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

RESIDENT/HUMANITARIAN COORDINATOR	**Mr. Eugene Owusu**

REPORTING PROCESS AND CONSULTATION SUMMARY

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

The after action review was conducted through two different meetings. The first one, held on 8 April 2015, focused on organizing the in-country reporting process and providing guidance on how inputs from CERF recipient agencies would be collected with the support of OCHA. The following organizations participated in that initial meeting: International Organization for Migration (IOM), World Food Program (WFP), United Nations Population Fund (UNFPA), United Nations International Children's Emergency Fund (UNICEF) and United Nations Office for Coordination of Humanitarian Affairs (OCHA) (Humanitarian Financing Unit on behalf of the HC's office).

After the dissemination of the draft report, a second meeting was held, on 1 June 2015, to discuss additional inputs from CERF recipient agencies and agree on lessons learned, challenges encountered during implementation and recommendations on how to improve implementation and reporting processes for future CERF grants. The meeting was attended by IOM, WFP and OCHA (Humanitarian Financing Unit on behalf of HC's office).UNICEF, UNFPA and WHO sent inputs by email as they could not attend due to another urgent meeting held the same day to discuss the cholera outbreak.

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 ☐

The report has been reviewed and contributed to by the relevant cluster coordinators/co-coordinators. It has not been formally tabled at an HCT or UNCT meeting though this will be considered for the future, possibly in conjunction with a discussion of other CERF allocations which are also to be reported on shortly (CERF grants received in June 2014).

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 ☐

Recipient agencies and cluster representatives have been involved throughout the reporting process as noted above, reviewing successive drafts. The final report, once cleared by the CERF Secretariat, will be circulated to agencies, clusters and partners. Consideration is being given to appropriate ways to share the report with government counterparts in view of the current operating context.

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: 147,207,498		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	14,933,150
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*)	13,590,944
	OTHER (bilateral/multilateral)	70,158,542
	TOTAL	**98,682,636**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 28-Mar-14			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	14-RR-CEF-071	Health	1,512,197
UNICEF	14-RR-CEF-072	Health-Nutrition	1,844,621
UNFPA	14-RR-FPA-021	Health	887,790
IOM	14-RR-IOM-026	Camp Management	6,644,297
WFP	14-RR-WFP-032	Health-Nutrition	750,445
WHO	14-RR-WHO-031	Health	3,293,800
TOTAL			**14,933,150**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies / IOM implementation	11,887,283
Funds forwarded to NGOs for implementation	2,824,587
Funds forwarded to government partners	221,280
TOTAL	**14,933,150**

HUMANITARIAN NEEDS

The humanitarian crisis that prompted the CERF allocations resulted from the outbreak of hostilities between different elements of the South Sudan armed forces that started in Juba on the evening of 15 December 2013 and quickly spread across the country, affecting most of the country's ten states. In February 2014, the ERC activated an IASC System-Wide Level 3 ('L3') Emergency Response for South Sudan.

The humanitarian situation continued to worsen in the first quarter of 2014 and was characterized by pervasive conflict, violence and insecurity; and the threat of widespread hunger. The number of people displaced by the end of March 2014 reached some 928,000, more than double the planning figure of 400,000 at the start of the crisis (and at the time of the previous CERF allocations in January 2014). Of these, some 708,900 were displaced within South Sudan, including some 77,000 who had sought refuge in eight UN bases, referred to as Protection of Civilians (PoC) sites, and 220,000 who had fled to neighboring countries.

Violence, looting and destruction were widespread. The violence caused extensive infrastructure damage and near complete destruction of livelihoods in the three states of Jonglei, Unity and Upper Nile. Health centers were looted or destroyed and there were no health workers to provide the necessary services. Medical and nutritional supplies were looted and health care workers displaced. There were major disruptions in the supply chain management system for essential medicines and medical supplies.

The situation exacerbated the health status of the children of South Sudan, which was extremely poor even prior to the crisis with only 45% of children less than 23 months having been vaccinated against measles and only 34% of them fully vaccinated (EPI coverage survey 2011/2012). Measles outbreaks were reported in many locations. Nutritional status also worsened.

While the challenges remained serious, the CERF application reflected a need for additional resources to support most critical and urgent operations within the available space. Funds were needed for prioritized and viable response activities to assist affected people who were within reach. The urgency of the need for further resources was exacerbated by seasonal issues. The imminent onset of rains in April presented further complexity, with a limited window of opportunity to improve displaced persons sites, and to pre-position supplies in the interior of the country for use during the rainy season which typically runs for 8 – 9 months, from April to mid-November. During the rainy season, many of the country's roads become impassable and the cost of pre-positioning by air becomes exorbitant. At the time of the CERF application, aid agencies had reached around 925,700 of the 3.2 million people to be assisted by June under the Crisis Response Plan (CRP) that had been revised and updated in February.

At the end of the project implementation period (January 2015) the total number of IDPs stood at 1,504,768 spread across 185 locations. Some 186,493 of these IDPs were living in eight PoC sites. An estimated 236,922 people in 21 host community locations were in need of assistance. Though the aid response to civilians had been significantly scaled up, conditions remain dire for the displaced population - even for those living in the PoC sites in UNMISS bases. While many IDPs were able to construct basic shelters with available materials, many still had little or no access to shelter. Furthermore, due to poor sanitation, over-crowding and limited supplies of clean water, a considerable risk of disease outbreaks remained. Water and sanitation services still fell well short of SPHERE standards in many locations, including Awerial County, Bentiu, Bor and Malakal. More generally, there was still an urgent need for improved site management to enhance security and safety, reduce tensions between displaced communities, improve public health and maximize the coverage and impact of critical services, such as healthcare, psychosocial support and sanitation.

II. FOCUS AREAS AND PRIORITIZATION

This CERF allocation aimed to cover the most critical and urgent gaps in the Camp Coordination and Camp Management, Health and Nutrition clusters to assist 345,000 people across seven states - Central Equatoria, Eastern Equatoria, Lakes, Jonglei, Unity, Upper Nile and Warrap.

The **CCCM Cluster** aimed to provide infrastructure and facilities in PoC sites and other settlements to reach around 200,000 people. This included humanitarian hubs in PoC sites from which aid agencies could operate. Initial planning for PoC sites had been based on a scenario in which the numbers of occupants would reduce gradually, with people staying for a relatively short period before returning home. However, the escalating and protracted crisis across the country led to people continuing to stay, with no indication that they were willing or able to return to their homes due to insecurity and the fact that the root causes of the displacement and protection concerns were yet to be addressed. On 26 February 2014 the HCT decided to prioritize the improvement of the conditions in PoC sites (in Bentiu, Bor, Juba, and Malakal) as the most feasible option in the medium term. Some early storms, ahead of the full onset of rains, exacerbated

conditions in the PoC sites with flooding, destruction of individual shelters and sanitation facilities, and associated increased risks of morbidity, mortality and violence. The storms also further shortened the period within with substantial, tangible improvements in conditions at the sites needed to be accomplished. There were increasing public health concerns. In Juba, work was ongoing to transfer some families whose shelters had been flooded or destroyed from UN Tomping to UN House, in parallel to the preparation of an additional site at the UN House. Improvements to sites in Bor and Malakal had also begun.

The **Health Cluster** aimed to provide 330,000 people (IDPs and other vulnerable groups) with life-saving primary and secondary health care, including immunization, surgery, and services for reproductive health and gender-based violence. The health cluster targeted the crisis affected states of Jonglei, Unity and Upper Nile, where disruption of health services was most significant, as well as the indirectly affected states of Central Equatoria, Lakes and Warrap, where many IDPs had arrived from crisis affected areas. The main priorities included: strengthening primary health care services to handle common morbidities; restoring the functionality of secondary health care in Jonglei, Unity and Upper Nile states; ensuring surgical capacity to manage the increasing number trauma cases and referrals for the critically wounded; undertaking vaccination campaigns to curtail spread of communicable diseases including measles and polio; procuring vaccines and supporting the cold chain; delivering medical supplies; and providing reproductive health interventions, including emergency obstetrical care and commodities for safe deliveries. All these were in line with the three strategic objectives guiding the health cluster response, to: provide emergency primary health care services for vulnerable people with limited or no access to health services; provide emergency response capacity for surgeries, including emergency obstetric care; and respond to health-related emergencies, including controlling the spread of communicable diseases, reproductive health care and medical services to survivors of gender-based violence, including mainstreaming of gender and protection. Health assessments carried out in some counties in Jonglei, Unity, and Upper Nile States indicated that health facilities were either destroyed or looted and there were no health workers to provide services. In addition there was little access to safe drinking water, poor hygiene and sanitation, and food insecurity resulting in poor nutrition status. These factors put displaced people at higher risk of disease outbreaks especially with the overcrowded conditions in the IDP sites.

The **Nutrition Cluster** aimed to prevent excess malnutrition related deaths among most vulnerable populations by targeting 80,000 children with therapeutic interventions, supplementary feeding programs, and vitamin supplementation. In line with the significant increase in the scale of unrest and displacement, projections indicated an increase in the number of cases of severe acute malnutrition and moderate acute malnutrition. At the time of this CERF application, the nutrition situation had deteriorated as demonstrated by MUAC screenings in the PoC sites and other locations. Assessments conducted in Eastern Equatoria, Jonglei and Warrap states indicated poor nutritional status with MUAC based SAM rates reaching up to 35.5%. In Awerial and Mingkaman (both in Lakes state), Panyjar (in Unity State) and Nassir (in Upper Nile State) more than 50% of the children screened were found to be malnourished. It was projected that the nutritional situation would further deteriorate due to severe food insecurity, especially in the population outside the PoC sites. In view of the high numbers of children that had been identified at risk of malnutrition, immediate response with nutrition services was deemed essential with continued surveillance activities to ensure timely response. The priority focus for use of the CERF resources was to ensure adequate coverage of nutrition services with an emphasis on increasing active case finding, strengthening referral mechanisms and the treatment of severe acute malnutrition. The target population was children between 6 and 59 months of age.

III. CERF PROCESS

South Sudan has strong humanitarian leadership and a well-established coordination architecture which enabled the HC, HCT and partners to react quickly to the outbreak of conflict and the ensuing needs. Following the onset of the crisis in December 2013 the HCT met three times every week, while the ICWG met twice. Additional platforms, including dedicated cluster meetings, pipeline management meetings and donor meetings further consolidated collective strategy and coordinated operations.

Following the activation of the IASC L3 Emergency Response on 11 February 2014, discussions were held with the HCT and ICWG to identify the most urgent needs and gaps across the clusters. After several meetings of the HCT and ICWG over a two week period, as well as one session with Heads of Cluster Lead Agencies, a list of prioritized, urgent funding requirements across eight clusters totaling some US$ 77 million was formulated. The HC and HCT deliberated on most urgent and immediate requirements as articulated by all clusters and across all sectors. The choices made for the CERF request also took into account additional pledges to the Common Humanitarian Fund (CHF) which triggered a new CHF Reserve allocation of US$20m, to optimize complementarity and overall effect of the two pooled funds.

To prepare this CERF application, clusters went through an iterative process of prioritization and re-prioritization with their respective partners in order to reach consensus around the most urgent, important and viable interventions with the potential for greatest impact on the population at risk. This included dialogue and planning between UN agencies and NGO partners. NGO participation was limited to

those with most capability and reach at the time, to ensure that the available resources were concentrated in defined impact areas for maximum effect. IOM, UNFPA, UNICEF, WHO and WFP led the detailed design, planning and implementation of the different initiatives within the respective clusters.

The **CCCM Cluster** prioritized activities through assessments and reports from the field, and through consultations with the humanitarian and beneficiary communities. Needs and gaps were identified through coordination with partners, and findings presented in cluster meetings. Based on these, the cluster identified priority locations and activities to be carried out. Coordination with other clusters and harmonization of the cluster strategy was carried out through the ICWG.

The **Health Cluster** held consultations within its "strategic advisory group" to agree on priority geographical areas and activities to address acute needs and based on the CERF lifesaving criteria. The group and implementing partners agreed on the key indicators for monitoring of the response. Technical officers from the three eligible UN agencies discussed and agreed on the specific tasks for each. Complementarities with allocations through the CHF and other emergency funds were discussed to ensure non duplication of efforts.

The **Nutrition Cluster** developed a common approach to address MAM and SAM in the 31 counties of the three most conflict affected states, leveraging WFP and UNICEF's respective logistical and technical expertise coupled with strong coordination with partners on the ground. The two UN agencies linked their MAM and SAM responses by using the same partner in any given location, wherever possible.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR				
Total number of individuals affected by the crisis: 1,504,768[1]				
The estimated total number of individuals directly supported through CERF funding by cluster/sector	**Cluster/Sector**	**Female**	**Male**	**Total**
	Health	192,420	177,580	370,000
	Health-Nutrition	58,718	58,216	116,934
	Camp Coordination and Camp Management	117,603	108,556	226,159

BENEFICIARY ESTIMATION

Through this CERF allocation recipient agencies reached some 427,800 direct beneficiaries and also supported humanitarian partners operating from the humanitarian hubs in PoC sites.

In estimating the number of beneficiaries, efforts were made to avoid any significant double-counting. Three differentiating bases were applied to reach a realistic estimate of beneficiaries: (1) by specific location of response (PoC sites and outside of PoC sites), (2) by number of children under five years, and (3) by type of activities (activities under each specific cluster supported under this CERF allocation). Differentiating by specific location of response, each recipient UN agency was requested to provide details of beneficiaries reached in and outside of PoC sites broken down by state and county. This enabled identification of overlapping and non-overlapping response by settlement type (in or outside of PoC sites) and geographic locations (state and county).

PoC sites and the IDP settlement in Mingkaman were the main overlapping response locations. Knowing that the CCCM component covered only PoC sites, the 226,159 beneficiaries reached through the CCCM cluster were counted as unique beneficiaries in the PoC sites and in Mingkaman. These beneficiaries also received health and nutrition services and were discounted when computing beneficiaries of health and nutrition services.

[1] At the time of submiting the CERF application in end of March 2014, the number of people displaced was 928,900. By December 2014, over 1,504,768 had been displaced.

For health, beneficiaries in overlapping response locations, particularly in the PoC sites in Bentiu, Bor, Juba, and Malakal and in Mingkaman, were discounted. Unique beneficiaries in non-POC sites were determined by summing up the estimated non-overlapping number of beneficiaries reached with UNFPA, UNICEF and WHO health components. This resulted in a number of unique beneficiaries reached through health activities in non-POC sites of 144,741.

An estimated 56,900 children under five years reached with nutrition activities by UNICEF and WFP in non-POC sites were considered as non-overlapping and counted as unique beneficiaries.

226,159 beneficiaries of CCCM activities in POC sites and the Mingkaman IDP settlement, 144,741 unique beneficiaries of health activities outside of POC sites, and 56,900 children under five benefitting from nutrition interventions outside of POC sites were added to provide the total number of beneficiaries reached.

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING

	Planned	Estimated Reached
Female	179,400	222,460
Male	165,600	205,340
Total individuals (Female and male)	345,000	427,800
Of total, children under age 5	103,500	116,934

CERF RESULTS

Through this CERF allocation recipient agencies reached about 427,800 direct beneficiaries with shelter services in camps; treatment of malnutrition, common ailments and gunshot wounds; vaccination against polio, measles and cholera; and reproductive health services. Collectively the planned targets of beneficiaries and of activity outputs were achieved, with the key results as follows:

Camp Coordination and Camp Management: The living conditions of about 226,000 people in camp settings were improved. This was done through expansion of the existing PoC sites in Juba UN-House (PoC1 and PoC2), Bentiu, Bor and Malakal. In Juba, IDPs were relocated from Juba Tongping PoC site to a new site in Juba UN-House (PoC3). Facilities and services such as education, water, sanitation, and health were upgraded and enhanced across PoC sites and the IDP settlement in Mingkaman. Biometric registration of IDPs was conducted in all PoC sites except Bentiu. Camp committees were established in 33 sites across the five states of Central Equatoria, Lakes, Jonglei, Unity, and Upper Nile. CCCM interventions reached key locations in 37 counties across these states.

Nutrition: Slightly over 116,900 children under five years benefited from nutrition services. Some 81,434 children were screened and 9,462 of them found suffering from severe acute malnutrition were treated. 213 metric tons of Supercereal Plus were distributed, sufficient to provide 35,500 children with supplementary food for one month. The actual results for treatment of malnutrition were higher than the planned targets due to the consolidation of UNICEF's staffing capacity in Jonglei, Unity and Upper Nile states. The provision of guidance and technical support to partners on ground was strengthened, as was the screening and treatment of malnourished children through the rapid response mechanism (RRM) in collaboration with WFP and partners in hard to reach locations. Three partners – two INGOs (ACF, Plan International) and one NNGO (UNIDO) received funds for expansion of their programs under the technical guidance of UNICEF.

Health: Almost 370,000 people benefitted from health services. Some 251,084 children below 15 years were vaccinated against polio; 241,526 children aged between 6 months and 15 years were vaccinated against measles; 97,638 children aged 6 to 59 months received vitamin A supplementation; and 87,360 children aged 12 to 59 months received deworming medication. Some 250,000 women, girls, boys and men were reached with critical reproductive health services, including services for the prevention and the management of the consequences of gender based violence and for HIV prevention. Some 98,776 IDPs received treatment for common illness, both in treatment centers and through mobile clinics. Mortality rates were maintained below the emergency threshold in all camps. A total of 1,157 casualties from gunshot wounds were successfully managed including through life-saving surgery, and 105 medical evacuations

were carried out. Life-saving drugs and medical supplies sufficient for 148,100 consultations over a period of six months were provided to health cluster partners.

CERF's ADDED VALUE

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

CCCM: CERF funding enabled IOM to quickly adapt to the displacement situation and implement life-saving activities to improve access to services for the displaced population, and enabled the CCCM cluster to operate at the level needed to respond to critical gaps. Camp Management structures and activities were immediately expanded through grants to partners for the implementation of CCCM activities in prioritized locations. The CERF allocation also enabled IOM to immediately scale up site expansion activities and hub improvements that resulted in improved living conditions and better access to services for IDPs in sites hosting the largest populations.

Nutrition: CERF funding supported the scaling up of nutrition programs in the states affected by the conflict, enabled UNICEF to procure supplies and strengthened its technical capacity building support. The availability of UNICEF nutrition staff (funded both by CERF and other donors) enabled closer accompaniment of partners, including training and monitoring which are needed for fast scaling up. CERF funding was confirmed in April 2014 and deliveries of supplies began in June 2014. This lead time is typical for South Sudan which is land-locked and has few roads, particularly for nutrition products procured from Europe. Because of shorter shelf lives, nutrition products are typically not held in WFP's Forward Purchasing Facilities. Supercereal Plus purchased using CERF funds allowed WFP to reach IDPs both within and outside of PoC sites.

Health: CERF funding was critical in meeting the urgent funding gaps for the procurement of cold chain equipment to replace equipment vandalized during the conflict. By re-establishing the cold chain system in the conflict affected states delivery of immunization services was made possible. CERF funding also enabled UNFPA to quickly procure and distribute the necessary supplies to scale up the response, and to quickly deploy staff to critical locations. CERF funding strengthened the emergency health response capacity at state level by supporting the strategic and timely prepositioning and distribution of life saving supplies. Health partners and the MOH were able to obtain supplies and respond swiftly as part of WHO's efforts to improve accessibility of basic life-saving services for vulnerable groups. This included response through mobile clinics.

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

CCCM: The immediate disbursement of CERF funding enabled rapid deployment of staff and resources to facilitate and continue the implementation of CCCM activities.

Nutrition: CERF funding enabled UNICEF to respond to time critical needs through the implementation of emergency vaccination campaigns among IDP and host populations, and to scale up nutrition activities in 31 priority counties. Additionally, due to intermittent access in the conflict affected states because of insecurity, multi-sectoral teams were deployed through the Rapid Response Mechanism (RRM) when access permitted, to conduct integrated vaccination campaigns and undertake emergency nutrition interventions in remote and hard to reach locations. The Emergency Operation under which WFP operated its blanket supplementary feeding program was officially launched in January 2014 and this CERF funding contributed to the WFP/UNICEF nutrition scale-up from July 2014.

Health: The availability of CERF funding alleviated suffering and prevented mortality in cases where death would have been imminent without intervention. For example, the 230 pregnant women that obtained an emergency caesarean section were likely to have died if this service was not available. The funding also enabled health actors to mitigate the risk of measles and cholera outbreaks by initiating and supporting emergency vaccinations in IDP settlements. The funds improved the availability of essential medical drugs and other emergency supplies in four referral hospitals and the primary state level health care facilities. Rapid deployment of epidemiologists and technical officers to the field was critical in saving lives, and the funding was instrumental in ensuring evacuation for people with gunshot wounds.

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

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

The CERF funding enabled IOM to support CCCM partners to either start up CCCM programs or to bridge gaps in funding from other sources in order to continue activities. In this way breaks in service provision were avoided. Moreover, through the approval of the no-cost extension (NCE), IOM was able to extend the project duration and utilize resources as co-funding for the further expansion of the Malakal PoC site. DFID had expressed interest in supporting the expansion but could not provide the full amount of resources needed. CERF funding was used to fill the gaps that could not be addressed by DFID funds. IOM's ability to demonstrate the availability of co-funding for the site expansion was essential for securing the DFID grant.

The CERF funding enabled UNFPA to make available emergency reproductive health kits to partners, and to support scale up of human and other resources for partner organizations. It also enabled UNFPA to allocate more internal resources to support the project and scale up its response.

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

Implementation of the CERF-funded activities required effective coordination between humanitarian actors in the conflict affected areas in order to achieve planned targets.

CERF funding:

- Allowed IOM to continue the coordinator role of the CCCM Cluster which enabled agencies and NGOs to effectively coordinate response in IDP sites. IOM recently undertook an evaluation of its coordination role within the cluster system between January and early October 2014.
- Prompted UNFPA to strengthen the coordination of the RH working group of the health cluster to ensure adequate scale and quality of RH services.
- Supported and strengthened the various coordination forums and health coordination mechanisms at central and state level. The availability of the core pipeline supplies enhanced coordination in terms of filling in critical gaps in the response of the health needs in the affected populations.

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

The funds received from the CERF enabled the enhancement and expansion of CCCM structures in IDP sites to facilitate access to services and improve living conditions for the IDP populations. The CCCM cluster led site developments to decongest overcrowding, and promoted improved protection and health.

The funds also contributed to the upgrading and continued operation of humanitarian hubs, essential to the overall response. While identified by the humanitarian community as a priority, at the time of this CERF allocation no other donor had expressed willingness to support the initiative. The CERF ensured that the humanitarian hubs remained operational, making available working and living space for humanitarian workers providing life-saving services in priority geographic locations.

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible**
Given the fluid security situation, UNICEF had to switch to a direct implementation model which required robust human resource capacity. While recognizing the guidelines that CERF has in regards to the proportion of funding that can be provided towards human resources, the reality on the ground may require a more flexible and context specific approach	CERF criteria can be more flexible regarding the proportion of human resource costs that can be included in budgets, in order to support implementing agencies facing many challenges linked to the country context, and where rapid response capacity is urgently required.	CERF Secretariat

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible**
The CERF funding received in April 2014 contributed to fortifying the CCCM cluster and mobilizing more funding sources for operations in PoC sites. CCCM cluster implementing partners would not have been able to maintain their operations without it.	Given that CERF Rapid Response funds are not predictable funding sources, CCCM partners with the support of the HCT should be encouraged to mobilize and fundraise outside of the CERF to continue addressing humanitarian needs within the PoC sites.	CCCM cluster partners with the support of HCT
There is a need for greater consultation about the programmatic priorities and planned activities during the planning stage.	Comprehensive inter-agency discussions about the programmatic priorities and interventions at the planning stage would help reduce the level of back and forth between OCHA and the CERF Secretariat and avoid multiple rounds of queries.	WHO, UNICEF, WFP, OCHA
Clear roles and commitments need to be defined between UNMISS and humanitarian partners when working inside UNMISS bases.	Clear definition of roles and responsibilities need to be agreed on and stakeholders should be held accountable in the event that responsibilities are not met.	UNMISS and ICWG.
Nutrition scale-up has not reached the level projected, particularly because of limited partner capacity.	WFP has already added additional nutritionists to its own operation to help cover the gap. However additional training for cooperating partners is necessary to ensure greater coverage is possible.	WFP
Prioritisation of activities at the cluster level helped to expedite the process of allocation and proposal submission	The HCT should continue to encourage prioritisation to take place at the cluster level	HCT

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	UNICEF	5. CERF grant period:	01.04.2014 – 30.09.14
2. CERF project code:	14-RR-CEF-071	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Vaccine preventable disease control through supplementary immunizations and outbreak response interventions		

7.Funding				
	a. Total project budget:	US$ 19,599,050	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 6,703,041	▪ *NGO partners and Red Cross/Crescent:*	US$ 64,813
	c. Amount received from CERF:	US$ 1,512,197	▪ *Government Partners:*	US$ 221,480

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	122,200	130,578	The total numbers reached were slightly higher but broadly in line with planned targets.
b. Male	112,800	121,226	
c. Total individuals (female + male):	235,000	251,804	
d. Of total, children under age 5	105,000	107,916	

9. Original project objective from approved CERF proposal

Contribute to the reduction of morbidity and mortality through the provision of rapid response and life-saving immunization services to vulnerable crisis-affected children (<15)

10. Original expected outcomes from approved CERF proposal

To vaccinate at least 235,000 vulnerable children under fifteen years against measles and polio through immunization campaigns

- Thirty integrated immunization campaigns carried out
- 235,000 children below 15 years vaccinated against polio.
- 225,000 children 6 months to 15 years vaccinated against measles.
- 95,000 children 6 – 59 months received vitamin A supplements.
- 85,000 children 12-59 months received deworming medication.
- # of RRT formed and deployed for critical immunization services
- # of vaccination campaigns carried out
- # of vaccines injection safety materials, procured and distributed
- # of Implementing partners receiving supplies from the pipeline

11. Actual outcomes achieved with CERF funds	
- 241,526 children 6 months to 15 years were vaccinated against measles. - 251,804 children below 15 years were vaccinated against polio - 97,638 children aged 6 – 59 months received vitamin A supplements. - 87,360 children aged 12-59 months received deworming medication. - 24 RRT formed and deployed for critical immunization services - 30 integrated vaccination campaigns carried out	
12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:	
The total numbers reached were slightly higher but broadly in line with planned targets.	
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):** Please describe how gender equality is mainstreamed in project design and implementation	
14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
No specific evaluation of the project has been undertaken although UNICEF undertakes evaluations of its programs on an ongoing basis as part of its general operating practices.	EVALUATION PENDING ☐ NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	5. CERF grant period:	11.04.14 – 10.10.14
2. CERF project code:	14-RR-CEF-072	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health-Nutrition		☒ Concluded
4. Project title:	Support to Nutrition Pipeline for Emergency Therapeutic Responses in South Sudan		

7.Funding				
	a. Total project budget:	US$ 43,700,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 29,340,450	▪ *NGO partners and Red Cross/Crescent:*	US$ 720,000
	c. Amount received from CERF:	US$ 1,844,621	▪ *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	35,788	39,903	The total numbers reached were slightly higher but broadly in line with planned targets.
b. Male	34,212	41,531	
c. Total individuals (female + male):	70,000	81,434	
d. Of total, children under age 5	70,000	81,434	

9. Original project objective from approved CERF proposal

To prevent excess mortality and morbidity associated with malnutrition among vulnerable populations including children (boys and girls)

10. Original expected outcomes from approved CERF proposal

Result	**Indicators**	**Target**
Children 6-59 months old are screened for acute malnutrition in targeted counties	• Number of children 6-59 months old screened	70,000 children below five years
Severely malnourished children below 5 years old have access to treatment in targeted areas	• Number and % targeted children 6-59 months with Severe Acute Malnutrition admitted to therapeutic care • % of severely malnourished children 6-59 months years admitted recovered.	8,800 >=75% recovery rate <10% death rate
Essential supplies available for use by the implementing	• Proportion of partners reporting no stock outs for therapeutic supplies (RUTF, F75, F100, Resomal)	100%[3]

[3] *The grant initially targeted four partners, subject to change based on the situation and mapping of additional needs.*

partners		

11. Actual outcomes achieved with CERF funds

- Against the target of 70,000 children, 81,434 aged between 6-59 months were screened for malnutrition
- 9,462 children below five (4,826 boys and 4,636 girls) with SAM were admitted to therapeutic care
- 80% of the admitted children with SAM recovered (above the Sphere Standard of 75%)
- The death rate for severly malnourished children stood at 2.93% (131 children)
- No partners reported stock outs for therapeutic supplies.

From the CERF funding, UNICEF was able to procure 9,000 cartons of RUTF, which was used in the treatment of children with SAM. Despite the conflict and access related issues, UNICEF and its partners were able to reach more beneficiaries than initially targeted. The presence of UNICEF staff on the ground in Jonglei, Unity and Upper Nile was instrumental in ensuring that partners could receive the guidance and necessary technical support to scale up interventions. UNICEF reached targeted children both through partners and through direct implementation using the RRM in areas where NGOs are unable to access due to insecurity.

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

The total numbers reached were slightly higher but broadly in line with planned targets.

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): Please describe how gender equality is mainstreamed in project design and implementation

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
No specific evaluation of the project has been undertaken although UNICEF undertakes evaluations of its programs on an ongoing basis as part of its general operating practices.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	WFP	5. CERF grant period:	11.04.2014 – 10.10.2014
2. CERF project code:	14-RR-WFP-032	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health-Nutrition		☒ Concluded
4. Project title:	Food assistance for Treatment and Prevention of Under nutrition in children aged less than 5 years and pregnant and lactating women		

7.Funding				
	a. Total project budget:	US$ 554,283,860	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 448,443,054	▪ *NGO partners and Red Cross/Crescent:*	US$ *28,241*
	c. Amount received from CERF:	US$ 750,445	▪ *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	18,624	18,815	There is no significant discrepancy between planned and reached numbers of beneficiaries.
b. Male	17,192	16,685	
c. Total individuals (female + male):	35,816	35,500	
d. Of total, children under age 5	35,816	35,500	

9. Original project objective from approved CERF proposal

To reduce risk of morbidity, severe acute malnutrition and death of children aged 6-59 months through the provision of blanket supplementary feeding to children in 'hot-spot' conflict affected areas in South Sudan

10. Original expected outcomes from approved CERF proposal

35,816 children (6-59 months) provided with supplementary food for one month

% of eligible children participating in the BSFP (target: >=70%)

% of targeted children who participate in an adequate number of distributions (target: 66%).

11. Actual outcomes achieved with CERF funds

Some 213 metric tons of Supercereal Plus were distributed, enough to provide 35,500 children (6-59 months) with supplementary food for one month.

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

No significant discrepancy between planned and actual

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): *1* **If 'NO' (or if GM score is 1 or 0):** Gender equality is mainstreamed through various channels in its Emergency Operation. However this nutrition activity very specifically targets one age group – children under 5. Both male and female children are targeted equally.	
14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☒
The July/August Food Security and Monitoring System report was released in October, with data collected from all ten states. The report showed an improvement in food security across the country according to seasonal trends, which was expected to continue through December 2014 in areas not affected by conflict. Levels of acute malnutrition remain critical in most conflict-affected areas. The FSMS nutrition findings show acute malnutrition at critical levels even in areas outside the conflict. Recent levels of severe acute malnutrition exceed historical norms.	EVALUATION PENDING ☐ NO EVALUATION PLANNED ☐

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNFPA	5. CERF grant period:	01.04.14 – 30.09.14
2. CERF project code:	14-RR-FPA-021	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Implementing the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) including HIV and GBV for increased caseload of displaced people in South Sudan		

7.Funding				
	a. Total project budget:	US$ 5,484,195	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 4,041,790	▪ *NGO partners and Red Cross/Crescent:*	US$ 0
	c. Amount received from CERF:	US$ 887,790	▪ *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	125,000	130,000	During this period, UNFPA has intensified its community mobilization to increase uptake and utilization of services. A majority of beneficiaries have been reached through increased GBV messaging and HIV prevention activities at the community level. Utilization of facility based services has also improved during this period.
b. Male	100,000	120,000	
c. Total individuals (female + male):	225,000	250,000	
d. Of total, children under age 5	n/a	n/a	

9. Original project objective from approved CERF proposal

To re-establish access to Reproductive Health services including GBV and HIV prevention services and information among IDPs to prevent excess maternal and newborn morbidity and mortality, in, Bentiu, Bor, Juba, Kwajok, Malakal and Mingkaman.

10. Original expected outcomes from approved CERF proposal

Outcomes/outputs

- Increased access to maternal health services
- Increased access to clinical management of rape survivors and GBV services
- Increased HIV prevention services and information
- Strengthened referral systems between health facilities for RH services

Key Indicators

- Number of dignity and RH kits procured (Target 313)
- Number of health workers trained (CMR, MISP, the rational use of kits, and community counselling – broken down by gender) (Target 90 participants)
- Number of pregnant women attending antenatal care at least once during a pregnancy (Target 6,250)
- Number of births assisted by skilled attendants (Target 5,000)
- Number of caesarean sections conducted (Target 250)
- Number of people treated for STI (Target 12,500, broken down by gender)

- Number of vaginal tears repaired (Target 750)
- Number of young people engaged in community mobilization and awareness activities (Target 200, broken down by gender)
- Number of condoms distributed (Target 918,000 pieces)

11. Actual outcomes achieved with CERF funds

Increased access to maternal health services.

1. UNFPA procured 315 assorted RH kits and distributed to health partners in Awerial, Bentiu , Bor, Kwajok and Malakal.
2. 7000 pregnant women were provided with ANC services in the various partners' clinics serving affected populations.
3. 12,000 pregnant women were given clean delivery kits;
4. 3050 deliveries out of the targeted 5000 were conducted by skilled birth attendants
5. 800 vaginal tears were successfully repaired
6. 232 Caesarean sections were conducted with this support

Increased access to clinical management of rape survivors and GBV services

7. UNFPA trained 100 (70 men and 30 women) frontline health workers on various RH topics including MISP, CMR, Rational use of RH kits. The trainings have been in Malakal, and Melut and Mingkaman. These health workers are now directly involved in the delivery of RH services in the various clinics in the affected areas.
8. UNFPA procured and distributed 2000 dignity kits to women and girls in Bor, Malakal and Mingkaman.

Increased HIV prevention services and information

9. 13,000 (5000 males and 8000 females) young people were reached with treatment, counselling and awareness activities on STIs and HIV. Over 870,000 male condoms and 6000 female condoms were distributed to sexually active person in the affected locations.
10. UNFPA identified and trained 200(90 males and 110 females) young people to conduct community mobilization and raise awareness in Bor and Mingkaman.

Strengthened referral systems between health facilities for RH services

11. 1500 pregnant women in need of services were referred to different levels of service outlets

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

The target for the indicator on number of dignity and RH kits procured is focused on RH kits and does not include the number of dignity kits. Therefore the reporting for both has been separated in the outcomes above. 2,000 dignity kits were procured and distributed under this grant.

Delivery at health clinics with supervision of a skilled birth attendant remained low, with only 3,050 reached out of the targeted 5,000. With continued community outreach and confidence building, more mothers will continue to choose to deliver in clinics with support of a skilled birth attendant.

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): Project was designed to ensure it meets the needs of vulnerable women, girls, boys and men. Whereas the project was largely focused on ensuring availability of supplies to provide services to the different groups, one of it is key premise is that the conflict has affected different gender differently and therefore service provision has to ensure all the concerns of the different gender are included in the project implementation. The community mobilization aspect of this project was particularly intended to ensure that nobody is left out.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
All the project resources were directed to meet the needs of those affected. No resources were allocated to evaluation, which was likely to be expensive, considering the conditions in which the project was delivered. This 6 months CERF is contributing to a large effort to save lives in South Sudan as part of the overall UNFPA Humanitarian response Plan which will be peer reviewed in mid to late 2015.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	IOM	5. CERF grant period:	10.04.2014 – 09.01.2015
2. CERF project code:	14-RR-IOM-026	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Camp Management		☒ Concluded
4. Project title:	Providing lifesaving interventions to IDPs in camps and camp like settlements through CCCM interventions		

7.Funding				
	a. Total project budget:	US$ 23,031,332	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 26,061,992	▪ *NGO partners and Red Cross/Crescent:*	US$ 2,011,533
	c. Amount received from CERF:	US$ 6,644,297	▪ *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	110,520	117,603	Displacement patterns remained highly fluid throughout project implementation. The increase in numbers reached may be due to the constant changes in numbers of IDPs entering and exiting locations as on-going insecurities leave individuals and families vulnerable.
b. Male	89,480	108,556	
c. Total individuals (female + male):	200,000	226,159	
d. Of total, children under age 5	40,880	45,231	

9. Original project objective from approved CERF proposal

To ensure the efficient and immediate delivery of multi-sectoral, life-saving response in camp-like settings, through the CCCM Cluster and its partners.

10. Original expected outcomes from approved CERF proposal

Outcome 1: CCCM structures are established/ remain in place at the county level in order to respond to rapidly changing needs of the displaced population.

Indicators:

- Number of partners receiving funding from rapid response funding mechanisms in a timely manner to carry out CCCM activities at the county level. (Target: seven partners)
- Number of counties with camp management teams in place at the county level with regular multi-sector services reporting and monitoring to an agreed reporting cycle (Target: 25 counties)
- Number of sites with representative camp committees in place and functional at the site level (Target: 100% of accessible sites in counties with CCCM partners)
- Number of sites where sector-specific needs are identified, information shared, and response coordinated through CCCM partners.

Outcome 2: UNMISS PoC sites and the Mingkaman spontaneous IDP settlement site are improved and expanded to alleviate over-congestion issues and reduce the risk of severe health and sanitation problems, as well as violence and unrest, during the rainy season

Indicators:

- Number of existing sites with site improvement works carried out. (Target: four existing sites)
- Number of new sites / expansions areas developed and accommodating IDPs. (Target: four new sites/expansion areas)
- Number of new sites / expansions areas developed and accommodating IDPs. (Target: four new sites/expansion areas)
- Number of existing and new sites where sector-established standards have improved (sectors include: Health, WASH) (Target: four sites)

Outcome 3: Emergency life-saving interventions of the wider humanitarian community are supported, through the running and improvement of humanitarian hubs in Malakal, Bentiu and Bor.

Indicators:

- Number of humanitarian hubs operational in Bentiu, Bor and Malakal (Target: three hubs)
- Number of humanitarian hubs improved in Bentiu, Bor and Malakal (Target: three hubs)
- Number of humanitarian workers provided with a common humanitarian workspace. (Target: 250 humanitarian workers)

11. Actual outcomes achieved with CERF funds

The CERF allocation to IOM helped provide services to 226,159 individuals, of which 117,603 were women (52%)

Outcome 1: CCCM structures are established/ remain in place at the county level in order to respond to rapidly changing needs of the displaced population.

- Four partners received grants through this project to carry out CCCM activities in four counties, supporting 226,159 beneficiaries. Grants were given to: ACTED, Danish Refugee Council (DRC), Internews, and People in Need (PIN).
- Regular updates from 25 counties are provided to the CCCM cluster team at the national level.
- 33 sites have recognized camp committees supported by INGOs/NGOs, government entities or religious groups, 60% of available sites.
- 55 displacement sites have been assessed and sector-specific needs identified, reports shared, and responses coordinated through CCCM partners.

Outcome 2: UNMISS POC sites and the Mingkaman spontaneous IDP settlement are improved and expanded to alleviate over-congestion issues and reduce the risk of severe health and sanitation problems, as well as violence and unrest, during the rainy season

- Site improvement works were carried out in existing areas in the PoC sites in Bentiu, Bor and Malakal and the spontaneous settlement in Mingkaman.
- Four expanded areas were developed in three PoC sites (Bor, Juba and Malakal) and in the spontaneous settlement in Mingkaman.
- As a result of site planning and site development in the PoC sites in Bor, Juba and Malakal and in the spontaneous settlement in Mingkaman, the living conditions of the IDP population have significantly improved. Access to services (education, health, WASH) has improved through effective site design and the construction of roads.

Outcome 3: Emergency life-saving interventions of the wider humanitarian community are supported, through the running and improvement of humanitarian hubs in Malakal, Bentiu and Bor.

- Hubs are established and functional in three locations: Bor, Bentiu and Malakal.
- Services in the three hubs were improved by upgrading facilities.
- As a result of increased demand for accommodation the hubs were expanded to host a total of up to 500 humanitarian workers. The number of humanitarian workers hosted in the three hubs during the project period was 452.

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

The number of partners receiving funding from rapid response funding mechanisms was targeted at seven. Only four partners received funds through IOM, as a result of assessments of the capabilities of partners and their potential achievements. A significantly larger number of humanitarian workers were based in the three humanitarian hubs. All other outcomes were achieved.

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): Please describe how gender equality is mainstreamed in project design and implementation

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
No evaluation is planned for this project. A large component of the project was undertaken by partners, and throughout implementation IOM undertook regular reviews to ensure that project delivery and expenditures were in line with planning and as reported by the partners.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	WHO	5. CERF grant period:	01.04.14 – 31.09.14
2. CERF project code:	14-RR-WHO-031	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Responding to health related emergencies in populations affected by the current conflict in the states of Jonglei, Upper Nile, Unity, Lakes and Central Equatorial in the Republic of South Sudan		

7.Funding				
	a. Total project budget:	$ 10,950,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	$ 2,550,000	▪ *NGO partners and Red Cross/Crescent:*	US$0
	c. Amount received from CERF:	$3,293,800	▪ *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	67,130	50,375	This was related to insecurity in some of the areas that were hosting the population, and mobility of the population in some of the areas. As part of the medical evacuation targets, it became increasingly difficult to pick persons from opposition held areas and referrals could not take place – many the potential referrals would not accept to come to Juba for treatment.
b. Male	69,870	48,400	
c. Total individuals (female + male):	137,000	98,775	
d. Of total, children under age 5	28,770	20,743	

9. Original project objective from approved CERF proposal

General Objective;

To contribute to the reduction of excess morbidity and mortality among internally displaced people and host communities affected by the current crisis, through strengthening health emergency response capacity in the states of CE, Jonglei, Lakes, Unity, Upper Nile and Warrap.

Specific Objectives

- To ensure that at least 80% of the targeted 137,000 internally displaced persons have access to primary and secondary health care services by the end of July 2014.
- To ensure that the State referral hospitals in the 6 targeted states are able to offer life-saving surgery by end of July 2014.
- To ensure 80% timeliness and completeness of early warning diseases surveillance, information management and epidemic data in the displacement areas and host communities, and facilitate timely response to 80% of all reported events.

10. Original expected outcomes from approved CERF proposal

- 80% (or 109,600) of the targeted displaced people and other vulnerable groups will receive treatment for illnesses for primary, referral and secondary care through mobile clinics or existing facilities
- 64,390 children under 15 in camps and counties with high concentration of IDPs are vaccinated against measles as a control measure of the current outbreak
- 250 health workers trained on case management, trauma management, disease surveillance, clinical management of sexual

violence and RH standards of care and others

- 80% timeliness and completeness of disease surveillance reporting and 90% of outbreak alerts / rumours investigated within 48 hours of notifications
- 1,800 conflict related injuries receive surgical services in the referral hospitals and 600 severely wounded patients benefit from medevac and referral to strategic management centers
- 137,000 conflict/violence displaced civilians Emergency supplies (5 inter-agency emergency health kits, 10 trauma, 5 diarrhea disease, HIV/TB drugs and PEP kits) strategically provided and distributed to health care service providers in the six states including the strengthening of supply chain management and improved warehouse capacity.
- 55,000 people in Malakal, Bor, and Melut receive two doses of oral cholera vaccination as a control measure of the outbreak

11. Actual outcomes achieved with CERF funds

- With support of the CERF allocation, total of 98,776 IDPs received treatment for the common illness in the treatment center and through mobile clinics and as such the mortality rates were maintained below the emergency threshold in all camps
- 100,527 children 0-59 months were immunized against measles in the IDP settlements and as a result there was no reported outbreak of measles and also according to surveillance report the number of measles cases declined
- Communicable disease reports were 68% complete and a total of 148 rumors were verified within a period of 78 hours and this improved the detection and containment of disease outbreaks like Hep E, Cholera and Khalazar
- 51,643 IDPS benefited from the OCV campaigns(two rounds) and were fully protected from the risk of getting cholera and hence surveillance data indicated reduction of isolated cases of cholera cases in the IDP camps
- Seven trainings were conducted and 222 health workers benefited from training in the areas of outbreak response and detection and as such were able to improve the reporting and verification of epidemic prone diseases
- At total of 1157 casualties from GSW were successfully managed and lifesaving surgery was provided to them. Of these 105 were successfully evacuated with the support of the CERF funds
- Lifesaving supplies were donated to health cluster partners and these were adequate to treat 148,100 consultations in the period of six months

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

A total of 137,000 IDPS were targeted for intervention and 73% of them were reached. This was slightly below the target of 80%, due to insecurity in some of the areas hosting IDPs and mobility of IDPs. The difference in the medical evacuations was due to security reasons, as it became increasingly difficult to collect people from opposition areas and referrals couldn't take place. Due to ethnic dimensions most of the referrals would not accept to come to Juba for treatment. Trained health workers were not easy to come by and the CERF grants trained only 89% of the targeted health workers. Regarding the OCV, the numbers were slightly lower than the targeted figure due to the fluidity of the IDP figures, especially in the Mingkaman and Bentiu. There is a possibility that a considerable number was missed, this is complicated by having the campaign being implemented in two rounds.

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): Please describe how gender equality is mainstreamed in project design and implementation

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
No evaluation is planned. WHO had planned a general after action review of its overall response to the crisis, including the CERF funded component, however this has not yet been undertaken.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Implementing Partner Name	Sub-grant made under pre-existing partnership agreement	Partner Type	Total CERF Funds Transferred to Partner US$	Date First Installment Transferred	Start Date of CERF Funded Activities By Partner*	Comments/Remarks
14-RR-CEF-071	Health	UNICEF	Hold the Child	Yes	NNGO	$9,957	24-Jun-14	30-Jun-14	
14-RR-CEF-071	Health	UNICEF	IMC	Yes	INGO	$54,856	5-Sep-14	12-Sep-14	
14-RR-CEF-071	Health	UNICEF	Pariang County Health Department	Yes	GOV	$30,524	29-Sep-14	1-Oct-14	
14-RR-CEF-071	Health	UNICEF	State Ministry of Health, Lakes	Yes	GOV	$47,508	1-Aug-14	8-Aug-14	
14-RR-CEF-071	Health	UNICEF	Bor County Health Department	Yes	GOV	$143,448	18-Aug-14	25-Aug-14	
14-RR-CEF-072	Nutrition	UNICEF	Action Against hunger	Yes	INGO	$587,809	21-Jun-14	1-Jul-14	
14-RR-CEF-072	Nutrition	UNICEF	UNIDO	Yes	NNGO	$26,786	18-Jun-14	30-Jun-14	
14-RR-CEF-072	Nutrition	UNICEF	Plan International	Yes	INGO	$105,405	16-Jun-14	30-Jun-14	
14-RR-IOM-026	Camp Management	IOM	ACTED	Yes	INGO	$1,165,922	22-Jul-14	15-May-14	Pre-existing agreement signed with implementing partner
14-RR-IOM-026	Camp Management	IOM	DRC	Yes	INGO	$495,835	13-Aug-14	1-Jul-14	Pre-existing agreement signed with implementing partner
14-RR-IOM-026	Camp Management	IOM	Internews	Yes	INGO	$278,037	24-Jul-14	10-Jul-14	Pre-existing agreement signed with implementing partner
14-RR-IOM-026	Camp Management	IOM	PIN	Yes	INGO	$71,739	11-Jul-14	1-Jun-14	Pre-existing agreement signed with implementing partner
14-RR-WFP-032	Nutrition	WFP	Joint Aid Management (JAM)	Yes	INGO	$2,847	12-Jun-14	1-Apr-14	Pre-existing agreement signed with implementing partner
14-RR-WFP-032	Nutrition	WFP	Community Agriculture Skills Initiative (CASI)	Yes	NNGO	$2,877	3-Jun-14	1-Apr-14	Field Level Agreement signed with other funding available
14-RR-WFP-032	Nutrition	WFP	Hold the Child (HTC)	Yes	NNGO	$13,949	15-Jun-14	1-Apr-14	Field Level Agreement signed with other funding available

14-RR-WFP-032	Nutrition	WFP	Smile Again Africa Development Organisation (SAADO)	Yes	NNGO	$5,407	11-Jun-14	1-Apr-14	Field Level Agreement signed with other funding available
14-RR-WFP-032	Nutrition	WFP	Samaritan's Purse	Yes	INGO	$3,162	11-Jun-14	1-Feb-14	Field Level Agreement signed with other funding available

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

AAR	After Action Review
ACF	Action Contre la Faim
ACTED	Agency for Technical Cooperation and Development
AECOM	Architecture Engineering Consulting Operations and Maintenance
AFOD	Action For Development
ANC	Antenatal Care
BSFP	Blanket Supplementary Feeding Program
CAP	Consolidated Appeal Process
CCCM	Camp Coordination and Camp Management
CE	Central Equatoria (State)
CERF	Central Emergency Response Fund
CHD	County Health Department
CHD/SMOH	County Health Department/State Ministry of Health
CHF	Common Humanitarian Fund
CMR	Clinical Management of Rape Survivors
CRP	Crisis Response Plan
CWC	Communication With Communities
DFID	Department For International Development
DRC	Danish Refugee Council
DTM	Displacement Tracking Matrix
EPI	Expanded Program on Immunization
ERC	Emergency Relief Coordinator
ETC	Emergency Telecommunications
FSL	Food Security and Livelihood
FSMS	Food Security Monitoring System
GBV	Gender Based Violence
GSW	Gun Shot Wound
HC	Humanitarian Coordinator
HCT	Humanitarian Country Team
HIV	Human Immunodeficiency Virus
HIV/TB	Human Immunodeficiency Virus/Tuberculosis
IASC	InterAgency Standing Committee
ICWG	Inter Cluster Working Group
IDP	Internally Displaced Person
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
IRC	International Rescue Committee
IRW	International Relief Worldwide
MAM	Moderate Acute Malnutrition
MISP	Minimum Initial Service Package (for sexual and reproductive health services)

MOH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
NCE	No Cost Extension
NFI	Non Food Items
NGO	Non-Governmental Organization
NNGO	National Non-Governmental Organization
NP	Non-violent Peace force
OCHA	Office for the Coordination of Humanitarian Affairs
OCV	Oral Cholera Vaccine
PEP	Post Exposure Preventive
PIN	People In Need
PoC	Protection of Civilians
RC	Resident Coordinator
RH	Reproductive Health
RRM	Rapid Response Mechanism
RRT	Rapid Response Team
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SMOH	State Ministry of Health
SPHERE	Refers to standards in The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response,
STI	Sexually Transmissible Diseases
TdH	Terre des Hommes
UN	United Nations
UNCT	United Nations Country Team
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNIDO	Universal Intervention and Development Organization
UNMISS	United Nations Mission in South Sudan
USG	Under Secretary General
WASH	Water, Sanitation and Hygiene
WFP	World Food Program
WHO	World Health Organization