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	Nutrition

CHF Cluster Priorities for 2013 Second Round Standard Allocation

Cluster Priority Activities for this CHF Round	Cluster Geographic Priorities for this CHF Round
i) Management of acute malnutrition: Treatment for SAM and MAM in children U5 years, P&LW and other vulnerable groups ii) Prevention of acute malnutrition in the vulnerable population targeted (optimal IYCF-E, nutrition education, supplementation, BSFP) iii) Provision of emergency preparedness and response services (rapids assessments and response, trainings on Nutrition in Emergencies) iv) Pipeline: Procurement and management of pipeline(s) from central to end user location v) Provision and strengthening of state-level coordination aimed at improving intervention outcomes	1. Jonglei-Pibor, Akobo, Nyirol, Ayod, Fangak, Pochalla, Urol, Duk 2. Upper Nile -Maban, Nasir and Ulang 3. Unity-Panyjar, Kouch, Mayom, Abiemnhom, and Mayendit 4. NBeG- Aweil East and North 5. Warrap- Twic and Abyei area 6. WBeG-Raga

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

Requesting Organization	
Concern Worldwide	
Project CAP Code	**CAP Gender Code**
SSD-13/H/55021/R/8498	2a
CAP Project Title *(please write exact name as in the CAP)*	
Integrated nutrition interventions for malnourished children and women in South Sudan	

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)*
NBeG	70%	*Aweil West (80% of payams) and Aweil North (60% of payams)*
Unity	30%	*Jaak & Mirmir payams, Kouch County*

Total Project Budget requested in the in South Sudan CAP	US$ 1,338,625
Total funding secured for the CAP project *(to date)*	US$ 405,000

Funding requested from CHF for this project proposal	US$ 349,995
Are some activities in this project proposal co-funded (including in-kind)? Yes ☒ No ☐ *(if yes, list the item and indicate the amount under column i of the budget sheet)*	

Direct Beneficiaries

	Number of direct beneficiaries targeted in CHF Project	Number of direct beneficiaries targeted in the CAP
Women:	9,487	903
Girls:	15,232	22,068
Men:	986	
Boys:	14,231	20,617
Total:	39,936	43,588

Indirect Beneficiaries

Total: 66,409

Catchment Population (if applicable)

281,124
Source: 5th Sudan Population and Housing Census, 2008 with 2.2% of annual growth rate

Nutrition activity beneficiary breakdown				
	Women	Men	Girls (under 5)	Boys (under 5)
SAM	NA	NA	625	583
MAM	2,808	NA	2,369	2,213
BSFP	NA	NA	0	0
IYCF promotion	9,470	953	Indirect	Indirect
Trainees	40	40	NA	NA
Micronutrient supplementation*	2,808	NA	15,232	14,231
Deworming*	NA	NA	15,232	14,231

* **Not** counting beneficiaries treated according to protocols (e.g. SAM or MAM treatment)

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

N/A

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

Proposed dates: 1 October 2013 - 31 March 2014
Number of months: 6 months

Contact details Organization's Country Office	
Organization's Address	Concern Worldwide, P.O. Box 140, Hai Negley, Juba
Project Focal Person	Fahad Zeeshan ross.hnpm@concern.net +211 913106989
Country Director	Pradip Sanyal, pradip.sanyal@concern.net +211 92 8800116
Finance Officer	Peter Macharia ross.cfc@concern.net +211 926 685115

Contact details Organization's HQ	
Organization's Address	Concern Worldwide 55 Camden Street, Dublin 2, Ireland
Desk officer	Eileen Morrow eileen.morrow@concern.net +353 1 4178045
Finance Officer	Louise McGrath Louise.mcgrath@concern.net +35314177764

SECTION II

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]

Aweil West (AW) and Aweil North (AN) in Northern Bahr El Ghazal (NBeG) State and Kouch County in Unity State in South Sudan remains the highest risk states for child malnutrition and mortality in 2013. Concern conducted SMART surveys in 2013 and found that Global Acute Malnutrition (GAM) rates (using WFH method) in all 3 counties are above the acceptable WHO emergency thresholds of 15%.

In AW the GAM prevalence is 17.8 % and Severe Acute Malnutrition (SAM) with/without oedema is 3.6 %. While in Aweil North the prevalence of GAM) is 26.4 % and SAM is 5.4%. The retrospective morbidity and mortality rate is also high for Aweil West Aweil North and Kouch Counties. It is evident especially in case of Aweil North due to fresh influx of returnees and in Kouch due to security situation where many health facilities are not providing health or nutrition services as almost all the staff left.

Kouch: CWW found a GAM rate of 17.0 % and SAM rate of 2.8%.[2] Crude mortality was estimated to be 1.90 [1.15- 3.12] /10,000/day and under five mortality rate was 4.89 [2.53-9.25] /10,000/day. These rates are well above the emergency thresholds of 1 and 2 out of 10,000 per day respectively. The prevalence of SAM was highest (4%) among children aged 6-17 months, indicating that this age group is mainly affected by the recent serious malnutrition situation. Furthermore, it appears that severe malnutrition as per WFH z-score is higher among girls (3.3%) than boys (2.3%. Almost three quarters (71.9%) of surveyed children had one or more symptoms of illnesses in the two-week period preceding the survey: the three main causes were fever/ malaria, diarrhoea and cough/ARI, affecting 67%, 39% and 26.4% of children, respectively.

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.

CWW is a leading nutrition actor and has implemented nutrition interventions in NBEG since 2000, and is positioned to mount a response in Unity. The proposed activities are integrated in overall health, nutrition and food security programmes addressing the underlying causes of malnutrition.[3]

[1] KPC report 2012 done by CWW.
[2] Concern Worldwide, Kouch Nutrition and Mortality Survey, April 2013
[3] As identified by UNICEF's conceptual framework for malnutrition. http://www.unicef.org/sowc98/silent4.htm

Without CWW's assistance, malnutrition rates in all 3 counties are expected to worsen due to 1) seasonal floods affecting food production while concurrently increasing the disease burden (AN, AW, Kouch), 2) border insecurity (AN), 3) large IDP presence (AN), 4) closure of health & nutrition facilities (Kouch). The 3 CHDs have limited capacity and lack of resources to implement nutrition interventions without support from CWW.

CWW has an excellent relationship with the AW, AN CHDs and has begun preliminary positive discussions with Kouch CHD. All interventions align with the Basic Package of Health & Nutrition Services (BPHS) and will strengthen the CHDs' systems and capacities. CWW partners with UNICEF & WFP to access nutrition supplies and is an active member of the nutrition cluster. CWW has funding for BPHS provision (excluding nutrition) in AW & AN from Crown Agents (DFID) and expects to receive further funding. This CHF is requested to carryout on-going Nutrition Intervention as the previous CHF is exhausted and new CHF will complement the on-going activities. This Nutrition intervention will cover mothers and children who are malnourished in Aweil North and Aweil West areas.

AW & AN: With CWW support (through Irish Aid funding), 22 health facilities in AW and 16 in AN are now providing nutrition services reaching 50.7% of the population[4]. This is a dramatic increase from 2010, before CWW support, when only 11 facilities in AN provided services. With CHF funding, CHF support will help us to maintain operational coverage of the programme interventions mentioned above, as Irish Aid funding has almost been exhausted.

Kouch: Currently no nutrition services in the 2 target payams (Rier PHCU in Jaak payam and Mirmir PHCC in Mirmir payam). CWW will support the CHD to initiate CMAM in 2 HF.

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

This project aims to contribute to the reduction of childhood mortality and morbidity related to malnutrition by supporting the provision of preventive, curative and promotive services as per the BPHS in 40 health facilities (22 in AW, 16 in AN and 2 in Kouch). The project interventions will target vulnerable host, returnee and IDP communities in the three counties. The project interventions align with the following cluster priorities:

i) Management of acute malnutrition: Treatment for SAM and MAM in children U5 years, P&LW and other vulnerable groups
ii) Prevention of acute malnutrition in the targeted vulnerable population (optimal IYCF-E, nutrition education, supplementation, BSFP) through the promotion of the community management of acute malnutrition.
iii) Provision and strengthening of state-level coordination aimed at improving intervention outcomes by building the capacity of CHD on Nutrition through trainings on CMAM and IYCF.

While, the nutrition commodities (for SC, OTP and SFP) will be secured from UNICEF and WFP, Concern Worldwide will focus on improving programme coverage and quality (delivery, record keeping and supervision) with CHF support. Further, CHF support will help us to deliver all the four components of CMAM in an integrated manner in AN & AW, and 3 components in Kouch[5]. In addition, with support from CHF CWW will build linkages between the community and health facilities to strengthen referral by 2014.. CWW will integrate nutrition interventions at community and facility levels i.e. as part of Community Health & Nutrition, Primary Health Care (PHC) with a special focus on maternal & child health and nutrition for better programme outcomes.

i) Management of Acute Malnutrition: The provision of facility based Targeted Supplementary Feeding Programme (TFSP) for malnourished children U5 and P&LWs in AW, AN and Kouch Counties will rehabilitate them and reduce the risk of deteriorating into SAM. SAM cases without complications will be treated through the Out-patient Therapeutic Programme (OTP) in all three counties, while children with SAM and medical complications will be managed in Stabilisation Centres (SC). In Kouch, these children will be referred to a SC in Bentiu. These activities will be conducted directly by health facility workers with close supervision and support by CWW staff.

ii) Prevention of malnutrition at community level CHF support will help CWW's, CHDs' and HHPs' efforts to reduce acute malnutrition, while delivering adequately supervised and quality nutrition services. CHF funding will also enable the implementation of a targeted and action oriented IYCF behaviour change strategy[6] which includes 1) group mobilisation, 2) Home Health Promoters and 3) mass campaigns. The IYCF behaviour change strategy was developed based on Barrier Analysis, Communities discussion through Boma Health Committee (BHC) and BCC workshop.
   a. The group mobilisation component will organise elderly women and PLW groups (aka Mother to Mother groups) for activities which will facilitate positive change in IYCF, health seeking, hygiene and sanitation practices using Concern Worldwide curriculum. Men's groups will also be established to increase the involvement of men in this community in IYCF issues. School health clubs will also be established to increase awareness about diet diversity among children.
   b. Special attention will be given to improve community outreach activities through structured training of Home Health Promoters (HHPs) as an essential component of CMAM on MUAC screening, early identification, referral and follow up of malnourished cases. CWW has already initiated community screening (for acute malnutrition and major childhood illnesses and Vitamin A supplementation through HHP). HHPs are volunteer community members and will be supervised by Concern staff to ensure that malnourished children are identified, referred and followed up on.
   c. Health and nutrition education and awareness is spread through active engagement where basic personal hygiene and health activities e.g. hand washing, balanced diet are promoted at schools, community events, etc. CHF support will be helpful to continue these preventive interventions. Practical cooking demonstration will be performed at the community level to prepare locally made nutritious meals for the prevention of malnutrition which will be more acceptable and

[4] AW SQUEAC survey, April 2013
[5] SC will not be implemented in Kouch, instead children with complications will be referred to a SC in Bentiu
[6] Reference the strategy

sustainable.

iii) CHD Capacity & Coordination In order to improve the technical capacities of facility staff, CHD and CWW staff on CMAM and IYCF, training (including counselling) and refresher courses will be organised. CWW's Global technical expertise and experience in CMAM will be utilised to train and mentor staff at all levels. Training on reporting of CMAM activities (minimum reporting procedures) will be conducted as great challenges were faced in 2012 regarding poor quality reporting due to the low capacity of both facility and CHD staff. On the job training will be provided in the form of mentoring to CHD staff during field visits.
The coordination with CHD will be increased through meetings for joint review of County Health Plan along with other stakeholders which will include Nutrition as essential element. The coordination mechanisms will be established to share the results at the SMoH and with Nutrition cluster. CWW will also participate in Nutrition cluster meetings at State level and at National level.

ii) Project Objective

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

- Reduce mortality and morbidity due to acute malnutrition among 5,790 children 0-59months of age in Aweil West, Aweil North and Kouch through SC[5], OTP and SFP programmes.
- Reduce morbidity due to acute malnutrition among 2808 Pregnant and lactation mothers in Aweil West, Aweil North and Kouch through OTP and SFP programmes.
- Improve knowledge and awareness on nutrition, Infant and young child feeding, hygiene and sanitation best practices through reaching 39,936 community members.
- Ensure Micronutrient deficiencies are prevented in children under five years of age and pregnant and lactating women through timely and appropriate supplementation of Vit-A, Folic acid and Iron.

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).

Activities will include but not limited to;

Overall Activities in three counties:

- Train 5 CWW staff on IYCF, BCC and 3 on SMART survey methodology.
- Conduct Post-harvest Nutrition Surveys in the three counties during the month of October, 2013
- Conduct barrier analysis for complementary feeding behaviours i.e. meal frequency and dietary diversity

Aweil West:

- Rehabilitation of and provision of supplies for SC, OTP/SFP facilities
- MUAC screening of 11,552 (Boys 5,580 & Girls 5,972) children under five years and 4,621 PLWs and referral of identified malnourished cases for appropriate care/treatment
- Improved nutrition care to 1,845 moderately malnourished under five children (Boys 891, Girls 953) and 1,396 PLWs and 497 severely malnourished children
- 80 severely malnourished children admitted and treated at the 2 stabilization Centre's to resolve medical complications which put the child at a mortality risk
- Training courses of 44 health workers from 22 health facilities and County Health Department staff Nutrition Officers on CMAM
- Training for 44 health workers and CHD staff on IYCF
- Provide vitamin A supplementation and deworming medicines to 11,552 (Boys 5,580 & Girls 5,972) children during the NIDs campaign
- Improved capacity of 250 Home Health Promoters (HHPs)/BHC members on MUAC and morbidity screening, referrals and follow ups, IYCF, community mobilisation and hygiene promotion
- CHD will be supported with support on fuel and maintenance for referrals, monitoring and supervisory visit support
- Conduct joint monitoring & supervisory visits with CHD once per month
- Conduct 750 group sessions including cooking demonstrations, health & hygiene promotion and IYCF sessions targeting 5,775 (Men: 495 & Women: 5280) through routine MCH services at health facilities, and community level activities involving PLWs, mother groups, men's groups and other caregiver groups in Aweil West County.
- Support in terms of child and mother nutrition will be provided through Mother support groups which are already established.
- Vit-A & deworming done through health facilities and data collected through CHD.
- 18 school health club Teachers trained on promoting improved health and nutrition practices in Aweil West

Aweil North:

- Rehabilitation of and provision of supplies for SC, OTP/SFP facilities
- MUAC screening of 15,572 (Boys 7,521 & Girls 8,051) children under five years and 6,229 PLWs and referral of identified malnourished cases for appropriate care/treatment.
- Improved nutrition care to 2,301 (Boys 1,112, Girls 1,189) under five children and 1,036 PLWs moderately malnourished and 605 severely malnourished children
- 42 severely malnourished children admitted and treated at the 1 stabilization Centre's to resolve medical complications which put the child at a mortality risk
- Conduct a SQUEAC coverage survey for the CMAM program in Aweil North in March 2014
- Training courses of 32 health workers from 16 health facilities and County Health Department staff Nutrition Officers on CMAM.
- Training for 32 health workers and CHD staff on Infant and Young Child Feeding
- Provide vitamin A supplementation and deworming medicines to 15,572 (Boys 7,521 & Girls 8,051) children during the NIDs campaign
- Improved capacity of 176 Home Health Promoters (HHPs)/BHC members on MUAC and morbidity screening, referrals and follow ups, IYCF, community mobilisation and hygiene promotion
- CHD will be supported with support on fuel and maintenance for referrals, monitoring and supervisory visit support.

- Conduct joint monitoring & supervisory visits with CHD once per month
- Conduct 545 group sessions including cooking demonstrations, health & hygiene promotion and IYCF sessions targeting 3,360 women through routine MCH services at health facilities, and community level activities involving PLWs, mother groups and other caregiver groups in Aweil North County
- Support in terms of child and mother nutrition will be provided through Mother support groups which are already established.
- Vit-A & deworming done through health facilities and data collected through CHD.
- 12 school health club Teachers trained on promoting improved health and nutrition practices in Aweil North

Kouch:

- Establishing two OTP/SFP sites in Rier PHCU of Jaak and Mirmir PHCC of Mirmir payams
- MUAC screening of 2,340 (Boys 1,130 & Girls 1210) children under five years and 936 PLWs and referral of identified malnourished cases for appropriate care/treatment
- Improved nutrition care to 436 children (Boys, 211 Girls, 225) and 376 PLWs moderately malnourished and 106 severely malnourished children
- Training courses of 4 health workers from 2 health facilities and County Health Department staff Nutrition Officers on CMAM.
- Training for 4 health workers and CHD staff on Infant and Young Child Feeding
- Provide vitamin A supplementation and deworming medicines to of 2,340 (Boys 1,130 & Girls 1210) children during the NIDs campaign
- Improved capacity of 23 Home Health Promoters (HHPs)/BHC members on MUAC and morbidity screening, referrals and follow ups, IYCF, community mobilisation and hygiene promotion
- CHD will be supported with support on fuel and maintenance for referrals, monitoring and supervisory visit support
- Conduct joint monitoring & supervisory visits with CHD once per month
- Conduct 68 group sessions including cooking demonstrations, health & hygiene promotion and IYCF sessions targeting 800 women through routine MCH services at health facilities, and community level activities involving PLWs, mother groups and other caregiver groups in Kouch County

iv). Cross Cutting Issues

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

Gender: CWW recognises the inequalities women face in the Dinka community and the value they can contribute to all circumstances therefore throughout our programming we will promote the full participation of women to ensure that their needs are addressed adequately. In a previous project CWW encouraged female participation in Boma Health Committees and we have also successfully negotiated for female HHPs to be recruited in previous project, which is a major achievement in this strongly male-dominated culture. A recent CWW evaluation found that gender inequity resulting in heavy workloads of women is one of the key factors underpinning poor infant and young child feeding practices and resulting malnutrition: women simply don't have time to feed their children adequately. The long travel times to clinics only add to women's workload. By ensuring continued coverage of nutrition services in AN & AW and providing coverage in 2 payams in Kouch, the project will reduce women's workloads by reducing time spent travelling and waiting for nutrition services. Furthermore, using the community conversation methodology, CWW will engage men, especially traditional leaders, women & grandmothers and PLWs to identify/address the causes of malnutrition in the community (including gender inequity).

HIV/AIDS: Each programme activity will be assessed to reduce HIV/AIDS related risks. Further, HIV/AIDS related issues will also be addressed at the community and facility levels during preventive & curative services. Awareness campaigns and PMTCT will be the main focus on this cross-cutting component. This is critical as only 4% of the mothers are aware of at least three effective ways of preventing HIV transmission[7]. The CWW's Programme Participants Protection Policy (P4) applies both to our work and that of our partners, thus reducing the risk of sexual misconduct. Project activities have been designed in way that they do not increase the vulnerability of programme participants to HIV&AIDS.

Environment: Environmental awareness will be promoted through different focus groups e.g. PLWs/Care Groups, BHCs, HHPs to promote production and utilisation of local food items e.g. vegetables, fruits & leafy vegetables to improve diet quality & diversity. HHPs will be utilised to promote environmental sanitation reducing the prevalence of waterborne diseases and infections e.g. diarrhoea.

Accountability: CWW will involve beneficiaries at all stages of the project cycle. An appropriate mechanism will be established for beneficiaries to put forward their complaints CWW without fear of reprisal.

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.

1. 29,464 (14,231 boys & 15,233 girls) children of 6-59 months and 11,785 PLWs screened for malnutrition, referred and followed up for appropriate care
2. 1,208 children under five years' treated in OTP
3. 121 children treated in SCs
4. 4,582 children and 2,808 PLWs treated in TSFP
5. 80 CHD staff have improved capacities on CMAM & IYCF
6. 449 HHPs/BHCs have improved capacities in outreach activities
7. 9,935 (Men: 495 & Women: 9440) have good knowledge of IYCF practices
8. Children in 20 schools are practicing and promoting personal hygiene actions
9. 3 SMART surveys and 1 SQUEAC coverage survey conducted

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.

[7] Concern Worldwide, 2012. Health Facility Assessment – A Baseline Assessment, November, 2012.

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	1.	Number of Children (under-5) admitted for the treatment of SAM Number of Stabilisation Centres providing standard services Number of OTP sites providing standard services	Total Children tx for SAM: 1,208 Total Children SAM with medical complications: 121 (Boys: 58 and Girls: 63) No. of Stabilisation Centres: 3 No. of OTP sites: 40
X	2.	Outpatient Therapeutic Program meet acceptable Sphere standards; i. Cure Rate (%) ii. Default Rate (%) iii. Death Rate (%)	i. >75% SPHERE standard ii. <15% SPHERE standard iii. <3% SPHERE standard
X	3.	Number of Children (under-5) and PLWs admitted for the treatment of Moderate Acute Malnutrition (MAM) Number of TSFP sites	Children: 4,582 (Boys: 2199, Girls: 2382) PLWs: 2,808 No. of TSFP sites: 40
X	4.	Targeted Supplementary Feeding Program meet acceptable SPHERE standards; i. Cure Rate (%) ii. Default Rate (%) iii. Death Rate (%)	i. >75% SPHERE standard ii. <15% SPHERE standard iii. <3% SPHERE standard
	5.	Number of Children de-wormed	Total: 29,464 (Boys: 14,231 & Girls: 15,233)
	6.	Number of Children supplemented with Vitamin A	Total: 29,464 (Boys: 14,231 & Girls: 15,233)
X	7.	Health and nutrition workers trained (includes health facility, CHD level) in CMAM & IYCF as per South Sudan guidelines.	Total staff: 80 CMAM: 80 IYCF: 80
X	8.	Training of CWW staff on IYCF, BCC and SMART methodology.	Total: 8 IYCF & BCC: 5 SMART: 3
	9.	Training of Home Health Promoters on MUAC screening, identification, referral and follow up.	Total HHPs: 449
	10.	IYCF & cooking demonstration sessions conducted	Total sessions: 1363 Total participants: 9,935 Men: 495 Women: 9440
X	11.	Number of SMART Surveys Conducted Number of SQUEAC Surveys Conducted	Total SMART surveys: 4 Pre-harvest: 3 No. of counties: 3 SQEAC Survey: 1
X	12.	No. of joint monthly supervisory visits conducted	40 (40 health facilities each receiving one joint visit in 6 months)
X	13.	No. of children screened in the community.	29,464 (Boys: 14,231 & Girls: 15,233)

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.

The project will be implemented directly by CWW in close partnership with the CHD. All relevant interventions will be integrated into MoH facilities as per the BPHS recommendation in close collaboration with the respective CHDs. Curative services including TSFP, OTP, SC will be provided in minimum of 38 targeted health facilities in Aweil West, Aweil North counties in NBeG State and TSFP and OTP services in 2 health facilities in Kouch. Community mobilisation activities will be facilitated through HHPs in close collaboration with BHCs and Mother Care Groups and involvement of community conversations. Capacity building of the CHD and Home Health Promoters will be done using MoH protocols towards treatment and prevention of acute malnutrition. CWW has been working for a sustainable approach to develop the capacity of health facilities' staff to tackle with acute malnutrition at county level.

CWW will recruit new staff for Kouch County of Unity state as it is the new area of intervention. The staff will be recruited for six months and will continue once more funding is available. The staff for Aweil North and Aweil West counties of NBeG will remain the same. The staff who will be recruited are Project officer (Nutritionist), Assistant project officer, Community mobilizer, Logistic officer and support staff for next six months.

CWW will be in close coordination with Unicef and WFP not only at cluster level but separate coordination meetings will be held with both partners. The coordination meeting with Unicef and WFP will be focusing on program progress, achievements, challenges and way forward. CWW will also invite Unicef and WFP in quarterly review of County Health plan at CHD level improve the communication and programme implementation.

vii) Monitoring and Reporting Plan

Data segregated by age and gender from project activities will be regularly collected, analysed and interpreted towards evidence based planning and action. From 2014, CWW will roll out DDG (digital data gathering) with support of HQ to collect SMART surveys

1. Joint monitoring & supervisory visits by CWW staff along with CHD representative(s) at County level to health facilities and communities will be conducted once per month
2. Monthly, quarterly and annual reports will be prepared by CWW staff using standard nutrition templates by nutrition team of CWW. These will show the progress in terms of number of target beneficiaries reached, results achieved and help to improve programming to achieve objectives
3. CWW will also send the nutrition cluster monthly report every month to show the progress on the nutrition indicators.
4. Monthly, quarterly and final report will be compiled for sharing with SMoH, CHD, Nutrition cluster and donors. These reports will

include a progress on the project achievements using output indicators as well as best practices and lessons learnt

5. SQEAC Coverage Survey and SMART Nutrition surveys will be conducted by CWW and CHD will provide service coverage and nutritional status of the population, which will help in future planning

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)
ECHO (No Cost Extension ends on 31st March'13)	75,000
Irish Aid Programme Fund (IAPF) (January to December'13) to co-fund Health & Nutrition interventions in NBeG	305,000
Crown Agents (HPF) / DFID (January to August'13) for HPF	25,000
Pledges for the CAP project	
None	

SECTION III:

LOGICAL FRAMEWORK		
CHF ref./CAP Code: SSD-13/H/55021	**Project title:** Integrated nutrition intervention for children and women in South Sudan	**Organisation: Concern Worldwide**

	Cluster Priority Activities for this CHF Allocation:	**Indicators of progress:**	**How indicators will be measured:**	**Assumptions & risks:**
Overall Objective	1) Management of acute malnutrition: Treatment for SAM and MAM in children U5 years, P&LW and other vulnerable groups	1.1). 29,464 (14,231 boys & 15,233 girls) children of 6-59 months and 11,785 PLWs screened for malnutrition, referred and followed up for appropriate care 1.2). 1,208 children under five years' treated in OTP 1.3). 121 children treated in SCs 1.4). 4,582 children and 2,808 PLWs treated in TSFP 1.5). 80 CHD staff have improved capacities on CMAM & IYCF	a). SMART survey. b). Monthly MRP reports. c). SQUAEC survey. d). Nutrition cluster meeting minutes	1) Availability of supplies i.e., RUTF & RUSF from UNICEF & WFP without breakdown of supply chain. 2) Access to services is not hampered by insecurity and flooding. 3) Availability of adequate and skilled health workers at the health facility level.
	2). Prevention of acute malnutrition in the vulnerable population targeted (optional IYCF-E, nutrition education, supplementation, BSFP)	2.1). 449 HHPs/BHCs have improved capacities in outreach activities 2.2). 9,935 (Men: 495 & Women: 9440) have good knowledge of IYCF practices 2.3). Children in 20 schools are practicing and promoting personal hygiene actions 2.4). 3 SMART surveys and 1 SQUEAC coverage survey conducted		
	3). Provision and strengthening of state-level coordination aimed at improving intervention outcomes	3.1) 6 state level Nutrition cluster meeting attended in course of the project period 3.2) 6 county level coordination meetings attended.		
Purpose	**CHF Project Objective:**	**Indicators of progress:**	**How indicators will be measured:**	**Assumptions & risks:**
	Reduce morbidity and mortality due to acute malnutrition amongst 5,790 children under 5 years of age and 2808 pregnant and lactating women in AN, AW & Kouch counties	At least 50% of eligible children aged 6 to 59 months have access to nutritional services and treatment performance indicators meet Sphere minimum standards 1). Wasting <15% 2). SAM <2% 3). Underweight <20%.	a). SMART surveys. b). SQUEAC survey. c).Monthly MRP reports	1) Availability of supplies i.e., RUTF & RUSF from UNICEF & WFP without breakdown of supply chain. 2) Access to services is not hampered by insecurity and flooding. 3) Availability of adequate and skilled health workers at the health facility level.

Results	**Results - Outcomes (intangible):**	**Indicators of progress:**	**How indicators will be measured:**	**Assumptions & risks:**
	Ensure appropriate quality treatment of malnutrition and improve the nutrition status of children under 5 years and of pregnant and lactating women in the programme areas.	29,463 (Boys 14,231 & Girls 15,232) children 6 to 59 months and 8,966 PLW screened for acute malnutrition A). Outpatient Therapeutic Program meet acceptable Sphere standards; i). Cure rate of >75% ii). Death rate < 10% in OTP. Iii). Defaulter rate <15% iv). Coverage >50%. B). Number of TSFP sites Targeted Supplementary Feeding Program meet acceptable SPHERE standards; i). Cure Rate >75% ii). Default Rate <15% iii). Death Rate <3%	a). Nutrition monthly, quarterly and annual reports. b). SMART Nutrition survey reports.	i) Positive attitude of the beneficiaries towards treatment. ii) Willingness of the communities to participate and play their role responsibly.
	Immediate-Results - Outputs (tangible):	**Indicators of progress:**	**How indicators will be measured:**	**Assumptions & risks:**
	Result 1: Improved access to quality OTP and SFP services among children 6-59 months and PLWs.	1.1) #/% of identified acutely malnourished children 6-59m and PLW that are referred to the appropriate CMAM service (SC, OTP & TSFP) 1.2) #/% of children 6-59m and PLW referred who are admitted to the appropriate CMAM service (SC, OTP & TSFP) 1.3) Number of Children (under-5) admitted for the treatment of SAM 1.4) Number of Stabilization Centres providing standard services 1.5) Number of OTP sites providing standard services 1.6) Number of Children (under-5) and PLWs admitted for the treatment of Moderate Acute Malnutrition (MAM) 1.7) Exit indicators for severe acute malnutrition reach or exceed SPHERE standards 1.8) Exit indicators for moderate acute malnutrition reach or exceed SPHERE standards	a) Nutrition monthly, quarterly and annual reports. b). Coverage survey reports c). Community Nutrition reports of referrals. d). Monthly MRP reports. e). Nutrition data from Health facilities.	i) Community willingness to participate in program activities. ii) Availability of supplies. iii) Health Facility staff are committed and willing to provide quality nutrition services.
	Immediate-Results - Outputs (tangible):	**Indicators of progress:**	**How indicators will be measured:**	**Assumptions & risks:**
	Result 2:	2.1) 20% of men & women who know the	a) Men & women have	a) Security situation doesn't allow

	Improve knowledge and awareness on nutrition, Infant and young child feeding, hygiene and sanitation best practices through reaching 39,936 community members.	importance of exclusive breastfeeding. 2.2) 30% of men & women who know at least 2 of the 5 critical times of hand washing. 2.3) Minimum of 1,363 IYCF sessions conducted. 2.4) 9440 mothers/women and 495 men who attended IYCF sessions. 2.5) 28% of children 6 – 23 meet the minimum meal frequency. 2.6) 5% of children 6 – 23 months meet the minimum acceptable diet. 2.7) 60% of children 0 – 5 months are exclusively breastfed. 2.8) 20% of caregivers washing hands at 2 critical times.	good knowledge of IYCF practices as a result of participation in IYCF related activities. b). IYCF session reports. c). SMART Survey (with FCS/HDDS)	to conduct the community mobilization sessions. b) Rainy season decrease the access to health facilities.
	Result 3: **Micronutrient deficiencies** are prevented in children under five years of age and pregnant and lactating women through timely and appropriate supplementation of Vit A, Folic Acid and Iron.	3.1) 50% of children 6-59 months received vitamin A supplementation. 3.2) 50% of children 12-59 months receive deworming medicines. 3.3) 70% of pregnant women received iron & foliate supplementation. 3.4) Minimum of 1,363 IYCF sessions conducted. 3.5) 9440 mothers/women and 495 men who attended IYCF sessions.	a) Nutrition survey reports. Monthly, quarterly and annual reports b). Immunization campaign reports from Health facilities. c). IYCF sessions reports	a). Access to the immunization campaigns and facility based services. b). Community willingness to participate in program activities. Availability of supplies. c). Availability of immunization supplies and cold chain.
	Result 4: **1)** Improved capacity of health workers and nutrition workers in CMAM & IYCF 2) Improved capacity of school health club teachers on health and nutrition issues. 3) Joint monitoring and supervisory visits conducted to program sites. 4) SMART & SQUEAC surveys conducted	4.1a) 80 (men-78 & women-2) CHD staff trained on CMAM & IYCF. 4.1b) 458 (Men-408 & women-50) Home Health Promoters (HHPs)/BHCs trained on MUAC screening, referral, follow ups and IYCF. 4.2a) 30 school health club teachers trained on management of school health clubs 4.3a) Minimum of 38 joint monitoring visits conducted. 4.4a) 1 SQUEAC survey conducted 4.4b) 4 SMART surveys conducted	a). CHD staff CMAM training reports. b). HHP training reports. c). training report of teacher on school health clubs. d). Monitoring reports e). SQUEAC and SMART survey documents.	a). CHD staff is not available for training. b). HHP are not trained due to bad security situation. c). Holidays in schools and delay in their trainings.
	Activities: Activities include;	**Inputs:** Inputs may include but not limited to;		**Assumptions, risks and pre-conditions**:
	Result-1: 1.1) Rehabilitate SFP/OTP sites/shelters.	a). Equipment. b). Therapeutic & Supplementary Food		a). Breakage in supply chain of RUTF.

	1.2) Conduct MUAC screening of children under-five years and PLWs from target communities in two counties and referral to the nearby health facilities 1.3) Admit and treat children and PLWs experiencing acute malnutrition in 40 health facilities. 1.4) Provide necessary supplies and equipment to CHD for effective management of acute malnutrition.	supplies. c). Training of CHD staff on CMAM d). Vehicles and related cost (fuel & maintenance). e). Stationary and IEC materials. f). Incentives for training & surveys participants.		b). low training participants due to other trainings. c). Bad security situation leading to low admissions.
	Result-2: 2.1) Conduct 1, 363 IYCF mother care group sessions. 2.2) Conduct Global Breastfeeding Week awareness sessions and campaigns.	a). CHD support inputs i.e., incentives, fuel, stationary and transportation for supervision. b). Salaries of CWW staff. c). Transportation support to carry supplies from UNICEF & WFP to warehouse/store and finally to health facilities.		a). Low IYCF trainings due to bad security or other reasons. b). slow transport due to bad roads and rainy season.
	Result 3: 3.1) Conduct deworming and vitamin A campaigns.	a). Stationary and supplies for trainings and community sessions and campaigns.		a). non availability of supplies i.e. deworming tablets and Vit-A capsules.
	Result 4: 4.1) Train health workers from 40 health facilities on CMAM & IYCF. 4.2) Train Concern staff on IYCF, BCC and SMART survey methodology. 4.3) Train 456 Home Health Promoters (HHPs)/BHCs on MUAC screening, referral, follow up and IYCF. 4.4) Train Boma Health Committee members. 4.5)Train school health clubs' teachers on health and nutrition education. 4.6) Conduct joint monitoring & supervisory visits with CHD. 4.7)Provide IEC material to 30 school health clubs. 4.8) Provide IEC materials to HHPs and BHCs members. 4.9) Conduct SMART nutrition surveys in the two counties. 4.10)Conduct SQEAC coverage Survey. 4.11) Participate in coordination meetings at County, State and National level.	a). Stationary and supplies for trainings and community sessions. b). Materials needed for school health club competition. c). IEC materials needed for Nutrition Education		a). Low turnover for CMAM training due to high workload on health facilities. b). High turnover of HHP's as they are volunteers and incentives are non-existing. c). Low joint monitoring due to other engagement of CHD staff. d). delay in SMART or SQUEAC survey due to bad security or weather.

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:	**1 Oct-2013**	**Project end date:**	**31 Mar-2014**

Activities	**Q1/2013**			**Q2/2013**			**Q3/2013**			**Q4/2013**			**Q1/2014**		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Activity 1 Rehabilitation of and provision of supplies for SC, OTP/SFP										×	×				
Activity 2 MUAC screening of 29,463 (Boys 14,231 & Girls 15,232) children under five years and 8,966 PLWs from target communities in two counties and referral of identified malnourished cases for appropriate care/treatment.										×	×	×	×	×	×
Activity 3 Provide nutrition care to 4,582 children and 2,808 PLWs moderately malnourished and 1,208 severely malnourished children in 3 counties.										×	×	×	×	×	×
Activity 4 121 severely malnourished children admitted and treated at the 3 stabilization Centre's to resolve medical complications which put the child at a mortality risk.										×	×	×	×	×	×
Activity 5 Training courses of 78 (Men: 76 & Women: 2) health workers from 38 health facilities (22 in Aweil West and 16 in Aweil North) and 2 County Health Department staff Nutrition Officers on CMAM											×	×	×	×	×
Activity 6 Train 5 Concern staff on IYCF, BCC and 3 on SMART survey methodology.											×		×		
Activity 7 Training for 78 health workers (Men: 76 & Women: 2) and 2 CHD staff on Infant and Young Child Feeding.										×	×	×	×	×	×
Activity 8 Conduct Post -harvest Nutrition Surveys in the three counties during the month of October, 2013										×					
Activity 9. Conduct a Squeac coverage survey for the CMAM program in Aweil North in March 2014.															×
Activity 10 Conduct barrier analysis for complementary feeding behaviours i.e. meal frequency and dietary diversity.														×	×
Activity 11 Provide vitamin A supplementation and deworming medicines to 29,463 (Boys 14,231 & Girls 15,232) children during the NIDs campaign.										×	×	×	×	×	×
Activity 12 Improved capacity of 456 (Men: 406 & Women: 50) Home Health Promoters (HHPs)/BHC members on MUAC and morbidity screening, referrals and follow ups, IYCF, community mobilisation and hygiene promotion.										×	×	×	×	×	×
Activity 13 CHDs will be supported with fuel and maintenance for ambulance and monitoring and supervisory visit support.										×	×	×	×	×	×
Activity 14 Conduct joint monitoring & supervisory visits with CHD once per month.										×	×	×	×	×	×
Activity 15 Conduct 1,363 group sessions including cooking demonstrations, health & hygiene promotion and IYCF sessions targeting 9935 (Men: 495 & Women: 9440) through routine MCH services at health facilities, and community level activities involving PLWs, mother groups, men's groups and other caregiver groups in both Aweil West and North counties.														×	×
Activity 16 30 school health club Teachers trained on promoting improved health and nutrition practices in Aweil West and Aweil North Counties.										×	×	×	×	×	×

*: TIMELINE FOR EACH SPECIFIC ACTIVITY MUST BE MARKED WITH AN X AND SHADED GREY 15%