrowing of

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

these gaps, other donors were encouraged to contribute smaller amounts to provide additional coverage of needs, in support of on-going projects.

Shelter
UNHCR received contributions for temporary shelter construction prior to CERF contribution, which were insufficient to cover the extent of needs identified in the required response. CERF funding largely complemented the remaining needs identified by UNHCR to fulfil its objective. Therefore, CERF funds did not assist with further fundraising.

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

Health
The relief responses were implemented in collaboration among UNICEF, MHAA, DOH, Rakhine State Health Department and relevant humanitarian implementing partners in Rakhine State under the coordination process of the health cluster. Technical and material support on the part of UNICEF, MHAA and DOH, as well as MHAA's ability and willingness to work on the ground, created more space for improved humanitarian partner coordination. WHO deployed one National Staff to improve coordination among health partner agencies and to facilitate the response activities. Because of the effective coordination and cooperation, more implementing partners involved in response activities and create more opportunities to work together and improved coordination amongst humanitarian community. CERF funded resources were used in coordination with partners providing health services to IDP camps. UNFPA was able to provide technical support to improve reproductive health services to IDP camps.

WASH
Coordination among humanitarian actors in the WASH cluster was enhanced as a result of CERF, not only through the collaboration between UNICEF, DRD, Relief International, Solidarités International, Oxfam and the Consortium of Dutch NGOs, but also among other WASH actors in Rakhine State. As a result of urgent gaps addressed through CERF, WASH actors were able to more easily coordinate on addressing other priority gaps, and determine who could and would work where and on which projects.

Shelter
The confirmed CERF funds enabled UNHCR, as Shelter Cluster lead, to define the extent of its ability to respond to identified needs. The predictability of UNHCR's engagement meant other actors could use available resources to direct to other urgent activities in a more timely manner.

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

V. LESSONS LEARNED

TABLE 6:OBSERVATIONS FOR THE CERF SECRETARIAT

Lessons learned	Suggestion for follow-up/improvement	Responsible entity
NA		

TABLE 7:OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
CERF funds helped mobilze trained health care providers (Midwives) to serve IDP camps where critical shortage of tarined health care providers continues. UNFPA deployed midwives played crucial role to start immunization services in addition to their core work of providing reproductive health services.	CERF allocation to health sector should to be increased in order to address critical shortage of reproducitve health services including pregnancy care.	Health sector and HCT
Project implementation was hindered on many occasions due to community misperceptions that aid was delivered in a partial way – favouring one community over another - rather than based on need. This led to the inability of teams to access certain locations.	Strong advocacy to community/IDPs, religious leaders and different levels of authorities should be undertaken at the very beginning of project implementation. Relationships of trust should be built among stakeholders. Where these sentiments persist, continue to develop relationships and promote messages explaining that aid is delivered primarily based on need. See if wider community concerns can be addressed.	All humanitarian implementing partners on the ground
Project implementaion was disturbed due to threats of hostile groups and security issues.	Communication and relationship building with local people of different groups is crucial. For example, it needs to be communicated that the health interventions are aiming to prevent occurrence of communicable diseases and outbreaks among the entire community and these interventions are beneficial to all community-members, including children and women, and not only benefecial to one group over another. Joint Humanitarian Advocay and Communications Strategy was developed to tackle this issue.	All implementing partners
Weak coordination among health implementing partners was observed at the start of the intervention. Coordination improved with formation of the health cluster with regular coordination meetings with all partners	To be maintained and strengthened.	All implementing partners and cluster/sector leads
More skilled staff is required to expand the resumption of routine immunization in IDP camps and remote uncovered villages.	Health partner agencies need to recruit and train basic health staff	Health Partner Agencies
Deployment of midwives and provision of reproducitve health supplies are critical to improve maternal health situation in IDP camps	Agencies to recruit midwives and doctors to continue provide reprodcutive health care including emergency pregnancy and child birth services. Resource Mobilzation is needed.	Health Partners with support from OCHA and HCT
Concerns regarding segregation need to be addressed.	The construction of temporary shelter and maintenance of humanitarian assistance has to be viewed as a stepping stone towards durable solutions and not a solution in itself. The inter-	All humanitarian actors.

	agency response has been very careful to make this distinction. The shelter is temporary both in design and materials used. The rationale was clearly life-saving.Shelters will be subject to degradation and also potential risk of fire (as demonstrated in December in Nget Chaung). Engagement in further temporary shelter construction or any heavy maintenance of shelters may lead to further segregation of communities and its potential negative consequences. Pressure must be maintained on the Government to facilitate durable solutions, while the inter-agency response takes care not to compound the risk of further segregation of communities though their actions.	

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	5. CERF grant period:	01.05.2013 – 31.10.2013
2. CERF project code:	13-CEF-057	6. Status of CERF grant:	☐Ongoing
3. Cluster/Sector:	Health		☒Concluded
4. Project title:	Addressing Life Saving Emergency Health Needs of the IDP Population in 5 townships for the upcoming monsoon season/ Response to the priority Sexual and reproductive Health Needs of IDP female population in three townships in Rakhine State		

7.Funding				
	a. Total project budget:	US$ 1,050,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 273,822	▪ *NGO partners and Red Cross/Crescent:*	US$ 88,090
	c. Amount received from CERF:	US$ 199,020	▪ *Government Partners:*	US$ 0

Results

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

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	19,975	29,090	The health needs of IDPs were higher than initially expected, and the employment of a conflict-sensitive approach in neighbouring and host communities, not only the population in camps, increased the targeted caseload. UNICEF was able to expand the number of beneficiaries reached through the CERF grant by using CERF funding primarily for supplies and only a portion of operational costs was funded by additional donor resources. Co-financing from other funding sources enabled UNICEF to cover the remaining operational costs to properly implement the health activities and adequately address critical gaps
b. Male	19,190	21,183	
c. Total individuals (female + male):	39,265	50,273	
d. Of total, children under age 5	2,742	7,884	

9. Original project objective from approved CERF proposal

- To reduce morbidity and mortality of children under age 5 and women due to common childhood illnesses, communicable and preventable diseases such as diarrhoea, ARI/pneumonia, malaria and others among IDPs in camps and affected population in Rakhine State by providing life-saving health services. (UNICEF)

10. Original expected outcomes from approved CERF proposal

The overall expected result will be reduced avoidable morbidity and mortality of the affected population.
From the above strategic Interventions the expected results are;

- Improved access to emergency care and basic health services at health facilities and mobile outreach health teams;
- Strengthened disease surveillance and dissemination of health information for action;
- Effective outbreak response and disease control interventions;
- All diarrhoea cases among children under age 5 in camps received life-saving treatment with oral rehydration and Zinc tablets;
- Critically ill patients referred to appropriate health facilities;
- IDP families are protected from malaria and mitigate risk of outbreak. IDPs with fever are tested with RDTs and confirmed malaria cases are treated with appropriate anti-malaria medicines.

11. Actual outcomes achieved with CERF funds

- A total of 30 health assistants (HA) from Myanmar Health Assistant Association (MHAA) were recruited through co-financing from other funding sources and placed in Sittwe Township, capital of Rakhine State, and four other townships - namely Pauktaw, Kyauktaw, Minbya and Myebon. At the beginning of the project, all MHAA staff received orientation training on

provision of lifesaving services to affected community as well as how to fill the monthly data/monitoring matrix form provided by UNICEF for reporting purpose. They formed 14 outreach groups, ten in Sittwe and one each in the four townships, each of which consisted of two HA, and two senior HA stationed in Sittwe for project supervision. The outreach groups visited IDP camps in five townships, six days a week on a rotational basis in coordination and cooperation with Sittwe State Health Department, Township Medical Officers (TMOs) from four other townships and other implementing partners. The groups provided life-saving curative services for common illness of IDPs such as diarrhoea, acute respiratory infections (ARI)/Pneumonia, malaria, dengue and other communicable diseases; injuries and trauma; as well as nutrition and health services in a comprehensive approach.

- During the project implementation period, a total of 50,273 IDPs and affected community (29,090 female and 21,183 male) including 7,884 (4,332 girls and 3,552 boys) children under age 5 were reached by life-saving curative and preventative services through MHAA. A total of 2,605 (1,182 females and 1,423 males) suspected malaria patients were tested with rapid diagnostic tests (RDT) and 164 (71 females and 93 males) confirmed malaria cases were treated with appropriate anti-malaria medicines in accordance with national malaria treatment guidelines by skilled personnel. Moreover, 747 children under age 5 (405 girls and 342 boys) with diarrhoea cases were treated with oral rehydration salts (ORS) and Zinc tablets and 219 (130 girls and 89 boys) pneumonia cases of children under 5 were treated with appropriate antibiotics.
- With this funding, life-saving medicines and health supplies, including 10,000 long lasting insecticidal net (LLIN), were made available in Sittwe and the other four townships in Rakhine State. All LLINs were distributed to affected families in five townships based on ratio of affected families living in the locations. The number of LLINs provided to families in different townships is as follows: 5,000 LLINs to Sittwe, 3,000 LLINs to Pauktaw, 950 LLINs each to Myebon and Minbya and 100 LLINs to Kyauktaw.
- A total of 55,583 (34,939 females and 20,644 males) IDPs and affected community members accessed health education sessions about the prevention of communicable diseases including hygiene and sanitation and early and correct treatment seeking behaviour. Information, Education and Communication (IEC) materials were distributed and target population was instructed in best practices for the reporting of the abnormal occurrence of communicable diseases, such as malaria and dengue, to mitigate risks for disease outbreaks.
- A total of 38 (23 females and 15 males) severely ill patients received referral support from IDP camps to Sittwe General Hospital during the reporting period.

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

NA

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):
If 'NO' (or if GM score is 1 or 0):
The project ensured all girls and boys as well as both adult genders received humanitarian assistances equally in terms of need and vulnerability.

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

If 'YES', please describe relevant key findings here and attach evaluation reports or provide URL
If 'NO', please explain why the project has not been evaluated
After action review workshop, in advance of the AAR conducted with the HCT, was undertaken jointly with WHO, UNFPA and UNICEF on 6 December 2013.

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	5. CERF grant period:	01.05.2013 – 31.10.2013
2. CERF project code:	13-CEF-058	6. Status of CERF grant:	☐Ongoing
3. Cluster/Sector:	Water, sanitation & Hygiene		☒Concluded
4. Project title:	Humanitarian WASH Response for IDPs in Rakhine State, Myanmar		

7.Funding				
	a. Total project budget:	US$ 2,600,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 2,000,044	▪ *NGO partners and Red Cross/Crescent:*	US$ 1,554,460
	c. Amount received from CERF:	US$ 2,000,044	▪ *Government Partners:*	US$ $ 116,204

Results

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

Direct Beneficiaries (UNICEF component)	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	15,300	49,123	The total beneficiaries reached through the provision of safe water access, latrine access and hygiene promotion activities were 38,859. The total reached was above the target of 30,000 due to an expansion of targeted areas (Ramree and Kyaukphyu to address emergent urgent needs) and fluctuations in targeted camp populations. 50,456 additional beneficiaries were reached through the construction of drainage systems in Sittwe only– a target that was not specified in the original proposal, though the activities were included.
b. Male	14,700	40,192	
c. Total individuals (female + male):	30,000	89,315	
d. Of total, children under age 5	4,500	13,397	

9. Original project objective from approved CERF proposal

With the inception of the monsoon rains, unless immediate action is taken latrine pits and shallow hand pumps will get flooded in thirteen at risk camps. This will result in contamination by both floodwater and by faeces that will spread, including of groundwater, which is the primary drinking water source, and the risk of water borne diseases will increase. The situation is further compounded by the very limited knowledge of hygiene practices prior to the displacement.

- To provide and improve quality of drinking water without causing risk to health for 30,000 IDPs through construction of shallow tube wells and household water treatment;
- To reduce the risk of spreading communicable diseases by providing appropriate sanitary toilets in sufficient numbers to 30,000 IDPs;
- To increase awareness on key public health risks, adopt measures to prevent the deterioration in hygiene condition and use and maintain the provided facilities by affected IDPs.

10. Original expected outcomes from approved CERF proposal

- 30,000 IDPs have access to safe drinking water, through provision of shallow tube-wells, water transport and water purification items, and water harvested from roof catchments of the new shelters;
- 30,000 IDPs (erroneously written as *households* in originally proposal) have access to sanitary toilets and washing areas, significantly reducing the risk of communicable diseases;
- 30,000 IDPs became aware of the importance of personal hygiene and are able to improve hygienic practices.

11. Actual outcomes achieved with CERF funds

- 38,859 IDPs in Sittwe, Pauktaw, Myebon, Kyaukphyu and Ramree have access to safe drinking water through the development and improvement of water sources (e.g. dug wells, tube wells, ponds, rainwater catchments). Tube wells were constructed and improved in camp schools. Water tanks were installed in camps, and treated through chlorination. Water distribution was conducted through the installation of a piping system in Sittwe. Household water treatment was supported through the distribution of water purification items, periodic bacterial testing of un-chlorinated water sources and chemical testing of new water sources, training beneficiaries in basic maintenance, and monitoring the operation of water sources by the WASH/camp committee.
- 34,310 IDPs Sittwe, Pauktaw, Myebon, Kyaukphyu and Ramree have reduced risk of communicable diseases as they have access to sanitary toilets and washing areas through the construction of gender-segregated semi-permanent latrines and the provision of hand washing facilities in camps. School latrines and tippy tap hand washing facilities were constructed in schools. Camp management committees were trained in latrine maintenance, monitoring and desludging, and latrine attendants were mobilized. Laundry and bathing spaces were constructed. For the disposal of waste, waste bins with segregated compartments were constructed, and waste management kits and waste incinerators were provided.
- 50,456 IDPs in Sittwe camps have an improved sanitation environment. A network of drainage channels was established around camps and around WASH facilities as a preventive measure to reduce the risk and spread of communicable disease.
- 34,310 IDPs in Sittwe, Pauktaw, Myebon, Kyaukphyu and Ramree Townships became aware of the importance of personal hygiene and have improved hygiene practices. Sufficient basic and supplementary hygiene kits were provided. Culturally and context specific IEC materials and equipment were distributed in line with identified key hygiene messages. Basic and refresher training for hygiene promotion was facilitated to community hygiene volunteers, health clubs, child to child groups and IDPs. Training was also facilitated on AWD preparedness and response as part of an AWD campaign. Community ownership and maintenance of WASH facilities was enhanced through sensitization and mobilization of key beneficiaries. Beneficiaries were supported in solid waste management and vector control. Monthly household monitoring of hygiene behaviours was undertaken through surveys, observation, and focus group discussions.

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

The total number of beneficiaries reached through the provision of safe water access, latrine access and hygiene promotion activities was 38,859. The number reached is above the target of 30,000 due to an expansion of targeted areas (Ramree and Kyaukphyu due to urgent needs) and fluctuations in targeted camp populations, made possible through the shifting of funds from personnel and supply costs that likewise were made possible through additional external funding. 50,456 additional beneficiaries were reached through the construction of drainage systems in Sittwe only – a target that was not specified in the original proposal, though the activities were included.

The shifting of $104,000 of funding planned for the government to NGO partners was done out of necessity as government resources were over-stretched during the rainy season and were unable to absorb the planned amount for additional or more expansive drainage systems. Additional resources from other donors were identified to cover UNICEF's human resources and supply costs, allowing UNICEF to shift an additional $300,000 of the CERF budget from these line items to implementing partner budgets, thereby supplying more of the budget to toward beneficiary support. The final budget shift amounted to 20 per cent of the total budget, and should have required a budget amendment request. The necessary request to the Humanitarian Coordinator was mistakenly not completed as a result of the additional funding coming suddenly and requiring immediate allocation.

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):
If 'NO' (or if GM score is 1 or 0):
Gender-specific needs are integrated into the project. Data collected throughout the project has been sex-disaggregated to ensure monitoring of equitable distribution of assistance, and appropriate targeting of interventions. Where possible, women are recruited to camp WASH committees in equal numbers to men so as to ensure women's voices are represented and that women's and girls' needs are addressed. WASH facilities are designed in order to respond to the different needs of girls and women – in particular in the provision of washing facilities for women and girls who are menstruating. Latrines and showers are considered for the need of increased privacy and security required for women. At least 10 per cent of the latrines for men and women will be accessible to those with disabilities or less mobility, such as older people. In line with SPHERE standards, different hygiene promotion sessions are used to target different age groups - children, teenagers and adults – and those with special needs. Teenagers have separate hygiene sessions for boys and girls. Understanding the important role of women in the health-seeking behaviour of families, hygiene promotion sessions are focused on women's attitudes and tailored to their availability. Women are targeted separately in raising hygiene awareness.

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

Bi-weekly and monthly monitoring is conducted for the project and feedback is continuously provided to partner NGOs for better quality assurance. Monitoring was done on both quantitative and qualitative measures to discover gaps, and track progress. Some key gaps and/or changes found through monitoring were as follows: In the construction of bathing and sanitation facilities it was discovered that beneficiaries were using water at higher rates than expected, providing information that there may be a water shortage during the dry season. Vehicles were difficult to rent for transportation of construction materials to Muslim camps. Updates were provided on status of construction and quality/usability of facilities, particularly during the rainy season when certain latrines flooded, or necessitated the addition of closing lids to control flies and stench. Water tanks planned for one camp were moved to another as the camp population shifted and was below the original target population at time of implementation.

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNFPA	5. CERF grant period:	01.05.2013 – 31.10.2013
2. CERF project code:	13-FPA-020	6. Status of CERF grant:	☐Ongoing
3. Cluster/Sector:	Health		☒Concluded
4. Project title:	Addressing Life Saving Emergency Health Needs of the IDP Population in 5 townships for the upcoming monsoon season/Response to the priority Sexual and reproductive Health Needs of IDP female population in three townships in Rakhine State		

7.Funding				
	a. Total project budget:	US$ 1,050,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 150,099	▪ *NGO partners and Red Cross/Crescent:*	US$ 56,623
	c. Amount received from CERF:	US$ 150,099	▪ *Government Partners:*	US$ 0

Results

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

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	17,000	29,005	Reached female beneficiaries are higher than planned because the number of people in need of midwifery services was underestimated during planning. A higher number of women than expected were able to be reached through this CERF grant.
b. Male	2,000	3,000	
c. Total individuals (female + male):	19,000	32,005	
d. Of total, children under age 5	1,000	1,498	

9. Original project objective from approved CERF proposal

- To reduce death and suffering that arise in the aftermath of recent unrest in eight townships of Rakhine State by providing health care services, with a focus on sexual and reproductive health, to affected populations through a coordinated approach and availability of quality services. (UNFPA)

10. Original expected outcomes from approved CERF proposal

The overall expected result will be reduced avoidable morbidity and mortality of the affected population.
From the above strategic Interventions the expected results are;

- Improved access to emergency care and basic health services at health facilities and mobile outreach health teams;
- Strengthened disease surveillance and dissemination of health information for action;
- Effective outbreak response and disease control interventions;
- All diarrhoea cases among children under age 5 in camps received life-saving treatment with oral rehydration and Zinc tablets;
- Critically ill patients referred to appropriate health facilities;
- IDP families are protected from malaria and mitigate risk of outbreak. IDPs with fever are tested with RDTs and confirmed malaria cases are treated with appropriate anti-malaria medicines.

11. . Actual outcomes achieved with CERF funds

In collaboration with State Health Department, United Nations Population Fund's (UNFPA) Implementing Partners (Myanmar Medical Association (MMA), Myanmar Nurse and Midwife Association (MNMA)) provided emergency Reproductive Health (RH) services for safe delivery, family planning, treatment of Sexual Transmission Infection (STI), and supported for instrumental delivery, caesarean section for delivery, management of abortion and new-born care through their static and mobile clinics in Sittwe, Pauktaw and Myebon. Through those services and by the help of cluster agencies (Médecins Sans Frontières- Holland

(MSF-H) and UNHCR (United Nations High Commissioner for Refugees)), a total of 26,284 people including 10,152 pregnant women received RH services i.e. 20,089 girls and women and 1,498 children under age 5 received the services and commodities supplied by UNFPA to government hospitals and township health departments (including Dar Pai Emergency Hospital), 4,697 beneficiaries (1,072 Male and 3,625 Female) were benefited from MNMA midwifery services including ante-natal care, safe delivery, post-natal care, birth spacing and referral services.

In collaboration with State Social Welfare Department and Association Francois-Xavier Bagnoud (AFXB), implementing partner of UNFPA, provided the training for 83 health workers and peer educators (57 female and 26 male) to provide counselling services. Professional counsellor, trained peer educators and trained health workers provided counselling to 5,767 beneficiaries (1,902 male and 3,865 female). 24 peer educators of AFXB working in IDP camps in Sittwe Township received on-the-job training to provide counselling at six women friendly spaces in IDP camps.

UNFPA, through Sittwe Township Health Department, AFXB, MNMA and UNHCR, distributed Dignity Kits to 1,369 beneficiaries (vulnerable IDP women in Sittwe and Kyauktaw Townships) through the project. Additional 5,421 dignity kits were made available for distribution, higher than the planned 3,200 based on assessed needs. Therefore, IDP women and girls in Sittwe were not only benefited the RH services but also benefited for counselling and awareness raising services and receiving dignity kits.

UNFPA made international procurement for 50 Emergency Reproductive Health Kits and distributed to three townships (Sittwe, Pauktaw and Myebon) Health Departments, Dar Pai Station Hospital, Sittwe General Hospital, MMA, MNMA and MSF-H. These kits assisted health care providers to manage the safe delivery (patients with clean delivery kits), to provide birth spacing services (with oral and injectable contraceptives), to treat sexually transmitted infections, perform clinical assisted delivery, manage complications of miscarriage and manage suture of tears and perform vaginal examination.

In collaboration with Maternal and Child Health (MCH)- Department of Health and MNMA, 12 project staff including 10 midwives were recruited to provide midwifery services through mobile RH clinics in Sittwe, Pauktaw and Myebon Townships. 3 midwives for each township were deployed for mobile clinics in IDP camps in villages under overall supervision and guidance from State Health Director and Township Medical Officers (TMO). 10 health facilities received emergency obstetric care equipment and RH commodities. MNMA midwives joined mobile teams managed MMA, Myanmar Health Assistant Association (MHAA) and Basic Health Staffs from the Ministry of Health (MOH). They provided mobile RH services 5 days/ week in all three townships. MNMA midwives provided RH services that include ante natal care, post natal care, family planning, health education and referral services in IDP camps and villages in Sittwe, Pauktaw and Myebon townships. In addition to provide services in mobile clinics, MNMA midwives conducted home visits and referred the high risk and emergency cases to respective township hospitals.

Key Indicators:

- 10 health facilities received emergency obstetric care equipment and RH commodities;
- 12 health care providers received orientation/awareness on provision of provide life-saving reproductive health services including gender-based violence (GBV);
- 10,152 pregnant women received quality ante-natal, natal and post natal services;
- 26,284 women of reproductive age, men and young people received reproductive health services in three townships (UNFPA planned and budgeted in three townships only). Three townships were Sittwe, Myebon and Pauktaw)
- One orientation and sensitization training on provision of life-saving reproductive health services including response to GBV conducted.

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

NA

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):
If 'NO' (or if GM score is 1 or 0):
The project has been targeted to address reproductive health needs of men and women addressed gender equality. Women's health issues are being addressed in this project which helped improve gender equality.

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

If 'YES', please describe relevant key findings here and attach evaluation reports or provide URL
If 'NO', please explain why the project has not been evaluated
Since the joint Project Evaluation workshop for CERF (**12-WHO-080, 12-CEF-131, 12-FPA-045)** was conducted on 25th July 2013 at Sittwe, Rakhine State, participated by Rakhine State Government, Department of Health (Nay Pyi Taw), Rakhine State Health Department, WHO, UNICEF, UNFPA and the implementing partner agencies, this project has not been evaluated. Separate project evaluation was not planned for this project.

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNHCR	5. CERF grant period:	01.05.2013 - 31.10.2013
2. CERF project code:	13-HCR-033	6. Status of CERF grant:	☐Ongoing
3. Cluster/Sector:	Shelter and non-food items		☒Concluded
4. Project title:	Emergency Shelter Assistance for displaced populations in Pauktaw and Myebon Townships in Rakhine State, Myanmar		

7.Funding				
	a. Total project budget:	US$ 4,828,806	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 4,457,212	▪ *NGO partners and Red Cross/Crescent:*	US$ 0
	c. Amount received from CERF:	US$ 2,500,000	▪ *Government Partners:*	US$ 0

Results

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

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	12,500	12,500	Original estimates based on the planned number of shelters target by CERF and other contributions remain unchanged. The number of actual occupants of shelters is estimated based on each shelter or longhouse having 8 units, with on average 5 persons per families. Based on actual number of shelters attributable to CERF funds (211 shelters), the number benefitting from CERF allocation is 8,440 IDPs. However, in Rakhine State, the average family size can be larger than the average of 5 used in these calculations so the actual number of beneficiaries may be higher. CERF funds were used to construct 74 community kitchens and 91 walkways (each walkway serving a cluster of 5 shelters) for 25,000 displaced persons. Walkways served a cluster of 5 shelters, benefitting an estimated18,200 IDPs. Kitchens also served a cluster of 5 shelters, benefitting an estimated 14,800 IDPs. Staffing support, as general support towards UNHCR's rainy season shelter activities, benefitted the larger objective of assisting 25,000 IDPs.
b. Male	12,500	12,500	
c. Total individuals (female + male):	25,000	25,000	
d. Of total, children under age 5	3,750	3,750	

9. Original project objective from approved CERF proposal

The shelter response aims at providing a life-saving and immediate temporary shelter response to approximately 25,000 displaced persons in advance of the harsh rainy season (May – October). The temporary nature of the shelter is underscored here. The intervention will be designed to also encourage early recovery towards the long-term objective of a more permanent solution for the population, in particular conditions that would facilitate their return to places of origin.

10. Original expected outcomes from approved CERF proposal

Immediate construction of temporary shelters to house approximately 25,000 displaced persons at high-risk due to the rainy season (May-October) in 7 sites in Myebon and Pauktaw Townships.

11. Actual outcomes achieved with CERF funds

CERF's funds, together with other donor contributions, were used to construct 460 elevated longhouse emergency shelters (8 family-units per long house), 104 ground level longhouse emergency shelters (8 family-units per long house), 93 elevated kitchen areas, 22 ground level kitchen areas, and 91 elevated walkways in both townships, the transportation and support shelter staff costs.
Specifically, CERF's funds constructed of 211 8-unit shelters, 74 community kitchens, and 91 walkways (each walkway serving a cluster of 5 shelters). The 211 shelters housed an estimated 8,440 IDPs. Walkways served a cluster of 5 shelters, benefiting an estimated 18,200 IDPs. Kitchens also served a cluster of 5 shelters, benefiting estimated 14,800 IDPs. The funds supported 4 shelter-related staff within UNHCR and supported transport for staff to and from Sittwe and the IDP sites in Myebon and Pauktaw. The temporary shelter was constructed through the rainy season and encountered delays due to threat of Cyclone Mahasen and relocation/return of IDPs to IDP sites in May, and other security and access challenges in selected IDP sites.

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

There were no significant discrepancies between planned outcomes and actual outcomes.

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): N/a.
If 'NO' (or if GM score is 1 or 0):
The project aimed to provide shelter for 25,000 IDPs in 7 sites in Pauktaw and Myebon Townships in Rakhine State. Beneficiaries were mainly families. UNHCR gave priority during implementation towards the protection of IDPs, in particular for vulnerable individuals, taking account of gender-related needs. Female single-headed households were among the categories assisted with shelter in priority.

As part of its overall protection lead, UNHCR has led efforts, with UNFPA, through the Protection Working Group in Rakhine to establish Gender-based Violence (GBV) support in IDP sites. Following an initial assessment, a strategy was established and referral pathways are being developed, as well as prevention/awareness initiatives are underway within the communities.
As part of Camp Coordination and Camp Management (CCCM) activities, which UNHCR leads, focal points have been designated to identify and assist extremely vulnerable individuals, including, for example, any separated or unaccompanied children, persons with disabilities, older persons in need of support or assistance. UNHCR applies a gender-sensitive approach in its protection work with vulnerable individuals.

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

If 'YES', please describe relevant key findings here and attach evaluation reports or provide URL
If 'NO', please explain why the project has not been evaluated
UNHCR carries out ongoing evaluation of its projects as part of its annual programme cycle. Regular onsite visits have been made to the shelters, kitchens and walkways that were constructed. A significant issue has been lack of firewood. Due to limitations on free movement in IDP sites, there has been a shortage of fuel for cooking. This has led IDPs in a number of sites to take wood from walkways, which led to unsafe/unstable walkways. Fire awareness activities were undertaken in the IDP sites due to assessed risk of fire. The Shelter Cluster, which UNHCR leads, has actively monitored and evaluated the overall shelter response by UNHCR, Government and other actors. The shelters constructed by UNHCR are in line with the Shelter Clusters standards.

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	WHO	5. CERF grant period:	23-05-2013 - 22-11-2013
2. CERF project code:	13-WHO-026	6. Status of CERF grant:	☐Ongoing
3. Cluster/Sector:	Health		☒Concluded
4. Project title:	Addressing Life Saving Emergency Health Needs of the IDP Population in 5 townships for the upcoming monsoon season Response to the priority Sexual and reproductive Health Needs of IDP female population in three townships in Rakhine State		

7.Funding				
	a. Total project budget:	US$ 1,050,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 325,453	▪ *NGO partners and Red Cross/Crescent:*	US$ 56,550
	c. Amount received from CERF:	US$ 150,453	▪ *Government Partners:*	US$ 15,000

Results

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

Direct Beneficiaries (WHO component)	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	16,000	24,500	The actual beneficiary number is more than planned as there were increased numbers of IDPs in each IDP camp and also increased in number of villages which do not have access for primary health care services. Mobile teams extended their activities to those villages and provided primary health care services. Children benefited increased because MHAA teams participated in pilot project of resumption of routine immunization in host villages.
b. Male	14,000	21,685	
c. Total individuals (female + male):	30,000	46,185	
d. Of total, children under age 5	3,000	4,500	

9. Original project objective from approved CERF proposal

- To reduce death and alleviate suffering of IDPs by addressing the major health risk factors that will arise with the upcoming rainy season and floods by providing emergency health care services and disease surveillance and outbreak response activities. (WHO)

10. Original expected outcomes from approved CERF proposal

The overall expected result will be reduced avoidable morbidity and mortality of the affected population.
From the above strategic Interventions the expected results are;

- Improved access to emergency care and basic health services at health facilities and mobile outreach health teams;
- Strengthened disease surveillance and dissemination of health information for action;
- Effective outbreak response and disease control interventions;
- All diarrhoea cases among children under age 5 in camps received life-saving treatment with oral rehydration and Zinc tablets;
- Critically ill patients referred to appropriate health facilities;
- IDP families are protected from malaria and mitigate risk of outbreak. IDPs with fever are tested with RDTs and confirmed malaria cases are treated with appropriate anti-malaria medicines

11. Actual outcomes achieved with CERF funds

- Access to emergency care and basic health services at health facilities and mobile outreach health teams were improved. 10 mobile medical teams from Sittwe, each mobile team from Kyauktaw, Minbya, Myebon, Pauktaw conducted daily visit to IDP camps in project townships covering both Rakhine and Muslim communities. Patients who need emergency care were transferred to Sittwe General Hospital.
- Disease surveillance and dissemination of health information for action were strengthened. WHO staff in Sittwe supported SHD and partner agencies to collect disease surveillance data from all IDP camps in affected Townships. Surveillance data were collected daily from IDP camps by surveillance teams using standard format and compiled, analysed and disseminated weekly to partner agencies. Analysed consolidated disease surveillance data were disseminated twelve times to partner agencies during project period.
- Immediate outbreak response activities were undertaken resulting no major disease outbreak occurred. Two events of sudden increased number of Acute Watery Diarrhoea cases were able to identify at Kyein Ni Pyin camp Pauktaw in June 2013 and Ohn Taw Gyi camp, Sittwe in September 2013. Mobile medical teams immediately conducted necessary investigations and response measures and the AWD outbreaks were controlled well in time.
- Critically ill patients were referred to appropriate health facilities. 30 critically ill patients who need emergency medical care or surgical or Obstetric operation were referred to Sittwe General Hospital and necessary treatments/operations were provided.
- Health sector coordination is functional both in Yangon and Sittwe level. During the project period, 6 regular health cluster coordination monthly meeting were conducted in Yangon and 12 regular health cluster coordination meeting (twice a month) were conducted in Sittwe.

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

There was no significant discrepancy between planned and actual outcomes.

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

WHO supported emergency medicines and rapid diagnostic test kits for communicable disease outbreaks and mobile medical teams. Mobile medical teams covered all male and female IDPs and children in the camps so that they would all benefit equally. Health education sessions also targeted for both male and female audience. Special attention and care were provided to the most vulnerable groups, pregnant women, children, elderly, handicap, and ill persons.

14. Has this project been evaluated?	YES ☐ NO ☒

If 'YES', please describe relevant key findings here and attach evaluation reports or provide URL
If 'NO', please explain why the project has not been evaluated

Throughout the project period, monitoring of implementing partners and their activities were regularly conducted by Field Health Coordinator by means of frequent visits to camps, review of progress reports and indicators, and direct communication with Yangon WHO Office.

National focal point for Emergency and Humanitarian Action (EHA) frequently travelled to Sittwe and visited IDP camps to monitor and supervise the activities.

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Implementing Partner Name	Partner Type	Total CERF Funds Transferred to Partner US$	Date First Installment Transferred	Start Date of CERF Funded Activities By Partner	Comments/Remarks
13-FPA-020	Health	UNFPA	MNMA	NNGO	$48,297	16-May-13	1-May-13	
13-FPA-020	Health	UNFPA	AFXB	INGO	$8,226	3-Sep-13	1-Jul-13	
13-CEF-057	Health	UNICEF	MHAA	NNGO	$88,090	25-May-13	7-Jun-13	
13-CEF-058	Water, Sanitation and Hygiene	UNICEF	RI	INGO	$531,270	28-May-13	18-Jun-13	
13-CEF-058	Water, Sanitation and Hygiene	UNICEF	OXFAM	INGO	$544,390	19-Jun-13	25-Jun-13	
13-CEF-058	Water, Sanitation and Hygiene	UNICEF	SI	INGO	$478,800	1-Jul-13	14-Jul-13	
13-CEF-058	Water, Sanitation and Hygiene	UNICEF	DRD	GOV	$116,204	7-Jul-13	1-Sep-13	
13-WHO-026	Health	WHO	MHAA	NNGO	$56,550	28-Aug-13	1-Sep-13	30 Health Assistants from MHAA were deployed to Sittwe, Kyauktaw,Minbya, Myebon and Pauktaw Township for provision of primary health care services by mobile medical team and surveillance of communicable diseases outbreaks and preventive leasures.
13-WHO-026	Health	WHO	DOH	GOV	$15,000	30-Sep-13	1-Oct-13	State Health Department managed to support referral services for severly ill patients from their IDP camps or isolated villages to nearest hospital. Re

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

AAR	After Action Review
ARI	Acute Respiratory Tract Infection
CERF	Central Emergency Response Fund
DFID	Department for International Development
DOH	Department of Health
DRD	Department of Rural Development
EHA	Emergency and Humanitarian Action
EWARS	Early Warning And Response Surveillance System
GAM	Global Acute Malnutrition
GBV	Gender Based Violence
HA	Health Assistant
HCT	Humanitarian Country Team
IDP	Internally Displaced Person
IEC	Information, Education and Communication
LLIN	Long-Lasting Insecticidal Net
MCH	Maternal and Child Health
MHAA	Myanmar Health Assistant Association
MMA	Myanmar Medical Association
MNMA	Myanmar Nurses and Midwife Association
MOH	Ministry of Health
MSF-H	Médecins Sans Frontières- Holland
NGO	Non-Governmental Organization
NNGO	National Non-Governmental Organization
ORS	Oral Rehydration Salt
PCA	Programme Cooperation Agreement
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RI	Relief International
SAM	Severe Acute Malnutrition
SEARHEF	South East Asia Regional Health Emergency Fund
SI	Solidarités International
STI	Sexually transmitted Infections
TA	Travel Authorization
TMO	Township Medical Officer
UN	United Nations
UNFPA	United Nations Population Fund
UNHC	United Nations Humanitarian Coordinator
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRC	United Nations Resident Coordinator
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization