RESIDENT/HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS SOLOMON ISLANDS RAPID RESPONSE FLOODS

RESIDENT/HUMANITARIAN COORDINATOR	**Ms. Osnat Lubrani**

REPORTING PROCESS AND CONSULTATION SUMMARY

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

An AAR was organized by the Resident Coordinator (RC) through the Pacific Humanitarian Team (PHT) on 10 July 2014. The one-day lessons learning exercise was attended by PHT members including cluster coordinators, donors, regional organizations and other stakeholders. Similarly, the Government of Solomon Islands convened a two-day workshop on lessons learnt from the Solomon Islands floods on 7 and 8 October 2014. This was also attended by UN agencies, the International Red Cross Red Crescent (RCRC) Movement, I/NGOs and donors.

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 UN agencies, NGOs, the RCRC Movement, cluster coordinators and government partners who were directly involved in the implementation of the CERF projects in the Solomon Islands.

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: US$ 13.6 million		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	1,776,123
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*)	N/A
	OTHER (bilateral/multilateral)	4,600,000
	TOTAL	**6,376,123**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 12 May 2014			
Agency	**Project code**	**Cluster/Sector**	**Amount**
WHO	14-RR-WHO-037	Health	626,433
UNFPA	14-RR-FPA-026	Health	165,574
UNICEF	14-RR-CEF-084	Multi-sector	275,062
UNICEF	14-RR-CEF-085	Water and sanitation	709,054
TOTAL			**1,776,123**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies/IOM implementation	970,496.67
Funds forwarded to NGOs for implementation	546,338
Funds forwarded to government partners	259,288.33
TOTAL	**1,776,123**

HUMANITARIAN NEEDS

In early April 2014, three days of heavy rain over the Solomon Islands resulted in widespread flash flooding in Honiara City Council (HCC) and all of Guadalcanal Province (GP). Multiple rivers burst their banks, washed away homes and destroyed infrastructure, including vital bridges, roads and water and sanitation facilities. The worst-affected areas were communities next to the Mataniko and Lungga rivers in the capital, Honiara, which burst their banks on 3 April. A total of 23 fatalities were confirmed across Honiara, Guadalcanal and Isabel Provinces, with an estimated 52,000 people directly affected. The flash floods were described as the worst disaster the Pacific has experienced in recent times. The flooding caused extensive damage to homes, infrastructure, health, livelihoods and agriculture. This resulted in 12,000 people being displaced and residing in approximately 30 evacuation centers. A State of Emergency was declared by the Solomon Islands Government (SIG) on 4 April

and the following day the government requested the support of the Pacific Humanitarian Team (PHT) and coordination support from the United Nations Office for the Coordination of Humanitarian Affairs (OCHA).

The airport was closed for 72 hours, delaying the arrival of relief items from Australia and New Zealand in the first few days of the emergency. In addition, there were more than 70 locations in GP alone where transport infrastructure was either damaged or destroyed. Key bridges in central Honiara were also heavily damaged or destroyed, increasing congestion and causing delays in transport of relief items, which further hampered relief efforts.

Of the estimated 52,000 people who were directly affected by the floods (24,960 female and 27,040 male), initial figures suggested 12,000 people were displaced and sheltered in evacuation centers in Honiara city during the peak of the floods. The Solomon Islands Red Cross conducted an initial registration of Internally Displaced Persons (IDPs) followed by a re-registration/verification process conducted by the National Disaster Management Office (NDMO) on 14 April. Initial registration figures were then down to 10,300 IDPs while returns were taking place on a daily basis but at a very slow rate. The other 40,000 were from GP and also required life-saving interventions in food, health, Water, Sanitation and Hygiene (WASH), protection and shelter.

The SIG led response efforts, with the support of humanitarian and development partners, and developed a three-month Humanitarian Action Plan (HAP), which included the priority response areas of health, WASH, protection, shelter and food security with an overall budget of USD13.6 million of which USD11.6 million remained unmet. Following the development of the HAP and discussions about priority interventions among relevant stakeholders as part of the ongoing country dialogue and analysis of funding resources available for humanitarian response, the PHT decided to seek CERF funding. The amount requested was aimed at jumpstarting an integrated response to complement the SIG effort in addressing immediate needs of affected people.

II. FOCUS AREAS AND PRIORITIZATION

The Ministry of Health and Medical Services (MHMS), with support from World Health Organization (WHO), United Nations Children's Fund (UNICEF) and other health and nutrition cluster partner agencies, carried out Initial Rapid Assessments (IRA) for the health and WASH sector in the flood-affected communities of HCC and GP. The rapid WASH and health assessment of 125 villages in GP and HCC covering approximately 50 per cent of the affected population indicated that only 10 per cent of assessed communities reported having adequate clean water; only 28 per cent of communities reported a functional toilet; 66 per cent of communities reported that more than 50 per cent of the population defecate in the open; only 4 per cent of communities reported adequate food while 27 per cent had received food assistance; only 29 per cent of births had been attended by a skilled personnel; and only 21 per cent of the communities had received health promotion messages. A further joint assessment conducted by the NDMO and humanitarian partners indicated that the National Referral Hospital, three health facilities in HCC and 21 of 38 health facilities in GP were not functional as a result of the flooding. Food security was also a concern, as flooding washed away food gardens for 77 per cent of the communities. Combined with the widespread practice of open defecation and lack of awareness of good hygiene practices in Solomon Islands, there were major public health risks. In the immediate aftermath of the floods, the number of reported diarrhoea cases increased dramatically. In addition, 138 additional cases of dengue fever were reported and surveillance reporting noted increases in malaria and respiratory and other influenza-like illnesses associated with overcrowding and lack of hygiene.

This was the second large disaster to strike Solomon Islands in just over a year (Temotu 8.2 EQ and tsunami, 6 February 2013) and it followed on a series of flood events across the provinces earlier in 2014. As a result the SIG's contingency budget for emergency response was already depleted and then was further burdened with the scope and scale of this emergency response and recovery requiring at a minimum US$29.0 million based on initial estimates. There were tremendous efforts in the initial few weeks of the response to address critical needs in WASH, food, health, protection and management of the evacuation centers. However, circumstances were overwhelming responders and cases of diarrhoea, influenza, and even malnutrition continued to increase based on surveillance and other observations. After the flooding, the number of cases of diarrhoea in the National Referral Hospital increased significantly, doubling in the first two weeks after the floods. The cases of influenza-like illness and dengue-like illness also moderately increased.

Underlying risk factors and disease drivers warranted urgent measures to prevent a further increase in morbidity and mortality resulting from contaminated and scarce water, food shortages and malnutrition, stagnating water, damage to health infrastructure, and crowding in evacuation centers. Only 5 per cent of the identified health activities in the HAP were funded at a time when provision of emergency health services (including reproductive health, treatment of malnutrition and supplementary immunization) were critical in flash flood affected areas. WASH activities listed in the HAP were only 6 per cent funded and many were life-saving in nature, particularly in regard to the evacuation centers and support to areas of IDP return.

Following extensive government and humanitarian agency consultations and the development of response strategies focusing on life saving interventions, partners prioritized shelter, health, WASH, protection and nutrition projects that were articulated in the HAP. The focus of these interventions was agreed to be the geographic areas that were most affected by the floods (GP and HCC), as evidenced by the assessment reports. Further prioritization by PHT partners based on gap analysis identified WASH, health, protection and nutrition as key areas where CERF funding would be required.

The provision of emergency health, nutrition and WASH services for the target population was coordinated through the cluster mechanism at national and provincial levels both in close consultation with MHMS, NGO partners, WHO, UNICEF and UNPFA through gap filling and addressing unmet health needs. Priority interventions were identified by a 4W matrix, using the HAP as a guiding document.

WASH and health projects funded by the CERF aimed at complementing government efforts to ensure availability of safe water, as well as access to primary health services. More specifically health projects sought to provide life-saving health and nutrition services to the flash flood affected communities and evacuation centers in HCC and GP through strengthening coordination among health, nutrition and other inter-cluster partners, emergency repair of health facilities, provision of mobile clinics, provision of emergency Primary Health Care (PHC) services including measles immunization, establishing an Early Warning and Response System (EWARS) to prevent outbreaks, and offering emergency Sexual and Reproductive Health (SRH) and Mental Health (MH) services.

The CERF funded projects that were expected to lead to greater resilience in the communities, early implementation and a quicker, more effective response to the life-saving needs (in health, WASH and protection) of the affected communities, and therefore support their quick return to secure livelihoods. Consultation with affected communities at all stages of the response was incorporated to strengthen the participation of and accountability to affected populations, further enhancing resilience.

The interventions were identified and prioritized as part of a country dialogue involving stakeholder forums, mainly the WASH, health and nutrition cluster, which was activated to address the disaster situation. The process was carried out with the support of the PHT, OCHA and technical agency staff within the country, regional and sub-regional offices.

III. CERF PROCESS

Following the SIG request for assistance, the PHT agencies were mobilized in support of national cluster arrangements, which were further elaborated and agreed with the NDMO and partners at an all-stakeholder meeting held on 9 April 2014. Partners were informed at the 11 April stakeholder meeting that a CERF funding request was under consideration and that this should be taken into account when discussing underfunded priorities in respective cluster discussions. PHT cluster leads supported national counterparts and the structure was used to develop a response plan that was endorsed by the National Disaster Council (NDC) on 22 April. In the process of developing the response plan, and in consultation with donors, there was a common recognition that critical gaps particularly in health, WASH, food and protection needed to be filled. Therefore the RC and PHT made a decision to explore CERF funding. On 16 April agencies identified priority life-saving activities that they deemed required urgent funding. This was compiled and initially reviewed in a teleconference between Honiara and Suva on 17 April, taking into consideration initial feedback from the CERF Secretariat.

On 21 April the RC convened a meeting of cluster lead agencies involved in the application process to further agree on priority areas under respective agencies and as a result the list of agencies and activities was further refined to: WASH activities by UNICEF; health and nutrition activities by WHO, UNICEF and UNFPA; and protection activities by OHCHR and UNFPA. A deadline for the application had to be moved from 24 to 28 April due to one agency's delay in consulting with its headquarters. With guidance from the PHT members, the RC and OCHA, similar consultations and discussions followed on the ground in Solomon Islands where meetings with the Humanitarian Country Team composed of NDMO, the Red Cross Red Crescent Movement, United Nations agencies and NGOs took place.

In the case of health and WASH, a further quick assessment was conducted in order to identify the areas that would benefit most from the CERF. This assessment was coordinated between the SIG led by MHMS, WASH and health cluster members and focused on institutions and communities in highly affected areas. Additionally the affected communities were involved in prioritization and identification of needs. Joint assessment contributions highlighted the needs as identified by the community members themselves. Without raising expectations, providing space for the affected populations to identify their priority needs effectively informed planned future response using the CERF funds. For example, during the WHO/MHMS assessment, teams used a combination of qualitative and quantitative methods including direct observation and interviews with community residents. The protection monitoring of evacuation centers was also a combination of observation as well as individual and focus group discussions that were then used to inform recommendations and activities to improve conditions in the shelters where IDPs were residing.

Though the protection cluster was one of those prioritized for CERF funding, following further consultations between the CERF Secretariat and the RC, the protection project was noted as not meeting the life-saving criteria and was eventually dropped.

A protection and gender review of the draft HAP cluster plans was undertaken by the initial deployment of the PHT protection cluster to ensure that, at a minimum, protection and gender considerations were reflected and mainstreamed in the overarching needs analysis and/or activities. The CERF application was based on the HAP and therefore reflected this position.

Agencies developed the projects, which were then reviewed by the gender specialist based in UNFPA for analysis and gender ranking based on the gender markers. OCHA assisted to compile the chapeau, which was submitted by the RC/HC to the CERF Secretariat. The CERF Secretariat reviewed and advised on changes required in its application after which MOUs were finalized and funds disbursed to individual CERF recipient United Nations agencies.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR

Total number of individuals affected by the crisis: 158,222

	Cluster/Sector	Female	Male	Total
The estimated total number of individuals directly supported through CERF funding by cluster/sector	Health	29,400	27,040	56,440
	Multi-sector	3,744	4,056	7,800
	Water and sanitation	17,088	18,512	35,600

BENEFICIARY ESTIMATION

The NDMO organized a series of meetings with the humanitarian community to coordinate actions, identify gaps and issues for advocacy and to continue to harmonize numbers of IDPs and affected individuals for the purpose of planning. It was apparent from the meetings that different organizations had registered or counted IDPs and other affected people at different locations at different times and that there were inconsistent counts. It was also apparent that due to the highly mobile nature of the IDPs in evacuation centers, it was difficult to ascertain the number. The meetings helped to standardize and resolve some of these differences at both evacuation centers and in affected areas. The United Nations planning figures for the CERF grant were derived from the overall IDP and directly affected figures agreed at the harmonization meeting, which was 52,000 directly affected people. Due to the delay in the disbursement of funds for the CERF project by close to two months after the emergency struck, the figures kept changing. Similarly, the disaster affected many people who were already vulnerable due to previous disasters and therefore the needs were higher than those identified as directly related to the disaster. Some communities who were living closely to the identified disaster areas were also affected but to a lesser extent and needed support due to their pre-disaster vulnerability status. This was apparent in the provision of services like health and WASH. Specific cluster meetings

called for CERF-related planning and further sector-specific assessments, as well as active involvement of the government lead agencies and the affected community, helped resolve some of these challenges. Eventually, joint meetings by leading cluster agencies involved in the CERF application process led to agreements on the figures reflected in the CERF proposals.

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING		
	Planned	**Estimated Reached**
Female	24,960	29,400
Male	27,040	27,040
Total individuals (female and male)	52,000	56,440
Of total, children under age 5	22, 282	22,282

CERF RESULTS

The CERF funded interventions were life-saving with main focus on prioritized health, nutrition and WASH needs of the affected people especially, health needs of women and children. Through CERF funds, the avoidable morbidity and mortalities were averted enhancing the existing disease surveillance and outbreak response system. The damage of health facilities and shortage of medicines in the affected areas was largely resolved due to the quick disbursement of made possible through CERF funding. The activities under the WHO managed CERF funds were implemented in collaboration with partner NGOs and national and provincial health authorities. Activities included (1) provision of essential emergency health care services through static and outreach services; (2) controlling the growing risk of epidemics through surveillance and early response and vaccination campaigns (such as measles); (3) tackling water contamination in order to avoid waterborne diseases; (4) community based health and hygiene information campaigns and (5) detection and treatment of acute and severe malnutrition cases This enabled WHO to reach the intended targets under the CERF project.

For the UNFPA led Project, the target of providing emergency reproductive health services to women, girls, boys and men as largely met and even exceeded due to the availability of CERF funds. More coverage was made for females than previously planned. The additional figures came from affected areas (Zones 1 and 6) which were not factored in the initial assessments which were used for CERF project proposals. The outreach done through NGOs reached fewer men than previously planned. The overall coverage was more by 1,750 due to the additional females reached through outreach programmes as explained above. The CERF funding also enables fostering of closer ties between the respective UN agencies and the implementing partners.

Under the UNICEF led multi-sector project, life-saving health and nutrition interventions were provided to more than 15,187 children under 5 years of age in the flood-affected communities: CERF money were sufficient to reach 7,800, the estimated number in the worst flood affected areas as previously intended. Complementary funds from other donors enabled a total of 15,187 children to be reached. This was crucial as the flood affected areas are in no way “contained” or isolated areas and vaccinating only those children would not enable population group immunity to be achieved

Under the WASH project, 42,062 flood-affected people (including 16,825 children) benefitted from WASH-related emergency response interventions, surpassing the original target of 35,600 beneficiaries. This was possible because a more detailed WASH assessment was conducted at the time UNICEF was awaiting CERF funding, leading to higher number of beneficiaries than previously proposed under the CERF proposal. While water and sanitation was directed to the displaced communities, hygiene awareness messages were distributed to displaced and affected communities alike in order to influence its effectiveness. Influenced by CERF funding, implementing partners mobilised their resources to reach a wider range of beneficiaries than planned.

Sixty two percent of the affected people were provided with access to safe and sufficient drinking water (five litres per person per day) within five months in Honiara city and the eastern and western parts of Guadalcanal Province, surpassing the planned target of 22,200 beneficiaries (43 per cent) intended under the CERF project. Water was trucked from filtration stations to evacuation centres, including Marara, Good Samaritan, Aola, Burns Creek and FOPA. 16,500 people were provided with access to safe drinking water through the provision of water purification tablets for 90 days after water trucking ended in order to safeguard water quality at point of use. Water tanks (3,000 and 5,000 litre capacity) were installed in evacuation centres, schools, health facilities and villages. Sixty-six water systems were repaired and rehabilitated to supply safe water for 13,891 people. Water quality monitoring at source was conducted on a monthly basis.

Within Output 2 of the WASH CERF project, 6,880 people were provided with access to safe sanitation, compared to a planned target of 8,000 people. In order to provide adequate sanitation, 106 latrines (58 for women and 48 for men) were repaired and installed in evacuation centres with the participation of the beneficiary communities. The smaller number of people reached as compared to planned was due to complementary interventions which were undertaken by other WASH sector partners while UNICEF was waiting for CERF funding. This resulted in under- expenditure of the allocated CERF funds. Sanitation was among the priority interventions during the response especially in schools and health centres where people were at risk of diarrhoeal outbreaks. Within Output 3, 42,062 people were reached with hygiene messages, promoting hand washing at critical times and safe water handling, surpassing the planned target of 35,600 beneficiaries. Over 200 hygiene kits, including bars of soap for hand washing, were distributed to health facilities to support family hygiene needs, especially for women and children

CERF funding not only enabled life- saving interventions to be implemented, thereby averting mortality related to the crisis but also fostered stronger partnership between the UN and implementing partners. CERF funding also encouraged resource mobilisation from other donors that led to faster recovery from the crisis. This being the first crisis in the Solomon Islands where CERF funds were mobilised, it enabled many partners including SIG to appreciate the added value of UN partnership in emergency situation. The lessons learnt from the implementation of CERF funded projects have left both the SIG and the PHT partners in a better position to respond to future crises.

CERF's ADDED VALUE

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

UNFPA released core resources to enable an immediate response to the emergency pending receipt of CERF allocations. CERF funding, once secured, enabled rapid procurement of reproductive health kits and immediate assessments of damage and repairs at the Solomon Islands Planned Parenthood Association (SIPPA) and CCA. CERF funding supported the Ministry of Health (MOH) renovation and collaboration to ensure SIPPA health service delivery points were repaired and outreach by volunteers was commenced**.** CERF funding enabled the health cluster to address immediate life-saving issues in evacuation centers and the community through disease surveillance, technical expertise and provision of essential PHC services via static and mobile health units. From the onset of the displacement, CERF supported a WHO team dispatched for rapid needs assessment, identification of immediate gaps, health issues and immediate priorities of the primary affected health clinics and referral hospital as the first-entry health facility for case referral from settlements and other nearby health facilities. CERF funds addressed the basic life-saving response by health cluster partners through provision of essential health service delivery in IDP settlements and the community.

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

Through disease surveillance and the emergency health response, outbreak risks were mitigated to reduce a risk of morbidity and mortality among the displaced and affected populations. CERF funds provided immediate assistance in terms of mobile

[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.).

teams with life-saving medicines and referral services. As several outbreaks followed the floods, CERF supported the mobile teams established to enhance the government response to the outbreaks, such as measles. There was a significant delay in obtaining approval for the CERF funds. UNICEF had insufficient discretionary funds to respond to the emergency and could not advance funds or activities while waiting for the CERF approval and disbursement. However, when the funds eventually arrived, the project facilitated work by experienced personnel with people in evacuation centers and affected communities. CERF funds helped to curb or reduce ongoing outbreaks of water- and sanitation-related health diseases such as diarrhoea. However, fewer cases of measles could have occurred had CERF funds been released earlier. UNFPA core resources were diverted to meet immediate needs, until CERF funds became available to sustain the response.

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

As the initial source of humanitarian funding to support newly displaced persons, CERF support was critical in terms of ensuring a timely and effective response to fill gaps in addressing critical health needs in the emergency situation. The overall donor support was limited though it would be a fair assumption to say CERF support did act as a catalyst for other humanitarian funding. CERF funds were used as initial support to maintain and continue basic health services to the displaced population and these services were further supported for extension and maintenance by other donor agencies. Despite the lateness in approval of CERF funds, WASH cluster partners mobilized additional funding of US$152,321 to complement expected CERF funding. UNFPA was able to use core resources to supplement CERF funding, and no further fundraising was necessary to meet the health sector needs**.** A significant amount of funds was needed and mobilized from other sources to complement the CERF funds but not as a direct result of obtaining the CERF funds (multi-sector).

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

CERF funds improved coordination at national, state and local levels through intra- and inter-sector coordination meetings, which facilitated regular information sharing among participants including government ministries, United Nations agencies and humanitarian organizations. The CERF process also contributed to the effective exchange of information and coordination. The CERF funding strengthened technical and referral partnerships between MHMS and those trained in the Minimum Initial Service Package for reproductive health in emergencies. CERF funding highlighted to SAFENET partners the need for closer collaboration and coordination to respond to Gender-Based Violence (GBV) in emergencies, and as a result, a mapping of front line service providers is currently underway**.** The proposal writing phase and the implementation phase of the CERF activities contributed to improved coordination through intra- and inter-sector coordination meetings, and also increased the knowledge and understanding of both the situation to be addressed and the “best practice” approach for community management of acute malnutrition and immunization with micronutrient supplementation and de-worming.

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

The SIG and humanitarian partners were appreciative and motivated by receiving attention and resources from CERF. Often, people in the Pacific Islands are forgotten and ignored because their small population size does not lead to them being prioritized. This time, they felt they got the aid they needed, and this was advantageous to the entire humanitarian partnership. Furthermore, the bilateral donors expressed appreciation that the United Nations was making this contribution through CERF, to complement their direct bilateral contributions and contributions through NGOs. The implementation of CERF-funded activities demonstrated to government and INGO staff the importance of partnerships, information management, sector coordination and Sphere standards to effective humanitarian responses. The project strengthened technical as well as operational partnerships between NGOs, government partners and UNICEF. Through CERF support UNICEF successfully demonstrated the importance of establishing basic WASH sector information systems that can be scaled up at the national level. WASH sector coordination was enhanced through the active participation of NGOs that partnered with UNICEF under this project. UNICEF, Save the Children and World Vision deployed experienced WASH international experts who successfully transferred global experience to national counterparts around various WASH-related aspects of emergency response.

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Emergencies that are judged to be small scale by population size affected have a proportionately high impact on small island countries. Concomitantly, capacity in governments and among humanitarian partners tends to be lower than in larger programme countries. It was the first time the cluster approach was introduced in the Solomon Islands, which brought a series of learnings, including the capacity required to rapidly develop CERF proposals of high standards. The numerous requests for revisions from the CERF Secretariat delayed the response and overextended staff who also needed to coordinate and deliver the response.	• The CERF grant helped in strengthening the cluster approach and strengthening partnerships especially with government counterparts. • Strong references were made to HAP during the drafting of the CERF proposals which reinforced the added value of United Nations effort. • Development of the CERF proposal and the decision to apply for the CERF came a bit later due to limited OCHA personnel presence in the country. Strong OCHA support in developing quick proposals to secure CERF funds with pace will be important in future. • To accommodate higher standards for CERF proposals, people outside of the Secretariat, with specialist knowledge in sector areas from different United Nations agencies, should be asked to review the proposals and work closely, in a facilitative manner, with the proposal writers. • United Nations agencies in the Pacific need stronger support and training in proposal writing and reporting from the CERF Secretariat. This should be done in advance before any disaster happens as part of preparedness. • There was a significant delay in obtaining approval for the CERF funds. CERF funds helped to curb or reduce ongoing outbreaks of water- and sanitation-related health diseases such as diarrhoea. However, fewer cases of measles could have happened had CERF funds been released earlier.	CERF Secretariat, OCHA and UN Agencies
The protection cluster proposal was not supported by the CERF Secretariat due to its failure to meet the life-saving criteria even after a lot of efforts were put into it by all stakeholders. This led to gaps in response.	The CERF Secretariat should indicate early especially in countries without adequate staff with knowledge and expertise on CERF project writing whether a project meets the life-saving criteria.	CERF Secretariat
There was insufficient OCHA staff in the Solomon Islands with sufficient knowledge on CERF process to guide many partners who were drafting the proposals. OCHA surge person came too late in the process. This led to CERF funds being released two months after the emergency happened.	CERF Secretariat should consider deploying specialized people even for a short period to quickly help put up a CERF proposal at the early stages of an emergency. Alternatively, it should train all available OCHA staff in ROP on CERF proposal writing.	CERF Secretariat
CERF application template was extensive and took time for partners to understand.	For smaller countries with less capacity on the ground and limited CERF experience, the CERF Secretariat should develop simpler templates.	CERF Secretariat

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Health cluster should remain active to address health challenges for better preparedness.	Periodic meetings in all provinces co-chaired by health authorities and regular sharing with OCHA, NDMO, PDMO, NGOs and among various clusters should occur through not only the acute emergency but continue through the early recovery and preparedness phase.	MHMS, health cluster stakeholders / WHO / OCHA
Although most PHT members were present on the ground, some were not present fulltime in the Solomon Islands. Some were operating remotely from Suva and this posed a challenge for information flow and verification.	It is important that the CERF proposal is developed from the ground with people in the country where a disaster happens. Agencies should deploy sufficient staff with full decision making capacity until the CERF drafting process is finalized. PHT decision making should be decentralized in such situations.	United Nations agencies
OCHA staff with sufficient expertise in helping partners draft the CERF proposals were not on the ground early enough.	For effective processing of CERF proposals, OCHA as the lead should be physically represented with people who have relevant skills in the country through the entire CERF processing period to support the preparation process.	OCHA / PHT / UN Humanitarian Coordinator Office
Protection coordination (a proposal prepared by the protection cluster) was critical but not supported by CERF and not fully implemented by the government and clusters.	Protection coordination was largely the role of the government IDP Welfare cluster, led by the Ministry of Women. Despite some technical support available through UNFPA, UNICEF and international NGO Oxfam (funded by the Australian Government), protection coordination was weak. Humanitarian protection in the Pacific is still a new concept and despite several workshops with government and NGOs, capacity building and on-the-ground technical support for coordination is needed.	Protection Cluster, particularly lead agencies (OHCHR/UNHCR), OCHA, government.
There was excellent partnership with the government at the HAP development stage. However, once the CERF funding decision was made, UN centric coordination mechanisms emerged.	Government should be more involved in the planning and development of the CERF proposals.	PHT, United Nations agencies
Assistance packages were not standardized and different assessment formats and methodologies were used at different stages of the response. Inconsistent assessment results led to delays in response and duplication at times.	Agree at PHT level and with governments on standard assessment formats and standard assistance packages.	PHT, United Nations agencies, cluster leads
Joint communication with government and other partners in public and private on what the United Nations was collectively doing with the	Need to develop media/joint communication plan with all stakeholders on what the United Nations was collectively doing with CERF funds to jointly respond to the situation.	PHT, RC, OCHA

CERF money to support government-led efforts was lacking.		
There were few staff in the region with experience in humanitarian operations. Many agencies therefore used their development staff, who also had other roles, to fill the gaps. This slowed down the pace at which the response was undertaken.	Encourage more training of available staff to "double hat" and bring in humanitarian staff on surge capacity much sooner if circumstances require.	SIG, cluster leads, United Nations agencies.
Gender advice was given by the gender expert, which was available to the PHT and CERF applicants. However, the advice was not taken on board by all recipient agencies.	Agree on gender marker indicators during the preparedness phase.	All United Nations agencies, PHT
To avoid duplication of supplies, United Nations agencies should continue working together during the implementation phase of the CERF grants.	Encourage joint discussions on progress of CERF grant implementation during PHT and Humanitarian Country Team meetings so that common issues and concerns can be addressed when identified.	RC, OCHA, United Nations agencies
There were significant local resources in the affected areas that could be strengthened to augment emergency response activities in the future.	A database should be prepared with information on all local NGOs and CBOs that were involved in the emergency, including their areas of expertise. In addition, these organizations should be encouraged to keep updated surge rosters of local people. Organize capacity building activities to strengthen not only the staff of these local organizations, but also cadres of potential volunteers and surge staff.	MHMS, NDMO, NGO and United Nations agencies

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	WHO	5. CERF grant period:	14.04.14 – 13.10.14
2. CERF project code:	14-RR-WHO-037	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health		☐ Concluded
4. Project title:	Provision of emergency health services to flash flood affected areas		

7.Funding			
	a. Total project budget:	US$ 2,282,945	d. CERF funds forwarded to implementing partners:
	b. Total funding received for the project:	US$ 674,378	▪ *NGO partners and Red Cross/Crescent:* US$
	c. Amount received from CERF:	US$ 626,433	▪ *Government Partners:* US$ 100,697

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	24,960	24,960	N/A
b. Male	27,040	27,040	
c. Total individuals (female + male):	52,000	52,000	
d. Of total, children under age 5	22,282	22,282	

9. Original project objective from approved CERF proposal

The overall objective of the CERF project is to provide life-saving interventions in direct response to the needs for health and nutrition services triggered by the floods to the affected communities and evacuation centers in HCC and GP. The major outputs include the provision of technical support in the management and coordination of the emergency response, the set-up of mobile clinics and emergency repair of the most-heavily damaged health facilities to restore critically needed health services, provision of emergency PHC services, and establishing a EWARS to respond to anticipated vector-borne and epidemic-prone diseases.

The target population for the CERF project is 52,000 out of more than 100,000 people affected across the two provinces (GP: 19 affected health facilities covering an estimated population of 64,000; and HCC: 3 affected health facilities (currently non-functional) covering an estimated population of 40,000).

10. Original expected outcomes from approved CERF proposal

CERF Project Results Framework		
Outcome statement	Provide life-saving health and nutrition interventions to the flood-affected communities in HCC and GP	
Output 1	**Increased access to essential health services with adequate referral system and medical supplies in stock at health facility level in flood affected HCC and GP**	
Output 1 Indicators	Description	Target for Indicator

Indicator 1.1	# and percentage of population covered by functioning health facilities and mobile clinics (average), by Province	104,000 / 100%
Indicator 1.2	# and percentage of affected health facility repaired and equipped	7 / 100%
Indicator 1.3	# of out-patient consultation/person/year	> 1 new visit/person/year
Indicator 1.4	Functional referral system exists	Yes
Indicator 1.5	# of IEHK, DDK procured	5 IEHK and 3 DDK
Output 1 Activities	Description	Implemented by
Activity 1.1	Set up of temporary health facilities (tents) and establish mobile clinic services and outreach teams	MHMS and WHO
Activity 1.2	Conduct emergency repair of affected health facilities including setting up an Oral Rehydration Treatment (ORT) corner in each facility	MHMS and WHO
Activity 1.3	Provide emergency PHC services in particular attention to children and pregnant and lactating women; maternal and neonatal intra-partum care, as well as to the elderly (which represents a relatively large proportion of the vulnerable population who will need support for chronic health conditions)	MHMS, UNICEF, WHO, MSF, SCA, UNFPA
Activity 1.4	Re-establish and enhance the referral system, including transport from the communities to primary and secondary health care facilities	MHMS, GP health office, HCC health office, and WHO
Activity 1.5	Procure and distribute essential medical supplies (IEHR and DDK)	MHMS, WHO
Output 2	**Disease surveillance and outbreak control system is fully functional, and reporting on any unusual events/outbreak within 24 hours in HCC and GP; confirming any alert, investigating any outbreak and providing response in case of the confirmation of an outbreak**	
Output 2 Indicators	Description	Target for Indicator
Indicator 2.1	Number of facilities with strengthened syndromic surveillance system in HCC and GP	7
Indicator 2.2	# of cases of acute diarrhoea per week in the National Referral Hospital (NRH)	<150
Indicator 2.3	# of health staff trained on EWARS and early identification and reporting	30
Output 2 Activities	Description	Implemented by
Activity 2.1	Establish the EWARS through strengthening MHMS's existing syndromic surveillance system including supply of drugs and materials (diagnostics)	MHMS, health facilities in HCC and GP; and WHO
Activity 2.2	Ensure systematic epidemiological data collection, compiling, analyzing and report dissemination by the health care workers for further health intervention decisions	MHMS, health facilities in HCC and GP; and WHO
Activity 2.3	Conduct emergency on-the-job training of health staff on EWARS and early identification and reporting of epidemic-prone diseases in the context of standing water and overcrowding	MHMS, and WHO
Output 3	**Scaling up the coverage of all the services of the RH Minimum Initial Service Package for emergency care focusing on prevention and care of new-born severe diseases**	
Output 3 Indicators	Description	Target for Indicator
Indicator 3.1	percentage of pregnant women availing pre-natal check-ups	ANC III visits coverage >

		90%
Indicator 3.2	# HF with Comprehensive Emergency Obstetric and New-born Care	4
Output 3 Activities	Description	Implemented by
Activity 3.1	Provide essential new-born care	MHMS, WHO and UNFPA
Activity 3.2	Provide essential and comprehensive maternal and new-born care in the peripheral health facilities and NRH	MHMS, WHO and UNFPA
Output 4	**Nutritional needs are assessed in the affected communities and ECs in GP and HCC**	
Output 4 Indicators	Description	Target for Indicator
Indicator 4.1	Number of children screened for acute malnutrition	450
Output 4 Activities	Description	Implemented by
Activity 4.1	Conduct immediate nutritional screening and surveillance to identify the moderate acute and SAM and refer them for life-saving interventions	MHMS, UNICEF, WHO

11. Actual outcomes achieved with CERF funds

Outcome 1: Provided life-saving health and nutrition interventions to the flood affected communities in HCC and Guadalcanal Province

Increased access to essential health services with adequate referral system and medical supplies in stock at health facility level in flood affected HCC and GP

- Seven (7) health facilities providing health care services to more than 50,000 people were rehabilitated and/or made functional (100% target)
- During the floods, six mobile teams were established in HCC with CERF funding, which provided medical services to: 211 children and 1,198 adult affected population (in temporary clinics and evacuation centers). In total, 3,537 people in HCC received health services thorough mobile teams.
- Immediately after the floods, more than 2,000 people presented or were referred to the NRH in HCC and Good Samaritan Hospital in GP for medical care for diarrhoea. ORS was provided by UNICEF.
- During the measles outbreak the 21 mobile teams established in Solomon Islands were fully supported with vehicles, drivers and fuel with CERF funding to support the outbreak control and vaccination activities. Teams in HCC vaccinated 10,578 children (6-59 months) and 61,733 5-30 year olds and in GP the teams vaccinated a total of 9,843 children (6-59 months) and 52,064 5-30 year olds during the measles campaign.
- Five international emergency health kits procured providing essential medicines for 50,000 people for 3 months.
- Three diarrhoeal disease kits procured.
- 100 new-born resuscitation kits procured.

Outcome 2: Disease surveillance and outbreak control system was fully functional, and reported on any unusual events/outbreak within 24 hours in HCC and GP; confirming any alert, investigating any outbreak and providing response in case of the confirmation of an outbreak

- The EWARS system and team responded to an average of 25 alerts per week. Alerts were responded to and verified within hours of receipt.
- Responded and contained outbreaks of diarrhoea, meningitis and significantly supported a country-wide measles outbreak.

- The epidemic threshold was exceeded in first week of EWARS and sustained for 5 weeks.
- 21 facilities (300% target) strengthened syndromic surveillance system in HCC (9 sites) and GP (12 sites)
- Trained 50+ health care workers on EWARS and early identification and reporting (167% target)
- Training of 25 health care workers (doctors and nurses) on the clinical management of diarrhea was conducted at NRH and in HCC clinics for staff.
- Measles management training was completed for health care workers in NRH.
- Standard Operating Procedures were developed and epidemic thresholds were set.
- WHO procured laboratory tests for leptospirosis, dengue and rotavirus.

Outcome 3: **Scaling up the coverage of all the services of the RH Minimum Initial Service Package for emergency care focusing on prevention and care of new-born severe diseases**

- Over 90% of the women attended pre- natal care in the affected areas. This was done jointly with MHMS and UNFPA
- As a result of the rehabilitation of the health clinic jointly with UNFPA, comprehensive maternal and new born care greatly improved.

Outcome 4: **Nutritional needs are assessed in the affected communities and ECs in GP and HCC**

- During joint mass screening for malnutrition of 6111children, out of the 7400 targeted for Honiara City SIA, 116 children were found to be malnourished: 110 (1.8%) with moderate acute malnutrition and 6 (0.1%) with severe acute malnutrition (SAM). All six were referred for treatment to the National Referral Hospital. Community-based management of SAM (C-SAM) without medical complications was also initiated in the post-emergency phase. The commencement of the C-SAM programme designed to actively screen for malnutrition cases in the community, has started to identify children with SAM and refer them for treatment to the NRH. 100% of SAM cases identified in the community are immediately referred for treatment and are receiving treatment at Good Samaritan Hospital in Guadalcanal Province, or National Referral Hospital in Honiara.
- The mothers/caregivers of the 110 children identified with Moderate Acute Malnutrition (MAM) during the mass screening in HCC, were counselled by health workers and given multiple micronutrient supplements to improve the quality of their diets. Other children identified through community screening for malnutrition following the C-SAM training are also referred to the community clinics for counselling. Because the communities are assessed to be food secure (through the Nutrition Survey), no special therapeutic foods were procured for children with MAM

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

N/A

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

If 'YES', what is the code (0, 1, 2a or 2b): 2a
If 'NO' (or if GM score is 1 or 0

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
Massive measles outbreak in the middle of the response further overstretched the capacity to carry out the evaluation. The health cluster has learnt from this process and will carry out evaluation in future	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNFPA	5. CERF grant period:	15.04.14 – 14.10.14
2. CERF project code:	14-RR-FPA-026	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Access to reproductive health and GBV referral for IDPs and returnees		

7.Funding			
	a. Total project budget:	US$ 327,590	d. CERF funds forwarded to implementing partners:
	b. Total funding received for the project:	US$ 203,308	▪ *NGO partners and Red Cross/Crescent:* US$
	c. Amount received from CERF:	US$ 165,574	▪ *Government Partners:* US$ 89,468

Results

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

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	26,000	29,400	More coverage was made for females than previously planned. The additional figures came from affected areas (Zones 1 and 6) which were not factored in the initial assessments which were used for CERF project proposals. The outreach done through NGOs reached less men than previously planned. The overall coverage was more by 1,750 due to the additional females reached through outreach programmes as explained above.
b. Male	5,200	3,550	
c. Total individuals (female + male):	31,200	32,950	
d. Of total, children under age 5	N/A	N/A	

9. Original project objective from approve

d CERF proposal

The overall objective of this CERF project is to provide essential and life-saving reproductive health information and services, as well as health and shelter services to GBV survivors, among the displaced communities in evacuation centers and flood affected communities in their area of return or relocation.

10. Original expected outcomes from approved CERF proposal

CERF Project Results Framework

Outcome statement	Scaling up the coverage of services in the Reproductive Health Minimum Initial Service Package and comprehensive care for women and women of reproductive age	
Output 1	30,000 displaced have access to essential sexual and reproductive health information and services, with adequate referral system and medical supplies in stock at health facility level in flood affected HCC and GP	
Output 1 Indicators	Description	Target for Indicator
Indicator 1.1	Number of pregnant and lactating women in evacuation centers and flood affected areas availing antenatal check-ups	ANC III visits coverage >90% for an estimated 1,200 antenatal

		and postnatal mothers over a three month period.
Indicator 1.2	Number of health facilities providing reproductive health services and supplies to flood affected populations	HCC 8, GCP 20 (1 national referral hospital and provincial clinics in places of return/relocation)
Indicator 1.3		
Output 1 Activities	Description	Implemented by
Activity 1.1	Procurement of medical kits and supplies for essential reproductive health care	UNFPA
Activity 1.2	Implement reproductive health information campaign to 25,000 women of reproductive age, targeting an estimated 1,200 antenatal and postnatal mothers over a three month period, and 5,000 adolescents as well as 5,000 partners.	MHMS, SIPPA
Activity 1.3	Procurement and distribution of hygiene and health supplies to women of reproductive age, targeting antenatal and postnatal.	UNFPA, MHMS, SIPPA
Output 2	5,000 IDP and returnee women and youth receive GBV information, medical and psychosocial support	
Output 2 Indicators	Description	Target for Indicator
Indicator 2.1	Number of psychosocial support outreach sessions	12
Indicator 2.2	Number of women, adolescent girls of reproductive age sensitized on GBV risk mitigation and response through information sessions in evacuation centers and areas of return	5,000
Output 2 Activities	Description	Implemented by
Activity 2.1	Implement SAFENET GBV outreach campaign in the evacuation centers and areas of return/relocation for 5,000 flood affected beneficiaries	Social Welfare Division, SAFENET and NGOs
Activity 2.2	Procurement of Dignity Kit and Post Rape Kit and distribution – for quantities, please refer to Project Budget, Section C)	UNFPA, MHMS and SIPPA
Activity 2.3	Provision of medical services and shelter to survivors of violence through grants to NGOs	MHMS, SIPPA and CCC

11. Actual outcomes achieved with CERF funds

Outcome 1: 30,000 displaced have access to essential sexual and reproductive health information and services, with adequate referral system and medical supplies in stock at health facility level in flood affected HCC and GP

- A total of 400 delivery kits, 5 contraception kits, 3 STI kits, 4 clinical delivery kits, 3 miscarriage and abortion related kits, 3 examination kits, 1 vacuum extractor, 2 referral kits and 1 blood transfusion kits distributed to affected people.
- Outreach sessions done for 1000 young adolescents aged between 14 and 29 in both Honiara and Guadalcanal as well as 35 victims of the Shelter house. During these sessions, information and advocacy on AHD, GBV and STI was given. Similarly, 10 young people were treated for STIs and 9008 condoms distributed.
- Outreach sessions done for 1000 young adolescents aged between 14 and 29 in both Honiara and Guadalcanal as well as 35 victims of the Shelter house. During these sessions, information and advocacy on AHD, GBV and STI was given.

Similarly, 10 young people were treated for STIs and 9008 condoms distributed

Outcome 2: 5,000 IDP and returnee women and youth receive GBV information, medical and psychosocial support

- In order to assess vulnerability and reach survivors of violence, UNFPA worked through the Ministry of Health and Medical Services which hosts the Solomon Islands SAFENET alliance of frontline responders to Violence against Women (VAW). In order to address managing Sexual Violence (SV), SIPPA distributed close to 3,000 IEC materials on sexual violence, conducted 28 awareness workshops and assisted two sexual violence survivors. Total estimated coverage was 2,000 participants. SIPPA also conducted 12 additional youth workshops on STI/HIV prevention, managing sexual violence and teenage pregnancy with an estimated total coverage of 700 young people. At the youth workshops, SIPPA distributed 20 hygiene kits for 20 teenage mothers.
- In Guadalcanal Province, SIPPA through its Community based educators (CBE) reached out to more than 3,000 youth from two (2) communities in Suaghi and Kolina which had been affected by the flash floods of April 2014.
- 200 dignity kits which included torch lights, radio sets and safe sex kits distributed to affected people.
- 5 rape treatment kits and additional 32 dignity kits distributed to the affected people.
- UNFPA supported medical services and shelter to survivors of violence. The two agencies most prepared to step up in the emergency scenario were SIPPA as well as Christian Care Association. Because both have strong community networks and a cadre of volunteers they were able to work with flood affected communities both in the evacuation centers as well as after their return to areas of origin.
- In partnership with the Ministry of Health and Medical Services and together with Christian Care Centre, UNFPA provided support for the rehabilitation of the Christian Care Centre meeting hall for the women as well as the rehabilitation of the Centre's kitchen.
- During the emergency response CCA responded to 12 young women, providing counseling and referral services at their shelter. SAFENET focused on engaging men in areas of return under the "Men as Partners" programme which includes gender and sexual reproductive health sessions**.**

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

Outreach to provincial regions was limited since at the time when the country was undertaking recovery efforts of the April flash floods, Solomon Islands was confronted with another emergency, the measles outbreak. The first measles case from this outbreak was reported in June 2014 and there had been 3802 cases of measles reported as of 5 October 2014. Most affected was Honiara with 849 cases and on Guadalcanal Province with 2,315 cases. Thus this outbreak stretched the already limited capacity base of the Ministry of Health and its partners to address more CERF project related 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): 2b
If 'NO' (or if GM score is 1 or 0

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
An overall evaluation was done by a protection specialist who was deployed to the Solomon Islands covering mainly protection and GBV issues. No further evaluation is planned**.**	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	5. CERF grant period:	01.05.14 – 31.10.14
2. CERF project code:	14-RR-CEF-084	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Multi-sector		☒ Concluded
4. Project title:	Immunization and Nutrition		

7.Funding				
	a. Total project budget:	US$ 605,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 460,062	▪ *NGO partners and Red Cross/Crescent:*	US$0
	c. Amount received from CERF:	US$ 275,062	▪ *Government Partners:*	US$ 69,123

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	3,744	3,744	N/A
b. Male	4,056	4,056	
c. Total individuals (female + male):	7,800	7,800	
d. Of total, children under age 5	7,800	7,800	

9. Original project objective from approved CERF proposal

The overall objective of the CERF project is to reduce excess mortality, identify and treat malnutrition, prevent malnutrition, through provision of nutrition and vaccination services to children under age 5 in the flood affected communities in Honiara and Guadalcanal, Solomon Islands.

10. Original expected outcomes from approved CERF proposal

CERF Project Results Framework

Outcome statement	Provide life-saving health and nutrition interventions to 7,800 children under age five in the flood affected communities in Honiara and Guadalcanal Province	
Output 1	Increased access to essential health services with adequate referral system and medical supplies in stock at health facility level in flood affected Honiara and Guadalcanal Province (GP)	
Output 1 Indicators	Description	Target for Indicator
Indicator 1.1	Measles, Vitamin A and deworming vaccination coverage	95% of 7,800 under five girls and boys in affected area reached with measles, Vitamin A, and deworming, with gender parity in coverage, by end of June 2014

Output 1 Activities	Description	Implemented by
Activity 1.1	Special emergency integrated Supplementary Immunization Activities (SIAs) for measles with Vitamin A and Albendazole supplementation targeting 7,800 under five children in HCC and GP	MHMS and UNICEF
Activity 1.2	Assure cold chain management at health facilities and in outreach teams	MHMS and UNICEF
Output 2	Malnutrition cases are identified, referred and treated and further deterioration in prevalence of malnutrition in children under age five is prevented in the affected areas.	
Output 2 Indicators	Description	Target for Indicator
Indicator 2.1	Percent of nurses (responsible for counselling families) and nurse aids equipped and trained on IYCF counselling in affected areas.	80% of each group
Indicator 2.2	Percent of children with SAM referred and treated	90% of children (boys and girls) with SAM
Indicator 2.3	Percent of children with MAM managed in the community.	70% Children (boys and girls) 6-9 months of age with MAM
Indicator 2.4	Timely procurement and distribution of requisite supplies	100% of supplies procured and distributed on time for planned activities
Output 2 Activities	Description	Implemented by
Activity 2.1	Key health care staff refreshed on best practices in counselling of mothers and care givers on optimal IYCF practices, including eliminating practices undermining breast feeding, adequate and appropriate complementary feeding and strengthening of the growth monitoring of children in affected areas.	MHMS, UNICEF
Activity 2.2	In coordination with WHO (that is responsible for medical treatment of Severe Acute Malnutrition cases in stabilization centers), ensure screening, referral to hospital and discharge follow up for SAM cases.	MHMS, UNICEF
Activity 2.3	Implement community-based Supplementary Nutrition Program for management of children with MAM.	MHMS, UNICEF
Activity 2.4	Implement micronutrient supplementation program (one mega dose of vitamin A and MNP)	MHMS, UNICEF

11. Actual outcomes achieved with CERF funds

Output 1

- Emergency supplementary immunization activities (SIAs) were conducted throughout Honiara City and in flood affected zones 1, 5 and 6 of Guadalcanal Province. CERF funds were used in the flood affected areas, and children in the rest of the city and elsewhere on the Island of Guadalcanal were reached with funds from other sources. With the combined funds, a total of 7,800 +children under 5 years of age were reached with the measles-rubella (MR) vaccine, Vitamin A supplementation and deworming medication (Albendazole). In addition, non-CERF funding was used to provide oral polio vaccines to children under 1 year of age. Based on project monitoring reports, 52 per cent of those reached were boys and 38 per cent were girls.
- To ensure cold chain management and assure vaccine potency, three ice-lined refrigerators and three solar chill

refrigerators were procured for the flood affected clinics.

- Community mobilization sessions and radio messaging on the supplementary immunization plus activity, is estimated to have reached affected communities with radio spot messages aired on Solomon Islands Broadcasting Corporation (SIBC) for 10 days, letters to all church leaders in Honiara City council and information sharing by health workers on the measles-rubella campaign.

Output 2

- A total of 51 health workers have been trained in the management of severe acute malnutrition (SAM), including Infant and Young Child Feeding (IYCF) counselling and growth assessment in the affected communities, during the national integrated SAM management training (11 health workers) , and the roll out training for community management of SAM (C-SAM- 40 health workers). This would represent between 70-80% of health workers (nurses and nurse aids) in the flood affected areas who are expected to provide IYCF counselling and growth assessment. An additional 25 community health volunteers were reached during the community sensitization meetings following C-SAM training.
- During mass screening for malnutrition of 6111children, out of the 7400 targeted for Honiara City SIA, 116 children were found to be malnourished: 110 (1.8%) with moderate acute malnutrition and 6 (0.1%) with severe acute malnutrition (SAM). All six were referred for treatment to the National Referral Hospital. Community-based management of SAM (C-SAM) without medical complications was also initiated in the post-emergency phase. The commencement of the C-SAM programme designed to actively screen for malnutrition cases in the community, has started to identify children with SAM and refer them for treatment to the NRH. 100% of SAM cases identified in the community are immediately referred for treatment and are receiving treatment at Good Samaritan Hospital in Guadalcanal Province, or National Referral Hospital in Honiara.
- The mothers/caregivers of the 110 children identified with Moderate Acute Malnutrition (MAM) during the mass screening in HCC, were counselled by health workers and given multiple micronutrient supplements to improve the quality of their diets. Other children identified through community screening for malnutrition following the C-SAM training are also referred to the community clinics for counselling. Because the communities are assessed to be food secure (through the Nutrition Survey), no special therapeutic foods were procured for children with MAM.
- Key nutrition messages that were developed in close consultation with the Health Promotion Unit and Nutrition team of MHMS were broadcasted on Paoa FM on both 15 minute radio talk back programs as well as x30 second radio spots. The 15 minute radio programs were scheduled for broadcasting twice weekly for a duration of four (4) months with key nutrition experts as guest speakers/panelists. The 6 x30 second radio spots included key messages on Breastfeeding (infant feeding), Young child feeding 6 – 24 months, Food safety/handling, Expressing and storing breast-milk, Balanced diet and Eating during illness that were rotated and broadcast at 6 times a day 7 days a week for a period of three (3) months. These key integrated messages were essentially targeted towards parents and caregivers in flood affected areas, but have benefited a national audience, due to the extensive reach of radio.
- All of the planned nutrition supplies were procured and supplied to the affected areas on time. Micronutrient supplementation was provided to mothers of children by health workers in communities (through mobile teams) and through clinics. However, a weak area was that initially poor communication on the use of MNPs to nurses in the community resulted in the insufficient distribution of the MNPs to children

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

The project fully achieved its outputs and outcomes using the CERF funds,.

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): 2a
If 'NO' (or if GM score is 1 or 0

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐

. There was oversight on the part of the implementing agency. As part of the learning process, it will carry out an evaluation in future.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	5. CERF grant period:	23.05.14 – 22.11.14
2. CERF project code:	14-RR-CEF-085	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Water and sanitation		☒ Concluded
4. Project title:	Solomon Islands emergency Water Supply, Sanitation and Hygiene (WASH) interventions for flood affected women and children		

7.Funding			
	a. Total project budget:	US$ 2,340,000	d. CERF funds forwarded to implementing partners:
	b. Total funding received for the project:	US$ 1,205,000	▪ *NGO partners and Red Cross/Crescent:* US$ 546,338
	c. Amount received from CERF:	US$ 709,054	▪ *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	17,088	17,088	The project reached 35,600 as planned. Under output 2, however, a lesser number of 6,880 beneficiaries were recorded for sanitation than the planned target of 8,800 people because other WASH partners already had installed toilet facilities the time UNICEF was awaiting CERF funding. There is therefore an under-utilization of CERF funds with some money to be reimbursed to CERF by UNICEF(US$36,000)
b. Male	18,512	18,512	
c. Total individuals (female + male):	35,600	35,600	
d. Of total, children under age 5	15,308	16, 825	

9. Original project objective from approved CERF proposal

Adequate provision of Water Supply, Sanitation and Hygiene (WASH) emergency response interventions for flood affected communities in evacuation centers, communities, schools and health facilities in Honiara City and priority health zones of Marara, Good Samaritan and Aola in Guadalcanal Province. The number of CERF Project beneficiaries has been estimated at 35,600 people who have been identified as a result of sectoral needs and the capacity of WASH partners on the ground.

10. Original expected outcomes from approved CERF proposal

UNICEF as a Co- cluster lead will ensure that there are no overlaps during the implementation. All beneficiaries listed are flood affected.

CERF Project Results Framework

Outcome statement	Adequate provision of Water Supply, Sanitation and Hygiene (WASH) emergency response interventions for flood affected communities in evacuation centers, communities, schools and health facilities Honiara City and priority Health Zones of *Marara, Good Samaritan* and *Aola* in Guadalcanal Province
Output 1	The target population (including women and small children) has access to safe and sufficient drinking water within a period of three to four months
Output 1 Indicators	Description — Target for Indicator

Indicator 1.1	# Girls, boys, women and men having access to adequate drinking water supply (5 liters/person/day) at the end of project	43% (22,200) of the most affected population
Indicator 1.2	Girls, boys, women and men have drinking water with free residual chlorine between 0.2 and 0.5 mg/l and/or absence of bacterial contamination	29% (15,000) of the most affected population
Output 1 Activities	Description	Implemented by
Activity 1.1	10,000 affected people will be reached by water supply through Water trucking for the first 30 days of the Project in parts of Marara, Good Samaritan, Aola, Burns Creek, FOPA and other evacuation centers	MHMS and UNICEF in collaboration with WASH cluster partners
Activity 1.2	10,833 people will have drinking water through provision of water purification tablets for 60 days after water tinkering end.	MHMS and UNICEF in collaboration with -WASH cluster partners
Activity 1.3	15,000 people will be reached by installation of water storage and distribution of jerry cans	MHMS and UNICEF in collaboration with -WASH cluster partners
Activity 1.4	7,200 people will benefit from Quick repairs and maintenance of 60 water sources (dug wells or bores) and water systems in communities and schools	MHMS and UNICEF in collaboration with WASH cluster partners
Activity 1.5	Monitoring of water quality will be conducted of sources of water on monthly basis	MHMS and UNICEF in collaboration with WASH cluster partners
Output 2	The target population (including women and small children) has access to safe sanitation within a period of three to 4 months	
Output 2 Indicators	Description	Target for Indicator
Indicator 2.1	Percentage and number of girls, boys, women and men using adequate excreta disposal facilities	15%(8000) of the affected population
Output 2 Activities	Description	Implemented by
Activity 2.1	40 repairs and restoration as well as rehabilitation of 80 latrines destroyed by floods in schools, health facilities and installing 40 in the evacuation centers. Separate facilities for men and women planned.	MHMS and UNICEF in collaboration with WASH cluster partners
Activity 2.2	Control and minimize open defecation among 5,400 people in evacuation centers, crowded communities, schools and health facilities through hygiene promotion activities.	MHMS and UNICEF in collaboration with WASH cluster partners
Output 3	The target population (including women and small children) receives, understands and uses hygiene messages and materials and practice good hygiene behavior within a period of 6 months	
Output 3 Indicators	Description	Target for Indicator
Indicator 3.1	Girls, boys, women and men reached with distribution of basic hygiene messages	68% (35,600) of the most affected population
Output 3 Activities	Description	Implemented by
Activity 3.1	Distribution of 200 Hygiene kits in health facilities.	MHMS and UNICEF in collaboration with WASH

		cluster partners
Activity 3.2	5400 Hygiene promotion for women and school children through information, education and communication including interpersonal communication	MHMS and UNICEF in collaboration with WASH cluster partners
Activity 3.3	30,200 affected reached through hygiene promotion activities, radio messaging and printed materials	MHMS and UNICEF in collaboration with WASH cluster partners

11. Actual outcomes achieved with CERF funds

Under this portion of the project 42,062 flood-affected people benefitted from WASH emergency response interventions.

Output 1

- 32,205 people (62 per cent) were provided with access to safe and sufficient drinking water (five liters per person per day) within five months, surpassing the planned target of 22,200 (43 per cent).
- 20,861 people (40 per cent) were supplied with drinking water with free residual chlorine between 0.2 and 0.5 mg per liter and/or absence of bacterial contamination, surpassing the planned target of 15,000 (29 per cent).
- Activity 1.1: 20,861 people were reached with safe water through the trucking of treated water from filtration stations to evacuation centers, including Marara, Good Samaritan, Aola, Burns Creek and FOPA. Water treatment was done through 'water filtration modules' (also known as No-Muds). In some of the evacuation centers water trucking lasted 60 days as opposed to the 30 days originally planned because of prolonged water needs. Women and girls were targeted ensuring they had easy access to water distribution points which were equipped with bladders tanks and a set of communal standpipes (tap stands)
- Activity 1.2: 16,500 people were provided with access to safe drinking water through the provision of water purification tablets for a period of 90 days after water trucking ended in order to safeguard water quality at point of use. Women and girls received orientation in proper use and dosage of water purification tablets and also ensuring they adequately promoted proper water handling in their respective households.
- Activity 1.3: 18,433 people benefited from the installation of water storage tanks and the distribution of jerry cans. 3,000 liter and 5,000 liter water storage tanks were installed in evacuation centers. 3,000 collapsible water containers (10 liters) were distributed to facilitate safe handling of drinking water. Water storage tanks to be located in central points where women and girls from within the camps/communities can have easy access.
- Activity 1.4: 13,891 people benefited from rapid repairs to and maintenance of 66 water sources (51 dug wells, five rainwater systems and 10 gravity fed systems) in communities and schools in Honiara's Burns Creek and parts of eastern and western Guadalcanal Province. Dug wells were cleaned to regain their original water depth and provided with proper linings and platforms. Rainwater systems were repaired by replacing damaged components such as guttering, downpipes and tank platforms. Gravity fed systems were repaired and rehabilitated by reconstructing water intake structures, replacing missing and broken pipes and ensuring pipes were properly buried. In all cases, communities participated by organizing community labor forces that supported NGO water technicians.
- Activity 1.5: Water quality monitoring at source was conducted on a monthly basis using CERF-supported testing equipment.

Output 2

- 6,880 people were provided with access to safe sanitation, including 1,221 girls, 1,259 boys, 3,052 women and 3,148 men, compared to a planned target of 8,000 people. There was an underutilization of funds on this component that UNICEF can reimburse to CERF.
- Activity 2.1: 106 latrines (58 for women and 48 for men) were rehabilitated/reconstructed in communities, schools and health facilities in eastern and western Guadalcanal Province. The facilities constructed were accessible and promoted the dignity of users as well as safety and privacy. Communities were consulted to ensure agreement on the positioning of latrines. Women and girls were consulted for their views and preferences in relation to positioning toilet facilities to safeguard their dignity, privacy, security and safety. In most cases women preferred toilets to be close to their dwelling units and with adequate water supply at all times
- Activity 2.2: Open defecation was reduced among 6,880 people in evacuation centers, communities, schools and health facilities through the installation of latrine facilities and through hygiene promotion activities. Hygiene messages promoted

safe fecal disposal and proper use of latrine facilities, among other things. Women and girls contributed to decision making especially locating toilets within the camps. Messages were disseminated through public health campaigns, posters, pocket guides and radio (including the youth radio talk back show aired on Solomon Islands Broadcasting Corporation (SIBC) radio).

Output 3

- 42,062 people were reached with hygiene messages, promoting hand washing at critical times and safe water handling, surpassing the planned target of 35,600 beneficiaries.
- Activity 3.1: Over 200 hygiene kits, containing bars of soap for hand washing, were distributed to health facilities to support family hygiene needs, especially for women and children.
- Activity 3.2: 20,000 hygiene promotion materials were distributed, targeting women and school children. IEC materials included 10,000 pocket guides (5,000 in Pidgin and 5,000 in English) and 10,000 colourful paper hands pamphlets with a message on each finger on key practices to keep families safe and healthy during emergencies. Women and girls were targeted for meetings ensuring they adequately received hygiene messages including hand-washing and water safety at point of use.
- Activity 3.3: 42,062 people received hygiene messages through hygiene promotion activities, radio messaging and printed materials. WASH messages were promoted through mass campaigns in the evacuation centers using posters, pocket guides and radio spots. In addition, for the first three weeks of the response, radio spots were played six times a day on two radio stations, SIBC and POA FM. World Vision and Save the Children deployed their volunteers and experienced hygiene promoters, who successfully facilitated child-friendly hygiene promotion approaches such as paintings, storytelling and the demonstration of hand washing with soap. Women, girls and school children were also reached with messages on the importance of using toilets and hand washing after defecating and before eating. Other public messages centered on safeguarding drinking water quality at source and point of use such as boiling, use of water purification tablets and safe water storage in recommended plastic water containers.
- The planning and implementation of WASH activities addressed gender equity and equality concerns which included access, use and deciding on water, sanitation, and hygiene. WASH needs varied across the communities and within the camps and target communities based on community sizes and nature of settlements. In whatever case, the assessment findings suggested women and girls were the primary users of water responsible for collecting, cooking and taking care of children. Demographic data was collected to capture number of men, women, boys, girls and boys in order to ensure that all groups were adequately consulted wherever necessary on water distribution, sanitation provision and hygiene promotion. Both men and women were engaged for collective decisions on WASH improvements and positioning of water and sanitation facilities. Water collection points were centrally located in order to facilitate easy access by women and girls. Women were targeted with hygiene messages that promoted hand-washing and water safety at point of use including proper use/dosage of the water purification tablets, boiling drinking water and safe water storage. In consultation with both men and women, toilets were located at easy access/reach areas by women, girls and children at any time of the day. Key factors for citing toilet facilities included user privacy, security and safety.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:	
N/A	
13. Are the CERF funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐
If 'YES', what is the code (0, 1, 2a or 2b): 2a **If 'NO' (or if GM score is 1 or 0):**	

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
.	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 Instalment Transferred	Start Date of CERF Funded Activities By Partner	Comments
14-RR-CEF-085	Water, Sanitation and Hygiene	UNICEF	World Vision SI	NO	INGO	$305,738	10-Sep-14	20-Jun-14	World Vision pre-financed their activities while waiting for their first instalment which was effected on 10 Sep 2014.
14-RR-CEF-085	Water, Sanitation and Hygiene	UNICEF	Save the Children	NO	INGO	$173,100	10-Sep-14	23-Jun-14	Save the Children pre-financed their activities while waiting for their first instalment which was effected on 10 Sep 2014.
14-RR-CEF-085	Water, Sanitation and Hygiene	UNICEF	Solomon Islands Red Cross	NO	Red Cross	$67,500	1-Sep-14	20-Jun-14	Solomon-Islands pre-financed their activities while waiting for their first installment which was effected on 1st Sep 2014.
14-RR-CEF-084	Multi- Sector	UNICEF	Ministry of Health and Medical Services	Yes	Government	$69,123	1-July-14	20-Jun-14	
14-RR-FPA-026	health	UNFPA	Ministry of Health and Medical Services	Yes	Government	$89,468	21- May- 14	14-April-14	
14-RR-WHO-037	Health	WHO	Ministry of Health and Medical Services	Yes	Government	$100,698	28-May-14	15-June-14	

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

AWD	Acute Water Diarrhoea
CBE	Community Based Educators
CCC	Christian Care Centre
C-SAM	Community-based management of Severe Acute Malnutrition
DDK	Diarrhoeal Disease Kit
DFAT	Department of Foreign Affairs and Trade
GBV	Gender Based Violence
GP	Guadalcanal Province
HAP	Humanitarian Action Plan
HCC	Honiara City Council
IDP	internally displaced persons
IEC	information, education and communication
IEHK	Italian Emergency Health Kit
ILI	Influenza like Illnesses
IPC	Interpersonal communication
IYCF	infant and young child feeding
MAM	moderate acute malnutrition
MEHRD	Ministry of Education and Human Resources Development
MHMS	Ministry of Health and Medical Services
MNP	micronutrient powder
MR	measles-rubella
NDMO	National Disaster Management Office
NEOC	National Emergency Operations Centre
NGO	Non-governmental organization
NZMFAT	New Zealand Ministry of Foreign Affairs and Trade
OPV	oral polio vaccine
PDMO	Provincial Disasater Manegement Office
PHT	Pacific Humaniatrian Team
RH	Reproductive Health
SAM	severe acute malnutrition
SI	Solomon Islands
SIA	supplementary immunization activity
SCA	Save the Children Australia
SIBC	Solomon Islands Broadcasting Corporation
SIG	Solomon Islands Government
SIPPA	Solomon Islands Planned parenthood Association
SIRC	Solomon Islands Red Cross
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WV	World Vision