South Sudan
2013 CHF Standard Allocation Project Proposal

for CHF funding against Consolidated Appeal 2013

For further CHF information please visit http://unocha.org/south-sudan/financing/common-humanitarian-fund
or contact the CHF Technical Secretariat chfsouthsudan@un.org

This project proposal shall be submitted by cluster partners in two stages to the Cluster Coordinators and Co-coordinators for each project against which CHF funds are sought. In the first stage, before cluster defenses, applying partners fill sections I and II. The project proposal should explain and justify the activities for which CHF funding is requested and is intended to supplement information already available in the CAP Project Sheets. The proposals will be used by the cluster Peer Review Team in prioritizing and selecting projects for CHF funding during CHF Standard Allocation round. Partners should also fill and submit to cluster coordinator/ co-coordinator the CHF Project Summary (Annex 1). In the second stage projects recommended for funding by the CHF Advisory Board must complete Section III of this application and revised/update sections I and II if needed.

SECTION I:

CAP Cluster	Health

CHF Cluster Priorities for 2013 Second Round Standard Allocation
This section should be filled by the cluster Coordinators/Co-coordinators before sending to cluster partners. It should provide a brief articulation of Cluster priority activities and geographic priorities that the cluster will recommend for funding from the CHF in line with the cluster objectives highlighted in the CAP 2013.

Cluster Priority Activities for this CHF Round

i) Provision of drugs/drug kits, medical supplies, reproductive health kits, vaccines and related supplies to facilities in high risk areas
ii) Strengthen or reestablish PHCC s and PHCUs in the affected areas including provision of basic equipment and related supplies to ensure essential basic curative services
iii) Maintain or strengthen medical referral services for emergency cases
iv) Support vaccination campaigns to the vulnerable communities while maintaining the expanded program for immunization
v) Strengthen communicable disease control, prevention, and emergency response capacity including provision of outbreak investigation materials and training of key staff
vi) Maintain surge capacity for emergencies and surgical interventions
vii) Conduct training on emergency preparedness and response at all levels
viii) Provide logistical support to prepositioning of core pipeline supplies to high risk states

Cluster Geographic Priorities for this CHF Round

1. Jonglei (Pibor, Pochalla, Ayod, Akobo, Fangak, Canal, Twic East)
2. Warrap (Twic, Gogrial East, Tonj North, Tonj East, Tonj South)
3. NBeG (Aweil North, Aweil East, Central, Aweil South)
4. WBeG (Raja)
5. Lakes (Awerial, Rumbek North, Cueibet, Yirol East)
6. Unity (Abiemnhom, Leer, Rubkona, Mayom, Koch, Mayendit, Pariang, Panyijar)
7. Upper Nile (Renk, Ulang, Nassir, Maban, Longechuck, Baliet)
8. Eastern Equatoria (Kapoeta North, East, Lopa)

SECTION II

Project details
The sections from this point onwards are to be filled by the organization requesting CHF funding.

Requesting Organization	
CCM - COMITATO COLLABORAZIONE MEDICA	
Project CAP Code	**CAP Gender Code**
SSD-13/H/55330	2a

CAP Project Title *(please write exact name as in the CAP)*
Ensuring health safety nets and EP&R to health needs of host, IDPs and returnees' communities in Greater Yirol (Lakes State) and Greater Tonj (Warrap State)

Project Location(s) - list State and County (payams when possible) where CHF activities will be implemented. If the project is covering more than one State please indicate percentage per State

State	%	*County/ies (include payam when possible)*
LAKES	80%	Greater Yirol (Awerial, Yirol East, Yirol West)
WARRAP	20%	Tonj East, Tonj South

Total Project Budget requested in the in South Sudan CAP	US$ 1,263,325
Total funding secured for the CAP project *(to date)*	US$ 797,918

Funding requested from CHF for this project proposal	US$ 200.000
Are some activities in this project proposal co-funded (including in-kind)? Yes X No ☐ *(if yes, list the item and indicate the amount under column i of the budget sheet)*	

Direct Beneficiaries *(Ensure the table below indicates both the total number of beneficiaries targeted in the CAP project and number of targeted beneficiaries scaled appropriately to CHF request)*

	Number of direct beneficiaries targeted in CHF Project	Number of direct beneficiaries targeted in the CAP
Women:	**22.343**	167,738
Girls:	**13.363**	32,225

Indirect Beneficiaries

Target population is composed of communities living scattered, in remote/ under served areas and cattle camps, IDP/returnees' camps, with very poor or discontinuous access to basic services (63% reached by CCM, 37% by CUAMM). U5 (41% of the beneficiaries) and women in reproductive age (approximately 37% of the beneficiaries, out of which at least 6% pregnant) are the most exposed to epidemic outbreaks and health complications

Men:	**13.298**	67,095
Boys:	**11.675**	35,225
Total:	**60.679**	**305,283**

due to low quality health care, poor health/nutrition education and hygienic conditions, men-driven RH decisions and delayed emergency response. Other MARPs categories include HIV+/TB patients and victims of inter-clan clashes. Health prevention/raising awareness target mostly caretakers (including men) and opinion leaders (community/religious leaders, local institutions) to promote safe health, hygiene and sanitation behaviors (at least 15% of the beneficiaries). Indirect beneficiaries count around 441,000 people (70% of the population in the catchment area).
In order to avoid overlapping with other projects implemented in the area, the proposed targets consider aournd 30% of the whole population acceding to the PHCC and PHCU in the mentioned areas.

Catchment Population (if applicable)

Approximately **670,000** people, including IDPs and returnees

Implementing Partner/s (Indicate partner/s who will be sub-contracted if applicable and corresponding sub-grant amounts)

Doctors with Africa – CUAMM

CHF Project Duration (12 months max., earliest starting date will be Allocation approval date)

Number of months: 6 months from 1 Oct 2013 to 3 Mar 2014

Contact details Organization's Country Office	
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Project Focal Person	*Corrado Di Dio (Lakes State)* *corrado.didio@ccm-italia.org* *+211 921276394* *Flori Bakalli (Warrap State)* *Areacoordinator.gt@ccm-italia.org* *+211 913391617*
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Finance Officer	*Mekonnen Abegaz* *Admin.ssd@ccm-italia.org* *+211 921899785*

Contact details Organization's HQ	
Organization's Address	CCM – Comitato Collaborazione Medica Via Ciriè 31/E 10152 Torino (Italy)
Desk officer	*Daniela Gulino* Daniela.gulino@ccm-italia.org Fax. +339 011/383945 Tel.+339 011/6602793
Finance Officer	*Francesca dal Maso* *amministrazione@ccm-italia.org* Fax. +339 011/383945 Tel.+339 011/6602793

A. Humanitarian Context Analysis

Briefly describe (in no more than 300 words) the current humanitarian situation in the specific locations where CHF funded activities will be implemented. Provide evidence of needs by referencing assessments and key data, including the number and category of the affected population[1]

Greater Yirol (Lakes) and Greater Tonj (Warrap) counties count 604.350 inhabitants (50% women, 50% men), 32,970 returnees (out of which 11,134 arrivals over the past 18 months) and around 32,680 IDPs, mostly resulting from seasonal floods, drivers of dramatic malaria and water-borne diseases incidence, or sub-tribal clashes, which raise the demand for emergency health services (62 deaths reported in Q1/Q2 2013, OCHA). Moreover, in 2013 measles outbreak erupted in Yirol West, after the 2012 outbreaks experienced in Awerial and Tonj East.
General health data are dire:

- maternal mortality: 2054/100,000
- neonatal mortality: 49/1,000
- U5 mortality: 106/1,000
- DPT3 coverage: 92% (31% in Tonj East, 61% in Yirol East, 63% in Yirol West) (GoSS 2011/2012).

In both host and IDP/returnees' communities, P&LW and U5 are the most exposed to health emergencies due to inadequate PHC service coverage, scarce hygiene practices, cultural barriers and dependence on men for survival (poor prevention. Almost 50% of the whole population (flood-affected communities, cattle keepers, fishing communities) can barely access static services and massive scale-up of outreaches is required to preposition health supplies and ensure surveillance and emergency response.

Yirol Hospital is the only facility with surgical capacities in Greater Yirol, while in Greater Tonj emergencies are referred to Marial Lou Hospital (Tonj North). PHC service provision in the whole project area seriously suffers from huge gap in qualified human resources, equipment, drugs and emergency referral means. In 2013MoH staffing remained unchanged from 2011/12 and the last governmental quarterly drug supply was received in Q1 2013. The Emergency Drug Fund is expected to come into force only in Q1 or Q2 2014.

CCM/CUAMM struggle to maintain the minimum level of quality service delivery, due to gaps in financial resources for EP&R, health surveillance, outbreaks control, strengthening of PHCU/C in remote areas and emergency treatment/referral.

B. Grant Request Justification

Briefly describe (in no more than 300 words) the reasons for requesting CHF funding at this time. Explain how CHF funding will help address critical humanitarian gaps in your cluster. Explain the value added by your organization (e.g. geographical presence). Indicate if any other steps have been taken to secure alternative funding.

The current allocation will able CCM/CUAMM to continue supporting the health & nutrition services delivery in Greater Yirol, Tonj East, Tonj South with focus on emergency activities; support the CHD; increment of community based referral system for emergency. The beneficiaries target is slightly different from the previous round: under the new HPF proposal, CCM will increase its presence in TE and TS while we are not going to work in Tonj North.
In Greater Yirol, CCM/CUAMM are the only SMoH partners, supporting 15 facilities (1 hospital, 4 PHCCs, 10 PHCUs). In Tonj East and South CCM supports 13 facilities (3 PHCCs and 10 PHCUs). CCM/CUAMM have MoUs with concerned SMoH, which have expressed satisfaction for the quality of the IPs' support). Currently, CCM/CUAMM are negotiating with the HPF in order to became the lead agency in the project counties, that will potentially increase the number of facilities supported in the area.
HPF can cover up to 75% of the PHCs service delivery costs, but NOT key health emergency activities (provision of drug kits/basic equipment to PHCC/Us, outreaches and vaccination campaigns, enhancing surveillance and disease control, strengthening the emergency referral mechanism and surgical capacities).

At June 2013, 22% of CHF-R1 resources were spent, 37% are committed and 41% shall be fully exhausted by September.

This proposal aims to ensure that:

- drugs are timely prepositioned to flood-affected, cattle camps' and fishing communities,
- supported facilities are provided with drugs and medical supplies,
- epidemiological surveillance and outreaches for communicable diseases are conducted,
- hospital surgical capacities are maintained and the referral system is enforced,
- CHD capacities are developed in EP&R.

Added values:

- Integration with Nutrition program
- partnership with CHDs for health system strengthening, TA on quality service provision and data gathering/analysis,
- Improved health service delivery for local communities and IDPs/returnees.

C. Project Description (For CHF Component only)

i) Contribution to Cluster Priorities

Briefly describe how CHF funding will be used to contribute to the achievement of the cluster priority activities identified for this allocation.

The overall objective of the project is **to maintain Greater Yirol and Greater Tonj population's access to health safety nets, mostly focusing on underserved communities, marginalized groups, IDPs and returnees**.

[1] To the extent possible reference needs assessment findings and include key data such as mortality and morbidity rates and nutritional status, and how the data differs among specific groups and/or geographic regions. Refer situation/data/indicators to national and/or global standards.

The project purpose is perfectly integrated within the Health Cluster strategy and is in line with at least 6 of the Cluster thematic priorities:

i) Provision of drugs/drug kits, medical supplies, reproductive health kits, vaccines and related supplies to facilities in high risk areas.
ii) Strengthen or reestablish PHCC s and PHCUs in the affected areas including provision of basic equipment and related supplies to ensure essential basic curative services.
iii) Maintain or strengthen medical referral services for emergency cases.
iv) Support vaccination campaigns.
v) Strengthen communicable disease control, prevention, and emergency response capacity.
vi) Maintain surge capacity for emergencies and surgical interventions.

Both static and outreach frontline health services are offered to the catchment population – focusing on women, girls/boys, people living under the poverty line, in flooded-remote areas, cattle camps, IDP/returnees' camps. Health emergency response (including 24/7 surgical capacities) is provided in Yirol Hospital serving Greater Yirol, while in Greater Tonj the referral system to county hospitals is enhanced.

Tonj East, Tonj South, Yirol East and Awerial are included among the Cluster priority areas; Yirol West belongs to Greater Yirol and its County Hospital is the only referral facility for the three Counties, permanently providing surgical and emergency response. Its inclusion in the project is functional to ensure the effectiveness of Greater Yirol referral system and the access of also Yirol East and Awerial population to emergency care. Further, the recent measles outbreak demonstrates the need of strengthening Yirol West capacities in providing PHC services and responding to emergencies, extending the support currently provided through mobile team to all the PHCUs in the county.

ii) Project Objective

State the objective/s of this CHF project. Objective/s should be Specific, Measurable, Achievable, Relevant and Time-bound (SMART)

Specific objective of the project is to ensure continuity of essential health service delivery (safety nets) and adequate emergency preparedness and response capacities - including surgical intervention and EmONC - in all Greater Yirol and Greater Tonj through:

- The increase of 15% in the utilization rate of PHC at facility level in 6 months, including at least 15% increment in women's access (monthly baseline: 1,200 boys, 1,300 girls, 1.450 men, 1.900 women);
- the increase of 15% in the access to emergency health service in 6 months (monthly baselines: 10 emergency surgical operations);
- the increase of 20% in the number of referred patients in 6 months (monthly baseline: 34 referred patients).

In order to avoid overlapping with other projects implemented in the area, the proposed targets consider aournd 30% of the whole population acceding to the health services in the mentioned areas.
For the objective and the identified expected results (see below) specific measurable indicators have been selected, most of which are indicated as Health Cluster priorities and/or are MoH requirements for health reporting since relevant to achieve the HSDP 2011 – 2016 targets, as well as health related MDGs.

The project timeframe (6 months) is adequate to meet the project objectives, since: (i) both implementing partners (CCM and CUAMM) are already operating and have functioning field bases in each target county; (ii) collaboration with institutional partners (Lakes MoH, Warrap State MoH and concerned CHDs in both states) has been established and is fruitful.

iii) Proposed Activities

List the main activities to be implemented with CHF funding. As much as possible link activities to the exact location of the operation and the corresponding number of direct beneficiaries (broken down by age and gender to the extent possible).

Output n. 1. Frontline health service provision to underserved host, IDPs and returnees' communities in Greater Yirol and Greater Tonj counties supporting up to 28 facilities (1 hospital, 7 PHCCs and 20 PHCUs).

1.1 Procurement/prepositioning and administration/informed distribution of essential/emergency drugs, non-medical supplies to the facilities (i.e., IEHK/DDK kits to face infectious diseases outbreaks).
1.2 Ensuring continuous OPD services in all facilities and IPD service in hospitals/PHCC, including trauma management and serious cases' stabilization.
1.3 Maintaining MISP in RH services (ANC/PNC, STIs, FP) and childhood disease integrated management in all supported facilities, especially to most vulnerable women and children (IDPs, returnees, victims of conflicts and violence).
1.4 Scaling-up EPI service provision in all supported facilities.
1.5 Enforcement of mobile clinics (outreach services) to serve remote/IDPs/returnees populations in the 5 counties, offering comprehensive MCH services to most vulnerable (unaccompanied children, U5, P&LW, victims of conflicts),
1.6 Training and TA for local health staff of up to 28 facilities on: (i) epidemic preparedness/EWARN, (ii) management of communicable diseases, (iii) surveillance.

TARGET

- U5 monthly consultation: 8.406 boys, 9.558 girls
- Adult consultations: 10.350 men, 13.494 women)
- ANC clients receiving IPT2: at least 1704
- Skilled attended deliveries: at least 600
- DPT3 (static and outreach): at least 2,646
- Trained facilities staff: 60 (at least 30% female)

Output n. 2 Effective response to emergencies, including health referral and surgical treatment, is ensured

2.1 Maintenance/strengthening of Yirol Hospital OT, Emergency Department, Surgical Wards to respond to emergencies.
2.2 Maintenance/strengthening of blood bank at Yirol Hospital to support the OT ensuring the prompt management of hemorrhagic emergencies.
2.3 Maintenance/equipment of PHCCs IPDs, maternity rooms and laboratories to enhance diagnosis/treatment/referral

capacities.

2.4 Upgrading Yirol West ambulance service;

2.5 On-the-job training of Yirol Hospital staff on surgical intervention, management and follow up of obstetric emergencies and neonatal complications.

2.6 Training of PHCC/PHCU staff on emergency response and referral (first aid, triage, trauma management patients' stabilization).

2.7 Epidemiological surveillance and organization of health emergency response (including. mass vaccination campaigns, namely measles).

TARGET

- Surgical emergency interventions: at least 108
- Emergency referrals: at least 12
- Emergency treatments (wounds/injured, burns, EmONC, blood transfusions): at least 270
- Measles vaccinations: at least 4,428
- Staff trained on emergency response and referral: 30 (at least 30% female)

Output n. 3 Health, Hygiene and Sanitation practices of host, IDPs and returnees' communities are enhanced and preventive health approach is promoted

3.1 Organization of daily health, hygiene & sanitation education sessions (prevention of communicable diseases/STIs/malaria, EPI, health seeking behavior, hygiene, mainstreaming HIV/AIDS related-issues) in all supported facilities, targeting caretakers (men and women);

TARGET

- Community members reached by health education messages: 9,000 (at least 30% men)

Output n. 4 Enhancing IDSR, EP&R capacities and PHC system management in Greater Yirol and Greater Tonj is improved

4.1 Training/TA for CHDs on epidemiological surveillance, MoH DHIS/IDSR, e-warn systems.

4.2 Scale up of joint CHD/implementing partners' supporting supervision of health performances in each target county.

4.3 Participation to the Health Cluster coordination mechanism (state and national).

4.4 Facilitation of inter-cluster coordination at state and national level (WaSH, Nutrition and Food Security clusters).

TARGET

- CHD members capacity built: 13

iv). Cross Cutting Issues

Briefly describe how cross-cutting issues (e.g. gender, environment, HIV/AIDS) are addressed in the project implementation.

DISASTER RISK REDUCTION is mainstreamed in all project components through the provision of basic health services for resident, IDPs and returnees' communities both at facility and outreach level, by implementing the following activities: (i) improving the emergency preparedness and control mechanisms, which will strengthen the current capacity of the PHCCs/PHCUs and CHDs to early detect and respond to any public health emergencies; (ii) maintaining the IPD within the PHCC; (iii) supporting the routine mass immunization for all children U5; iv) strengthening the referral system to the next level of care

ENVIRONMENT: (i) incinerators and placenta pits for hazardous waste management are in use and periodically maintained in all CCM supported facilities and in Yirol County Hospital, (sharps, needles, syringes, blades and bottles) are incinerated while rests of waste are burned to ash in the disposal pit (ii) the outreach teams shall be trained on how to manage the waste material produced during the outreaches visits, (iii) periodic maintenance will be regularly done on the ambulance and project vehicles as well as on HFs' generators, in order to limit the waste of fuel and related-emissions, (iv) most of the facilities hosting a cold chain system have a solar fridge and a solar panel system is set in all CCM Office/residence compound.

HIV: CCM/CUAMM will ensure that the universal procedures to prevent HIV and AIDS are respected and implemented, as well as thatthe staff is informed on HIV/AIDS prevention. Posters and leaflets will be distributed in the PHCC/PHCU. On top of it, implementing partners shall ensure:(i) mainstreaming of FP (including contraceptives distribution) in comprehensive RH services, (ii) promoting VCT and PMTCT services availed in Yirol Hospital (priority target: prisoners, soldiers, youths, P&LWs, TB/HIV positive persons), (iii) facilitating the counseling and referral of HIV positive patients to facilities where ARV treatment is available, (iv) including HIV/AIDS awareness messages in health education sessions at facility and community level, (v) guaranteeing universal precautions and safe blood supply during direct transfusions (surgery), (vi) managing the consequences of sexual violence, including provision of PEP and linking with protection cluster for client follow-up.

GENDER: (i) equal opportunity of accessing health services offered by the involved HFs will be ensured to both male and female patients; (ii) mobile clinic service in the most remote areas and critical contexts (as returnees and IDPs camps) will mostly address women, as they are usually more penalized by HFs distance because of their home care duties and of some traditional rules regulating their movements; (iii) reproductive health enhancement shall be mainstreamed, (iv) men and opinion leaders will be targeted by health educations / sensitization sessions, in order to promote women's right to health care. Moreover, women will play a great role in the successful implementation of the project activities through: (i) active participation of the female health staff in the health activities, including outreach and health education sessions, (ii) involvement of community TBAs and women's CBOs in the catchment area to valorize women's skills and capacities (mediation, knowledge of the context, pear-to-pear communication, etc.), promote gender balance in RH and FP decision-making and to make health promotion and sensitization more effective.

CAPACITY DEVELOPMENT: theoretical and on the job trainings and coordination meetings involving both health personnel and institutional partners (State and County level) have been included as main project activities to concretely enforce the early warning and health emergency risk reduction and ensure adequate sustainability to the project. The identified implementation modalities (see below) envisage and pursue full and active involvement of the institutional stakeholder in the project follow up and consistent monitoring, as well as in the regular info and data sharing with other stakeholders to better coordinate emergency response and manage integrated resources. As far as health personnel is concerned, when availability of qualified health staff is limited, also the

task shifting approach (endorsed by WHO), backed by continuous supportive supervision is pursued.

v) Expected Result/s

Briefly describe (in no more than 100 words) the results you expect to achieve at the end of the CHF grant period.

The project is aimed at achieving 4 main results, which are strictly linked to the overall and specific objectives of the project and which the above mentioned activities stem from:

1. **Frontline health service provision to underserved host, IDPs and returnees' communities in Greater Yirol and Greater Tonj counties, supporting up to 28 facilities (1 hospital, 7 PHCCs and 20 PHCUs).**

- all supported facilities are properly equipped, staffed and provided with essential drugs for emergency EP&R;
- all the supported facilities have functional OPD/IPD, MISP for RH and EPI services, with scaling-up capacities in case of emergency;
- IDPs, returnees and isolated communities are reached by mobile clinics;
- Local staff is trained on (i) epidemic preparedness/EWARN, (ii) management of communicable diseases, (iii) surveillance.

2. **Effective response to emergencies, including health referral and surgical treatment, is ensured:**

- Yirol Hospital emergency and surgical capacities are boosted (including blood transfusions);
- emergency referrals system in the whole project catchment area is enhanced:
- Yirol Hospital staff is trained on surgical intervention, management and follow up of obstetric emergencies and neonatal complications;
- PHCC/PHCU staff is trained on emergency response and referral (first aid, triage, trauma management patients' stabilization);
- timely response to possible outbreaks id provided (namely via mop ups, mass campaigns, based on needs).

3. **Health, Hygiene and Sanitation practices of host, IDPs and returnees' communities are enhanced and preventive health approach is promoted:**

- community members (men and women, including IDPs and returnees) are sensitized on safe health and hygiene practices;

4. **IDSR, EP&R capacities and PHC system management in Greater Yirol and Greater Tonj are improved:**

- concerned CHDs capacities in surveillance, DHIS/IDSR reporting and e-warn systems are strengthened;
- participation to the Health and inter-Cluster coordination mechanisms at State and National level is ensured.

List below the output indicators you will use to measure the progress and achievement of your project results. At least three of the indicators should be taken from the cluster defined Standard Output Indicators (SOI) (annexed). Put a cross (x) in the first column to identify the cluster defined SOI. Indicate as well the total number of direct beneficiaries disaggregated by gender and age.

SOI (X)	#	Output Indicators (Ensure the output indicators are consistent with the output indicators that will be used in the results framework section III of this project proposal).	Target (indicate numbers or percentages) (Targets should be disaggregated by age and sex as per the standard output indicators list and add-up to the number of direct beneficiaries identified page 1)
X (2)	1.	number of >5 consultations (male and female)	23.844
X(3)	2.	number of <5 consultations (boys and girls)	17.964
X(4)	3.	Number of measles vaccinations given to under 5 in emergency or returnee situation	4.428
X(5)	4.	Number of births attended by skilled birth attendants	600
X(7)	5.	Number of antenatal clients receiving IPT2 second dose	1.704
X(11)	6.	Number of health workers trained in MISP / communicable diseases / outbreaks / IMCI / CMR	90

vi) Implementation Mechanism

Describe planned mechanisms for implementation of the project. Explain if it is implemented through implementing partners such as NGOs, government actors, or other outside contractors.

Project implementing partners are the INGOs CCM (Comitato Collaborazione Medica) and CUAMM – Doctors with Africa, respectively Lakes SMoH partners for health care service provision in Awerial/Yirol East and Yirol West counties (25 facilities expected to be supported from September 2013: 5 in Awerial, 7 in Yirol East, 13 in Yirol West). CCM also is Warrap SMoH partner in Greater Tonj (18 facilities supported: 6 in Tonj East, 8 in Tonj South). CCM/CUAMM share similar vision/mission, core sectors of intervention and have operational MoU signed with concerned SMoH for supporting the provision of integrated primary/secondary health care and nutrition services in the respective catchment areas. Strengthening local health system through collaboration with stakeholders and researching for synergies, preventing duplications or establishment of parallel health/nutrition structures, are CCM/CUAMM pillars in program planning and implementation. Both CCM/CUAMM are registered INGOs in SS and acknowledged also by the national MoH. At local level, smooth collaboration with CHD and other local institutions (Counties Manager, RRC Office, Commissioner, etc.) is already in place.

CCM/CUAMM partnership ensures effective coordination in maintaining frontline basic health safety nets in primary health service provision as well as timely answer to health emergency and/or emergency referral for life saving interventions. Existing coordination to enhance the referral system, build CHD capacities and raise community awareness on preventive health and outbreaks control shall be strengthened and targeted actions shall be planned to answer the needs, which shall have been identified. Expansion of outreaches, enforcement of effective referral system and focus on awareness raising for preventive health practices are meant at widening population access to and utilization of health safety nets services, as well as to expand the surveillance capacities.

CCM/CUAMM structure already in place in the mentioned areas is sufficient to ensure the smooth implementation of the present project .The project design is based on sound collaboration among CCM/CUAMM, health institutions at state and county level, other stakeholders (OCHA, WHO, UNICEF, UNFPA, other INGOs CBOs). In order to ensure proper coordination, adherence to the activity plan and capacity of prompt project adjustments (when required), 2 project coordination bodies will be purposely established and

meet on regular basis to ensure achievement of expected results:

- MANAGEMENT COMMITTEE (one per county): Composed of CHDs Manager and CCM/CUAMM Project Managers, the MC will meet on monthly basis in each county and will be responsible for: (i) defining/consolidating/readjusting the work plan, (ii) sharing information and data on the activities carried out and in pipeline, (iii) debating possible project implementation challenges and identifying the related way forward, (iv) providing technical assistance in the project supervision, (v) consolidating quarterly project reports, (vi) representing the Project board in front of local stakeholders and when project-related decisions are taken.
- STEERING COMMITTEE (one per State): Composed of Lakes/Warrap State MoH DG (or his/her delegate), CCM/CUAMM Country Representatives in South Sudan (or his/her delegate), the SC will meet on quarterly basis and will be responsible for: (i) supervising the general project implementation and provide related feedback/advice to the Management Committee, (ii) facilitating integration of the project with other health activities in the catchment areas, (iii) linking with other stakeholders at federal and state level (Nutrition & Health Clusters, WaSH clusters, UNFPA, WHO, UNICEF, other INGOs, etc.) to facilitate the project implementation and promotion.

vii) Monitoring and Reporting Plan

Describe how you will monitor and report on the progress and achievements of the project. Notably:

1. Explain how will you measure whether a) Activities have been conducted, b) Results have been achieved, c) Cross-cutting issues have been addressed, and d) Project objectives have been met
2. Indicate what monitoring tools and techniques will be used
3. Describe how you will analyze and report on the project achievements
4. Ensure key monitoring and reporting activities are included in the project workplan (Section III)[2].

CCM/CUAMM shall ensure continuous monitoring of project activities by:

- EFFECTIVE REPORTING SYSTEM: (i) compilation of daily/weekly/monthly health facility registers, (ii) compilation of outreach reports, (iii) compilation of monthly and quarterly reports for concerned CHDs and State MoH (DHIS reporting tools), (iv) compilation of quarterly progress report for the SC and the donors, (v) monthly and quarterly reports to HQ project department. With regard to data collection and analysis, utilization of DHIS shall ensure integration of project data within the MoH reporting system.
  The Health Cluster both at National and State level will be kept informed on project progress through CCM/CUAMM representative participation at the monthly meetings (see activity 4.3).
- QUALIFIED TECHNICAL ASSISTANCE: both implementing partners have envisaged employment of technical human resources skilled in Health and emergency related program management and supervision, responsible for assisting local health staff at both facility and outreach level. They will be based in each main project location and will ensure daily supervision of the quality of the services provided and consistency of data collected. (see also activity 4.2)
- M&E OFFICER: CCM staff includes M&E officer based in SS Head Office (Juba), who will be responsible of periodic visits in the project areas, to check about indicators, targets and performances. The same role will be played by CUAMM Country Manager;
- EXTERNAL MONITORING: implementing partners will share periodical information and data on the project implementation with Health Cluster focal persons both at Lakes State and federal level, to compare views and get additional inputs and comments.
- STEERING COMMITTEE & MANAGEMENT COMMITTEE: among the SC ToR, supportive supervision and technical assistance to the MC throughout the project implementation is included. The MC shall utilize the project logical framework and work plan as primary tools to assess project performances, achieved versus expected results/targets and respect of the timeframe;
- EFFECTIVE FINANCIAL MONITORING SYSTEM: (i) CCM accounting systems is based on the double-entry system, which records transactions into journals and ledgers. Daily transactions, including purchases, cash receipts, accounts receivable and accounts payable are recorded using a specific accounting software which is reconcile on a weekly/monthly basis under the supervision of HQ administrative department;II) Budget follow-up are elaborated and approved by HQ project department together with the request for funds (ii) procurement plan is elaborated at the begin of the project and review on a quarterly basis with the support and supervision of HQ procurement officer; III) compilation of financial report is elaborated by CCM/CUAMM country administration with the support of a Project accountant and subsequently approved by HQ administrative department.

D. Total funding secured for the CAP project

Please add details of secured funds from other sources for the project in the CAP.

Source/donor and date (month, year)	**Amount** (USD)
CUAMM (Yirol West - Lakes). Donors: Italian Ministry of Foreign Affairs, UNICEF, EU	191,803 USD
CCM (Awerial and Yirol East – Lakes). Donors: Crown Agents	167,460 USD
CCM (Greater Tonj – Warrap). Donors: UNICEF, Crown Agents	220,000 USD
Pledges for the CAP project (for the period October 2013 – March 2014)	
CUAMM (Yirol West - Lakes). Donors: Italian Ministry of Foreign Affairs, UNICEF, EU	29,745 USD
CCM (Awerial, YE, TE, TS). Donors: UNICEF	50,000

[2] CHF minimum narrative reporting requirements will include the submission of a final narrative report and where applicable a narrative mid-term report. Narrative reports will include a progress on the project achievements using the outputs indicators listed in this project proposal.

SECTION III:

LOGICAL FRAMEWORK		
CHF ref./CAP Code: SSD-13/H/55330/R/6703	**Project title:** . Ensuring health safety nets and EP&R to health needs of host, IDPs and returnees' communities in Greater Yirol (Lakes State) and Greater Tonj (Warrap State)	**Organisation:** Comitato Collaborazione Medica (CCM)

Overall Objective	**Cluster Priority Activities for this CHF Allocation:** *What are the Cluster Priority activities for this CHF funding round this project is contributing to:* • Maintain the existing safety net by providing basic health packages and emergency referral services • Strengthen emergency preparedness including surgical interventions • Respond to health related emergencies including controlling the spread of communicable diseases •	**Indicators of progress:** *What are the key indicators related to the achievement of the CAP project objective?* - Basic health packages and emergency referral services maintained and fully functional in 100% of the supported facilities (1 hospital, 7 PHCCs and 20 PHCUs); - Incidence rates for selected communicable diseases relevant to the local context (malaria, measles, ARI, diarrhea, etc) are decreased; - Health emergency successful treatment rates do improve	**How indicators will be measured:** *What are the sources of information on these indicators?* - Quarterly Narrative project reports for donors and WSMoH, - Quarterly Technical Performance reports for donors and SMoHs, - Monthly DHIS/HMIS data - Weekly IDSR data	
Purpose	**CHF Project Objective:** *What are the specific objectives to be achieved by the end of this CHF funded project?* To maintain Greater Yirol and Greater Tonj population's access to health safety nets, mostly focusing on underserved communities, marginalized groups, IDPs and returnees.	**Indicators of progress:** • *What indicators will be used to measure whether the CHF Project Objectives are achieved. Indicators may be quantitative and qualitative* - The increase of 15% in the utilization rate of PHC at facility level in 6 months, including at least 15% increment in women's access (monthly baseline: 1,200 boys, 1,300 girls, 1.450 men, 1.900 women); - the increase of 15% in the access to emergency health service in 6 months (monthly baselines: 10 emergency surgical operations); - the increase of 20% in the number of referred patients in 6 months (monthly baseline: 34 referred patients).	**How indicators will be measured:** *What sources of information already exist to measure this indicator? How will the project get this information?* • Intermediate and final project report; • Consolidated official health data from concerned SMoHs and CHDs; • Other data sources (OCHA, IOM, etc.)	**Assumptions & risks:** *What factors not under the control of the project are necessary to achieve these objectives? What factors may get in the way of achieving these objectives?* • Internal and cross-borders political stability; • Institutional willingness to effectively target emergencies; • No movement restrictions for implementing partners
Results	**Results - Outcomes (intangible):** *State the changes that will be observed as a result of this CHF Project. E.g. changes in access, skills, knowledge, practice/behaviors of the direct beneficiaries*. Specific objective of the project is to ensure continuity of essential health service delivery (safety nets) and adequate emergency	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged outcomes?* Women: 22.343 Girls: 13.363	**How indicators will be measured:** *What are the sources of information on these indicators?* • DHIS reporting system; • EPI reports • Training reports and attendance sheets	**Assumptions & risks:** *What factors not under the control of the project are necessary to achieve the expected outcomes? What factors may get in the way of achieving these objectives?* - Collaboration of concerned State and local institutions (SMoHs, concerned

	preparedness and response capacities - including surgical intervention and EmONC - in all Greater Yirol and Greater Tonj through vii) Provision of drugs/drug kits, medical supplies, reproductive health kits, vaccines and related supplies to facilities in high risk areas. viii) Strengthen or reestablish PHCC s and PHCUs in the affected areas including provision of basic equipment and related supplies to ensure essential basic curative services. ix) Maintain or strengthen medical referral services for emergency cases. x) Support vaccination campaigns. xi) Strengthen communicable disease control, prevention, and emergency response capacity. xii) Maintain surge capacity for emergencies and surgical interventions.	Men: 13.298 Boys: 11.675 Total: **60.679** Out of the total **60.679** beneficiaries: - 46,818 (77,16%) will have access to frontline health services (Outcome 1) - 4,824 (7,99%) will have access to emergency health services, including surgical emergencies (Outcome 2) - 9,000 (14,83 %) will be sensitized on Health, Hygiene and Sanitation (Outcome 3) - 13 (0,02%) are CHD members capacity built on EP&R (Outcome 4)		CHDs, HIV/AIDS Commission, etc.); - Conducive environment for INGOs in the project counties; - Collaboration from other stakeholders (UN agencies, other IPs and in Nutrition/WaSH, returnees' sectors).
	Immediate-Results - Outputs (tangible): *List the products, goods and services **(grouped per areas of work)** that will result from the implementation of project activities. Ensure that the outputs are worded in a manner that describes their contribution to the outcomes.* • **Output n. 1. Frontline health service provision to underserved host, IDPs and returnees' communities in Greater Yirol and Greater Tonj counties** **Output n. 2:**	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged outputs?* *Ensure the indicators identified in Section II (v) of this proposal are adequately inserted in this section.* **Output 1:** - number of >5 consultations (male and female) : 23.844 - number of <5 consultations (boys and girls): 17.964 - Number of births attended by skilled birth attendants: 600 - Number of antenatal clients receiving IPT2 second dose: 1704; - Number of health workers trained in MISP / communicable diseases / outbreaks / IMCI / CMR 90 **Output 2:** - Surgical emergency interventions:	**How indicators will be measured:** *What are the sources of information on these indicators?* **For Outcome n. 1:** - Health facilities patients' registers (daily, weekly, monthly), - Health facilities drug consumption registers (daily, weekly, monthly), - Health facilities monthly and quarterly reports (DHIS, EPI, MCH, Malaria sentinel report), - Outreach registers, - Training attendance sheets. **For Outcome n. 2:** - Yirol Hospital Emergency	**Assumptions & risks:** *What factors not under the control of the project are necessary to achieve the expected outcomes? What factors may get in the way of achieving these objectives?* - **For Outcome n. 1:** **- Concerned SMoHs ho**nour the provisions of the MoU signed with CCM and CUAMM for collaboration in Primary and Secondary Health Service provision in selected counties of Warrap and Lakes State, - Project funds are timely availed - Local communities, IDPs and returnees do acknowledge and are willing to access/utilize hospital services **For Outcome n. 2:** - Project funds are timely availed

	Effective response to emergencies, including health referral and surgical treatment, is ensured	at least : 108 - Emergency referrals: at least 12 - Emergency treatments (wounds/injured, burns, EmONC, blood transfusions): at least 270 - Measles vaccinations: at least 4.428 - Staff trained on emergency response and referral: 30 (at least 30% female)	Department registers (daily, weekly, monthly), - PHC facility referral data, - EPI registers (both static and outreach) - Training attendance sheets, programs and pictures	- Local communities, IDPs and returnees do acknowledge and are willing to access/utilize hospital services - Concerned CHDs, RRC and other local institutions are supportive in coordinating IPs activities in providing humanitarian aid to host population, IDPs and returnees to prevent overlapping, - Local authorities are supportive in mobilizing community members on EP&R
	Output n. 3 **Health, Hygiene and Sanitation practices of host, IDPs and returnees' communities are enhanced and preventive health approach is promoted**	**Output 3:** - Community members reached by health education messages: 9,000 (at least 30% men)	**For Outcome n. 3:** - Health Education registers, - Workshop Reports and Pictures and attendance sheets.	**For Outcome n. 3:** - Concerned CHDs, RRC and other local institutions are supportive in coordinating IPs activities in providing humanitarian aid to host population, IDPs and returnees to prevent overlapping, - Local authorities are supportive in mobilizing community members on EP&R
	Output n. 4 **Enhancing IDSR, EP&R capacities and PHC system management in Greater Yirol and Greater Tonj is improved**	**Output 4:** - CHD members capacity built: 13	**For Outcome n. 4:** - Training attendance sheet, report and pictures - Health Clusters minutes / attendance sheets	**For Outcome n. 4:** - Concerned SMoHs prioritize the maintenance of effective CHDs in their agenda, by recruiting/monitoring adequate staff
	Activities: *List in a chronological order the key activities to be carried out. Ensure that the key activities will results in the project outputs.* **Output 1:** 1.1 Procurement/prepositioning and administration/informed distribution of essential/emergency drugs, non-medical supplies to the facilities (i.e., IEHK/DDK kits to face infectious diseases outbreaks).	- **Inputs:** - *What inputs are required to implement these activities, e.g. staff time, equipment, travel, publications costs etc.?* <u>1,1 Inputs:</u> - Human resources: Procurement Officer - Logistic/procurement capacities - Collaboration with concerned institutions (federal and state MoH, CHD, Commissioner, etc.) - Coordination among partners on the ground		**Assumptions, risks and pre-conditions:** *What pre-conditions are required before the project starts? What conditions outside the project's direct control have to be present for the implementation of the planned activities?* <u>1.1 Assumptions, risks:</u> - Availability of procurement protocols/guidelines; - Suppliers' and transporters' respect of contract timing, - Roads condition

	1.2 Ensuring continuous OPD services in all facilities and IPD service in hospitals/PHCC, including trauma management and serious cases' stabilization.	1,2 Inputs: - Human resources: PHC Supervisors - Collaboration with SMoHa to sustain local qualified health staff, - Collaboration with concerned CHD and other stakeholders on the ground - Cultural mediation		1.2 Assumptions, risks: - No staff turnover; - Availability of pharmaceuticals and other medical supplies,
	1.3 Maintaining MISP in RH services (ANC/PNC, STIs, FP) and childhood disease integrated management in all supported facilities, especially to most vulnerable women and children (IDPs, returnees, victims of conflicts and violence).	1,3 Inputs: - Human resources: MCH Supervisors, - Collaboration with SMoH to sustain local qualified health staff, - Collaboration with concerned CHDa and other stakeholders on the ground - Cultural mediation		1.3 Assumptions, risks: - No staff turnover; - Availability of pharmaceuticals and other medical supplies,
	1.4 Scaling-up EPI service provision in all supported facilities.	1,4 inputs: - Human resources: PHC/EPI supervisors - Logistic and movement capacities - Collaboration with concerned institutions (federal and state MoH, CHD, Commissioner, etc.) - Coordination among partners on the ground		1.4 Assumptions, risks: - Movement capacities, - Availability of functional vehicles - Availability of functional cold chains
	1.5 Enforcement of mobile clinics (outreach services) to serve remote/IDPs/returnees populations in the 5 counties, offering comprehensive MCH services to most vulnerable (unaccompanied children, U5, P&LW, victims of conflicts),	1,5 Inputs: - Human resources: PHC/EPI supervisors - Logistic and movement capacities - Collaboration with concerned institutions (federal and state MoH, CHD, Commissioner, etc.) - Coordination among partners on the ground		1.5Assumptions, risks: - Movement capacities, - Availability of functional vehicles - Supportive communities

	1.6 Training and TA for local health staff of up to 28 facilities on: (i) epidemic preparedness/EWARN, (ii) management of communicable diseases, (iii) surveillance.	1.6Inputs: - Human resources: PM, Procurement Officer - Procurement, contracting and transportation capacities, - Effective power system - Community involvement		1.6 Assumptions, risks: - Availability of standard protocols/guidelines; - Collaborative attitude from CHD; - No staff turnover.
	Output 2: 2.1 Maintenance/strengthening of Yirol Hospital OT, Emergency Department, Surgical Wards to respond to emergencies.	2.1 Inputs: - Human resources: PM, Procurement Officer - Procurement, contracting and transportation capacities,		2.1. Assumptions, risks: - No stuff turnover - Availability of the needed drugs and consumables - Availability of constructors and building materials - Availability of the needed equipment
	2.2 Maintenance/strengthening of blood bank at Yirol Hospital to support the OT ensuring the prompt management of hemorrhagic emergencies.	2.2 Inputs: - Human resources: PM, Procurement Officer - Procurement, contracting and transportation capacities, - Effective power system - Community involvement		2.2. Assumptions, risks: -Collaborative aptitude from potential blood donors -Cold chain regular running -Lab regular functioning
	2.3 Maintenance/equipment of PHCCs IPDs, maternity rooms and laboratories to enhance diagnosis/treatment/referral capacities.	2.3 Inputs: - Human resources: PM, Procurement Officer - Procurement, contracting and transportation capacities, - Community involvement		2.3 Assumptions, risks: - Availability of contractors and construction materials; - Availability of stores
	2.4 Upgrading Yirol West ambulance service and in Greater Tonj.	2.4 Inputs: Human resources: PHC supervisor, Referral capacities		2.4 Assumptions, risks: -Movement capacities and road accessibility -Availability of adequate vehicles
	2.5 On-the-job training of Yirol Hospital staff on surgical intervention, management and follow up of obstetric emergencies and neonatal complications.	2.5 Inputs: - Human resources: trainers - Link with MoH at federal level to ensure continuous update on training strategies, manuals, priorities, etc. - Procurement capacities (training		2.5 Assumptions, risks: -Staff positive aptitude -No high staff turnover -Availability of enough qualified mentoring staff

		materials)		
	2.6 Training of PHCC/PHCU staff on emergency response and referral (first aid, triage, trauma management patients' stabilization).	2.6 Inputs: - Human resources: PHC Supervisors and trainers, - Link with MoH at federal level to ensure continuous update on training strategies, manuals, priorities, etc. - Procurement capacities (training materials)		2.6 Assumptions, risks: - Availability of standard protocols/guidelines; - Collaborative attitude from CHD; - No staff turnover.
	2.7 Epidemiological surveillance and organization of health emergency response (including. mass vaccination campaigns, namely measles).	2,7 Inputs: - Human resources: PHC/EPI supervisors - Logistic and movement capacities - Collaboration with concerned institutions (federal and state MoH, CHD, Commissioner, etc.) - Coordination among partners on the ground		2.7 Assumptions, risks: - Collaborative attitude from CHD; - Basic IT capacities;
	Output 3: 3.1 Organization of daily health, hygiene & sanitation education sessions (prevention of communicable diseases/STIs/malaria, EPI, health seeking behavior, hygiene, mainstreaming HIV/AIDS related-issues) in all supported facilities, targeting caretakers (men and women);	3.1 Inputs: - Human resources: PHC Supervisors, - Link with MoH at federal level to ensure continuous update on training strategies, manuals, priorities, etc. - Cultural mediation, - Community involvement		3.1 Assumptions, risks: - Availability of standard protocols/guidelines; - No staff turnover; - collaborative community attitude
	• **Output 4:** 4.1 Training/TA for CHDs on epidemiological surveillance, MoH DHIS/IDSR, e-warn systems.	4,1 Inputs: - Close and continuous collaboration with CHD; - DHIS utilization capacities		4.1 Assumptions, risks: - Availability of standard protocols/guidelines; - Collaborative attitude from CHD; - No staff turnover.
	4.2 Scale up of joint CHD/implementing partners' supporting supervision of health performances in each target county.	4,2 Inputs: - Networking and communication capacities; - Close and continuous		4.2 Assumptions, risks: - Collaborative attitude from CHD; - Basic IT capacities; - Road accessibility / freedom of movement

		collaboration with CHD; - DHIS utilization capacities		
	4.3 Participation to the Health Cluster coordination mechanism (state and national).	<u>4,3 Inputs:</u> - Networking and communication capacities; - Close and continuous collaboration with concerned CHDs and SMOHs; - Movement capacities		<u>4.3 Assumptions, risks:</u> - Road accessibility / freedom of movement - Availability of functioning vehicle
	4.4 Facilitation of inter-cluster coordination at state and national level (WaSH, Nutrition and Food Security clusters).	4<u>,4 Inputs:</u> - -Networking and communication capacities; - -Close and continuous collaboration with CHD; - -Movement capacities		<u>4.4 Assumptions, risks:</u> - Road accessibility / freedom of movement - Availability of functioning vehicle

PROJECT WORK PLAN

This section must include a workplan with clear indication of the specific timeline for each main activity and sub-activity (if applicable).
The workplan must be outlined with reference to the quarters of the calendar year.

Project start date:	01 Oct 2013	Project end date:	31 Mar 2014

Activities	Q3/2013			Q4/2013			Q1/2014			Q2/2014			Q3/2014		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1.1 Procurement/prepositioning and administration/informed distribution of essential/emergency drugs, non-medical supplies to the facilities (i.e., IEHK/DDK kits to face infectious diseases outbreaks)						x	x								
1.2 Ensuring continuous OPD services in all facilities and IPD service in hospitals/PHCC, including trauma management and serious cases' stabilization.				x	x	x	x	x	x						
1.3 Maintaining MISP in RH services (ANC/PNC, STIs, FP) and childhood disease integrated management in all supported facilities, especially to most vulnerable women and children (IDPs, returnees, victims of conflicts and violence).				x	x	x	x	x	x						
1.4 Scaling-up EPI service provision in all supported facilities.							x	x	x						
1.5 Enforcement of mobile clinics (outreach services) to serve remote/IDPs/returnees populations in the 5 counties, offering comprehensive MCH services to most vulnerable (unaccompanied children, U5, P&LW, victims of conflicts)				x	x	x	x	x	x						
1.6 Training and TA for local health staff of up to 28 facilities on: (i) epidemic preparedness/EWARN, (ii) management of communicable diseases, (iii) surveillance.							x								
2.1 Maintenance/strengthening of Yirol Hospital OT, Emergency Department, Surgical Wards to respond to emergencies				x	x	x	x	x	x						
2.2 Maintenance/strengthening of blood bank at Yirol Hospital to support the OT ensuring the prompt management of hemorrhagic emergencies.				x	x	x	x	x	x						
2.3 Maintenance/equipment of PHCCs IPDs, maternity rooms and laboratories to enhance diagnosis/treatment/referral capacities				x	x	x	x	x	x						
2.4 Upgrading Yirol West ambulance service.				x	x	x	x	x	x						
2.5 On-the-job training of Yirol Hospital staff on surgical intervention, management and follow up of obstetric emergencies and neonatal complications.				x	x	x	x	x	x						
2.6 Training of PHCC/PHCU staff on emergency response and referral (first aid, triage, trauma management patients' stabilization).					x			x							
2.7 Epidemiological surveillance and organization of health emergency response (including. mass vaccination campaigns, namely measles).				x	x	x	x	x	x						
3.1 Organization of daily health, hygiene & sanitation education sessions (prevention of communicable diseases/STIs/malaria, EPI, health seeking behavior, hygiene, mainstreaming HIV/AIDS related-issues) in all supported facilities, targeting caretakers (men and women);				X	X	X	x	X	x						
4.1 Training/TA for CHDs on epidemiological surveillance, MoH DHIS/IDSR, e-warn systems						x			x						
4.2 Scale up of joint CHD/implementing partners' supporting supervision of health performances in each target county.						x			x						
4.3 Participation to the Health Cluster coordination mechanism (state and national).				x	x	x	x	x	x						
4.4 Facilitation of inter-cluster coordination at state and national level (WaSH, Nutrition and FSL clusters).				x	x	x	x	x	x						
M&E 1. Data collection and reporting at HFs and County Level				x	x	x	x	x	x						
M&E 2. Reporting to the Cluster (narrative , financial, technical report)							x			x					
M&E 3. Technical monitoring on project development				x	x	x	x	x	x						