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
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	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, Koch, Mayom, Abiemnhom, and Mayendit **4**. NBeG- Aweil East and North **5**. Warrap- Twic and Abyei area **6**. WBeG-Raga

SECTION II

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

Requesting Organization	
CCM/CUAMM	
Project CAP Code	**CAP Gender Code**
SSD-13/H/55145/R/6703	2a
CAP Project Title *(please write exact name as in the CAP)*	
Enhancing EP&R to nutrition 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)*
Warrap	40	*Tonj East, Tonj South*
Lakes	60	Awerial, Yirol East, Yirol west

Total Project Budget requested in the in South Sudan CAP	US$ 822,000
Total funding secured for the CAP project *(to date)*	US$ 473.592

Funding requested from CHF for this project proposal	US$ 225,000

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	Number of direct beneficiaries targeted in CHF Project	Number of direct beneficiaries targeted in the CAP
Women:	11,254	53,600
Girls:	8,747	70,350
Men:	764	15410
Boys:	8,898	70,350
Total:	**29,663**	**209,710**

Nutrition activity beneficiary breakdown[1]

	Women	Men	Girls (under 5)	Boys (under 5)
SAM			431	430
MAM			418	417
BSFP	N/A	N/A	N/A	N/A
IYCF promotion	6,383	709		
Trainees	15	40		
Micronutrient supplementation*	1,640		1,975	1,824
Deworming*			1,975	1,824

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

Indirect Beneficiaries

Target population is composed of communities living scattered, in remote/underserves areas and cattle camps, IDP/returnees' camps, with very poor or discontinuous access to basic services (75% reached by CCM, 25% by CUAMM). U5 (59% of the beneficiaries) and women in reproductive age (approximately 38% of the beneficiaries, out of which at least 50% pregnant) are the most exposed to epidemic outbreaks and health complications 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. Nutrition 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 least13% of the beneficiaries). Indirect beneficiaries count around 441,000 people (70% of the population in the catchment area).

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)

CUAMM Doctors with Africa

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

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

Contact details Organization's Country Office	
Organization's Address	CCM – Comitato Collaborazione Medica Juba – Munuki. Suk Melitia
Project Focal Person	*Corrado Di Dio (Lakes State)* *corrado.didio@ccm-italia.org* *+211 921276394* *FloriBakalli (Warrap State)* *Areacoordinator.gt@ccm-italia.org* *+211 913391617*
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Finance Officer	*MekonnenAbegaz* *Admin.ssd@ccm-italia.org* *+211 921899785*

Contact details Organization's HQ	
Organization's Address	CCM – Comitato Collaborazione Medica Via Ciriè 31/E 10152Torino (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

SECTION III

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[2]

Greater Yirol (Lakes) and Greater Tonj (Warrap) inhabitants are 604.350 (50% women), 32,970 returnees (11,134 arrivals over the past 18 months) and 32,680 IDPs, resulting from seasonal floods or sub-tribal clashes (62 deaths reported in Q1/Q2 2013, OCHA).Poverty prevalence rate is 48.9%, while general health data are:

- maternal mortality: 2054/100,000
- neonatal mortality: 49/1,000
- U5 mortality: 106/1,000

[1] Beneficiaries of MAUC screening and CHD capacity building are notincluded.

[2] 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.

- DPT3 coverage: 61% in Yirol East, 63% in Yirol West *(GoSS 2012).*

WFP estimates 80,996 and 254,881 people to be respectively highly and moderately food insecure (Yirol East/Yirol West conditions are called 'deteriorated'). Nutrition data are steadily above WHO recommended standards:

- Awerial: CCM SMART survey validated in May 2013 reported 21,1% GAM, 17.1% MAM, 4% SAM;
- Yirol East; CCM data for Q1/Q2 2013 show 36.4% GAM, 26.8% MAM, 9.6% SAM;
- Yirol West: an assessment conducted by CUAMM in March 2013shows vulnerable population, whose nutritional status is permanently at risk (U5 MAM prevalence is 2,5%, SAM 3%, women's SAM is 2%, MAM 7%).
- Tonj East and Tonj South:.CCM data collected during PHC service provision (MUAC screening for U5) show 5% SAM rate in Tonj East, 4% SAM rate in Tonj South.

Nutrition activities in Greater Yirol started in September 2012, thanks to CHF and UNICEF support to CCM/CUAMM (the only PHC service providers in the counties). In Tonj East and South Nutrition activities are not integrated within the PHC system, which risks to duplicate SPs' efforts and decrease action effectiveness. CCM/CUAMM, supported by HPF in all the 5 Counties, have applied as leading agency for the 5 Counties health system strengthening. Should submitted proposals be positively evaluated, from September CCM would start negotiations with concerned parties to fully integrate Nutrition Program within the PHC system also in Tonj East and Tonj South, in line with BPHS recommendations.

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.

Greater Yirol and Greater Tonj are poorly served by integrated PHC & Nutrition services, due to the institutional lack of human, technical, financial resources and capacities to set up emergency response to internal clashes, IDPs movements, returnees' influx, floods, food insecurity, outbreaks.

As consequences of the HPF county-wide funding approach, CCM and CUAMM could remain the only Health service providers in the 5 counties, responsible also for integrating Nutrition program within PHC system. The new scenario will require additional funds to respond to all needs, with the advantage to improve Health and Nutrition integration and strengthen local institutions' capacities.

The project will continue the on going nutrition program in GY, complementing what is being done up to now with CHF funds and other partners (mainly UNICEF and WFP) support and starting integration of Nutrition activities in GT, where the nutrition services are risking a stoppage (as consequence the number of beneficiaries is higher than in the CHF13-1). The funding allocated in this second allocation should be considered as a top up from the fund received in the first allocation in 2012.

Nutrition activities will be integrated with MCH services, nutrition education within health education session. People accessing health facilities will benefit from nutrition services, while the communities will have access to nutrition programs through outreaches. In order to reduce the number of defaulters registered in the first phase of the project, outreaches will be reinforced in order to:

- Clearly identify the defaulters;
- talk to the mothers/families and understand the reasons for the choice (transport, lack of education)
- to strengthen the education of the individual family;
- designing a plan for ongoing support (weekly visit, for example) to reinforce the messages.
- identify a person to serve as community support and control over family.

HPF can support minimal preventive component of nutrition program but CANNOT support the key and expensive treatment component. UNICEF supports mostly focuses on supplies and logistics.

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CHF resources are crucial to complement CCM/CUAMM secured funds, covering financial gaps for:

- human resources,
- SC/OTP set up/reinforcement,
- expansion of outreach capacities,
- trainings,
- institutional and staff capacity building.

During Q2 2013 CCM/CUAMM spent 21% and committed 35%of CHF R1 resources. The still available funds will be exhausted by September 2013.

Added values:

- CCM/CUAMM long-standing partnership with SMoHs/CHDs
- integration of CHF project within broader programs supported by other donors
- expansion of nutrition services in Tonj East, Tonj South.

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.

In line with the Nutrition Cluster overall objective, the project aims at continuing the provision of preventive and treatment nutrition services to vulnerable population in Greater Yirol of Lakes State and starting nutrition activities in Tonj East and Tonj South (Warrap State), where most of the population suffers from high malnutrition/food insecurity rates, poor access to basic health and hygiene

services, remote hotspots and high influx of IDPs and returnees.

The Project answers to at least 3 of the 5 identified Cluster priorities:

a) the integrated management of acute malnutrition in children under five, pregnant and lactating women, and other vulnerable groups;
b) the prevention of malnutrition in vulnerable population (pregnant and lactating women and children under five) through micronutrient supplementation, the provision of supplementary foods, support of infant and young child feeding, and health and nutrition education;
c) provision and strengthening of state and county-level coordination aimed at improving intervention outcomes.

Besides CHF funds, IPs will rely on other supports, involving more donors and stakeholders and integrating this intervention in their wider programs to ensure a comprehensive answer to the assessed needs. IPs will continue engaging with other stakeholders on the ground to prevent overlapping and look for synergies to increase effectiveness of the program (namely Plan/KHI for the referral of MAM cases in Awerial). The proactive involvement of the local population, through the creating/strengthening of HCs (in which female participation will be encouraged), tasked with peer-to-peer education, will support the promotion of nutrition service and will enhance nutrition surveillance across the communities. Where present, also women's group shall be proactively involved in awareness-raising activities

ii) Project Objective

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

To expand access to and utilization of Nutrition preventive and curative services for MARPs (P&LWs, women and boys/girls U1/U5 living under the poverty line, in remote or underserved areas, including IDPs and returnees in Greater Yirol (Awerial, Yirol East and Yirol West counties) - Lakes State and Tonj South and Tonj East - Warrap State.

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. Integrated nutrition services for U5 and P&LW in Greater Yirol and in Greater Tonj are consistently provided in 1 hospital, 6 PHCC and 6 PHCUs

- Consolidation of Yirol Hospital SC and support of Adior PHCC SC, based on assessed needs (Lakes State).
- Maintain OTPs in PHCC/Us in Greater Yirol;
- Start OTP in up to 2 facilities in Tonj East, 2 facilities in TS; 1 facility in Yirol East, 1 facility in Awerial.
- Procurement and prepositioning and distribution of essential/emergency drugs and nutrition supplies for SAM/MAM treatment and management of the related complications at facility level.
- Maintaining coordination (through coordination meetings and MoUs with other IPs: namely Plan/KHI and concerned SMoH) between OTP and STFP services in Greater Yirol counties, when SAM and MAM cases are treated by different partners.
- Maintaining of integrated ANC/PNC and nutrition services for P&LW, including ordinary screening and micronutrient supplementation, in Yirol County Hospital MCH and gradually introducing it in all the PHCC/Us in the whole project catchment area;
- Maintaining integrated U5 growth monitoring within EPI/OPD ordinary service provision, including micronutrient/Vitamin A supplementation and deworming, in Yirol County Hospital MCH and gradually introducing it in all the PHCC/Us in the whole project catchment area;
- Enhancing the emergency referral system through improved coordination among partners/stakeholders.
- Theoretical / on the job training of health staff on (i) Integrated Management of SAM/MAM, (ii) IYCF and (iv) complicated cases emergency referral.
- TA and supportive supervision to health staff responsible for nutrition data collection/recording and drug administration.

DIRECT BENEFICIARIES OUTPUT 1:

- U5 SAM cases treated: 861 (50% girls)
- U5 MAM cases treated: 835 (50% girls)
- Health staff trained/supervised: 55 (27% women)
- U5 MAM cases referred to partners: 750

Output 2. Acute malnutrition is prevented for both U5 and P&LW in host and IDP/Returnee communities in the catchment area

- Implementation of at weekly outreaches, covering the entire targeted counties and targeting underserved areas, cattle-camps, IDP/returnees camps, marginalized households.
- Organization of weekly nutrition education sessions (breastfeeding, dietary intake, complementary feeding, food hygiene and preparation, FP and RH etc.) at facility and/or outreach level in all supported hospitals/PHCC/PHCU, targeting caretakers (men and women) and women in childbearing age.
- Organization of targeted education sessions on safe nutrition/feeding practices for U5 and P&LWs for opinion leaders and peer-

to-peer educators (i.e. Village Health Committees, Home Health Promoters, religious leaders, community/cattle-camps leaders).

DIRECT BENEFICIARIES OUTPUT 2:

- U5 screened (MUAC): 11,400 (50% girls)
- P&LW screened (MUAC): 3,216
- U5 supplemented with Vitamin A and dewormed: 3,799 (50% girls)
- P&LW supplemented with macronutrients: 1,640
- Community members reached by nutrition messages (IYCF): at least 7,092 (at least 10% men)

Output 3. Nutrition EP&R capacities at Greater Yirol, Tonj East and Tonj South county level are enhanced

- Training and TA to concerned CHDs and selected health staff (both male and female) on (i) MoH and Nutrition Cluster reporting tools, (ii) nutrition surveillance and e-warning systems.
- Set up /scale up of joint CHD/implementing partners' supporting supervision mechanism of nutrition-related health facilities performances;
- Effective participation to the Nutrition Cluster coordination mechanism at state and national level.
- Facilitation of inter-cluster coordination system at state and national level (with Health, WaSH and Food Security clusters).

DIRECT BENEFICIARIES OUTPUT 3:

CHD members capacity built on nutrition surveillance, program planning/implementation/supervision, record keeping: 15

iv). Cross Cutting Issues

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

DRR: Disaster risk reduction is mainstreamed in all project components by supporting basic nutrition services for children U5, PL&W both at facility and outreach level and by strengthening the nutrition EP&R of CHDs and selected Health/Nutrition staff.

ENVIRONMENT: The targeted Hospital, PHCCs and PHCUs adhere to the infection control and universal precautions policies as it is recommended by the Ministry of Health andPublic sanitation. Mitigation measures include: (i) incinerators for hazardous waste management are in use and periodically maintained in all CCM-CUAMM supported facilities; (ii) during outreaches, safe collection and waste dumping will be ensured; (iii) food preparation education sessions will mainstream environment education on the collection/use/management of cooking materials (charcoal/wood) (iv) vehicle movements will be effectively planned and coordinated in order duplications of trips to be avoided and several passengers from more stakeholders to be transported.

HIV/AIDS: (i) nutrition surveillance and services will be fully integrated in the health system, including HIV/AIDS prevention promotion (availability of VCT/PMTCT services at hospital level), (iii) nutrition education sessions at both facility and outreach level will also address PMCTC (including infant breastfeeding for HIV+ mother), nutrition requirements for people living with HIV&AIDS, and HIV prevention (within FP education).

GENDER: Girls/women (including most vulnerable ones, like pregnant women, women head of households, women victims of violence, women living in cattle camps) are part of the project main target and are direct beneficiaries of most activities. Moreover, women will play a great role in the successful implementation of the project activities through active participation of the female health/nutrition staff in the nutrition activities, including outreach and nutrition education sessions. Gender mainstreaming is pursued through (i) equal opportunity of accessing nutrition services; (ii) mobile clinic targeting mostly women, penalized by home care duties and traditional rules regulating their movements; (iii) organization of awareness raising and nutrition education sessions targeting also men and opinion leaders to facilitate behavioral changes.

CAPACITY DEVELOPMENT; theoretical and on the job trainings involving both nutrition personnel and institutional partners have been included as main project activities to concretely enforce the early warning and nutrition emergency risk reduction in Greater Yirol and Tonj East and Tonj South 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.

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. Frontline nutrition services for U5/P&LW in Greater Yirol, Tonj East and South
   - 2 SCs (Greater Yirol)
   - 11 OTPs
   - SAM/MAM identified
   - P&LW provided with ANC/PNC/nutrition
   - U5 provided with EPI/nutrition
   - Nutrition emergency referral system
   - HFs staff trained on nutrition services and data record

2. U5/P&LW malnutrition prevented in IDP/returnees' communities
   - Underserved communities reached by outreaches nutrition services
   - Caretakers sensitized

3. Nutrition EP&R capacities enhanced
   - CHDs - on record-keeping tools, surveillance and e-warning
   - CHD/IPs joint supportive supervision on needs/performances strengthened.
   - Participation in the Nutrition Clusters
   - Links among clusters

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 (4)	1.	Number of Children admitted for the treatment of SAM	861(At least 50% girls)
x (7)	2.	Number of Children admitted for the treatment of MAM	835(At least 50% girls)
x (11)	3.	Number of Children supplemented with Vitamin A	3,799
x (12)	4.	Number of P&LWs and U5 supplemented with Micronutrients	5,439 (U5 3,799 and PL&W 1,640)
x (16)	5.	Number of Health and nutrition workers trained	55
x (17)	6.	Number of Community members made aware through the community education sessions	7,092

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 and Warrap SMoH partners for health care service provision in Awerial/Yirol East and Yirol West counties and Tonj East and Tonj Sout counties. 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 adequate support and supervision to integrated PHC & Nutrition service delivery and emergency response in all Greater Yirol and in Tonj East and South. Existing coordination to enhance the referral system, build CHD capacities and raise community awareness on nutrition shall be strengthened and targeted actions shall be planned to answer the needs identified, especially during the previous CHF Rounds (starting Nutrition services establishment and integration). Outreaches, support to the existing SC and OTP and enforcement of effective referral system at state level are meant at widening population access to and utilization of frontline and emergency nutrition services, as well as to expand the nutrition surveillance capacities.

CCM/CUAMM structure already in place in the mentioned areas is sufficient to ensure the smooth implementation of the present project. In order to expand the nutrition activities in Warrap State, on one new nutrition expatriate expert will be recruited. ToR and vacancy have been already prepared in order to launch the recruitment process in September, after the official approval of the present proposal.
The project design is based on sound collaboration among CCM/CUAMM, health institutions at state and county level, other stakeholders (UNICEF, WFP, other INGOs and 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 and 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.

The wider cooperation IPs are creating with the CHD of the targeted Counties (TA, co-location, regular meetings…) will be functional to ensure project implementation and reorientation in line with the local needs and constant monitoring and evaluation

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 technics 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)[3].

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 (Nutrition Cluster 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. Monthly reports to the national Nutrition Cluster shall be timely submitted. 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 3).

- QUALIFIED TECHNICAL ASSISTANCE: both implementing partners have envisaged employment of technical human resources skilled in Nutrition programme 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 activity 3 for what concerned the supervision system on HFs performances)
- 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 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. IPs and concerned CHDs shall start having regular planning meeting, both internal and with the PHCUs and the VHCs. Data coming from project M&E will informthe discussion, providing the base to define further interventions to address nutrition problems or to re orientate the ones on going. Project report data will be also used to brief the State authorities on County situation, supporting a wider decision-making process on the steps to be done to improve people Health and Nutrition status.
- EFFECTIVE FINANCIAL MONITORING SYSTEM: (i) CCM and CUAMM accounting systems are 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; 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	99,892 USD
CCM (Awerial and Yirol East – Lakes). Donors: UNICEF, Crown Agents	123,700 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	30,018
CCM (Awerial and Yirol East – Lakes). Donors: UNICEF, Crown Agents	29.204

[3] 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-13/55145_R2_CCM	**Project title:** Enhancing EP&R to nutrition needs of Host, IDPs and Returnees' communities in Greater Yirol (Lakes State) and Greater Tonj (Warrap State)	**Organisation:** CCM Comitato Collaborazione Medica

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:* • The integrated management of acute malnutrition in children under five, pregnant and lactating women, and other vulnerable groups; • The prevention of malnutrition in vulnerable population (pregnant and lactating women and children under five) through micronutrient supplementation, the provision of supplementary foods, support of infant and young child feeding, and health and nutrition education; • Provision and strengthening of state and county-level coordination aimed at improving intervention outcomes.	**Indicators of progress:** *What are the key indicators related to the achievement of the CAP project objective?* - U5 SAM cases treated - U5 MAM cases treated - U5 supplemented with Vitamin A and dewormed - P&LW and U5 supplemented with macronutrients - Health staff trained/supervised on Nutrition related topics - U5 screened (MUAC) - P&LW screened (MUAC) - Community members reached by nutrition messages (IYCF)	**How indicators will be measured:** *What are the sources of information on these indicators?* • SC/OTP registers • Outreaches registers • Community activities reports	
Purpose	**CHF Project Objective:** *What are the specific objectives to be achieved by the end of this CHF funded project?* To expand access to and utilization of Nutrition preventive and curative services for MARPs (P&LWs, women and boys/girls U1/U5 living under the poverty line, in remote or underserved areas, including IDPs and returnees in Greater Yirol (Awerial, Yirol East and Yirol West counties) - Lakes State and Tonj South and Tonj East - Warrap State.	**Indicators of progress:** • *What indicators will be used to measure whether the CHF Project Objectives are achieved. Indicators may be quantitative and qualitative* • the number of SAM cases treated at SC/OTP level in the project catchment area in 6 months; • the number of SAM patients with medical complications referred to higher level facility in 6 months; • the number of U5/P&LW screened through MUAC measurement (static and outreach), • the number of women and care-takers (including men and community leaders) sensitized about Nutrition in 6 months.	**How indicators will be measured:** *What sources of information already exist to measure this indicator? How will the project get this information?* • SC/OTP registers • Outreaches registers • Community activities reports	**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 nutrition emergencies; • No movement restrictions for implementing partners • Conductive weather conditions
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*	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged outcomes?*	**How indicators will be measured:** *What are the sources of information on these indicators?* • SC/OTP registers	**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?*

	beneficiaries. 1)Frontline nutrition services for U5 and P&LW in Greater Yirol and Tonj East and Tonj South are integrated in the PHC service provision in up to 1 hospital, 6 PHCC and 6 PHCUs 2) Severe and moderate malnutrition is prevented for both U5 and P&LW in host and IDP/returnees' communities in the catchment area: 3)Nutrition EP&R capacities at Greater Yirol, TonjEast and Tonj South level are enhanced	Monitoring the progress toward the achievement of the total beneficiaries Women: 11.254 Girls: 8.747 Men: 764 Boys: 8.898 **Total: 29.663** Out of the total direct beneficiaries **8,43%** will have access to frontline nutrition services (Outcomes 1) **91,52%** will be prevented from SAM and MAM (Outcomes 2) **0,05%** will contribute to nutrition EP&R County Capacities enhancement (Outcomes 3)	• Outreaches registers • Community activities reports	• Internal and cross-borders political stability; • Institutional willingness to effectively target nutrition emergencies; • No movement restrictions for implementing partners • Conductive weather conditions
	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.** Integrated nutrition services for U5 and P&LW in Greater Yirol and in Greater Tonj are consistently provided in1hospital, 6 PHCC and 6 PHCUs **Output 2.** Acute malnutrition is prevented for both U5 and P&LW in host and IDP/Returnee communities in the catchment area	**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.* **For OUTPUT 1:** - U5 SAM cases treated: 861 - U5 MAM cases treated: 835 - Health staff trained/supervised: 55 - U5 MAM cases referred to partners: 750 **For OUTPUT 2:** U5 screened (MUAC): 11,400 P&LW screened (MUAC): 3,216 U5 supplemented with Vitamin A and	**How indicators will be measured:** *What are the sources of information on these indicators?* **For OUTPUT 1** -SC/OTP registers -Training attendance list -Referral Records **For OUTPUT 2** -SC/OTP registers -Outreaches registers -Community activities reports	**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?*

	Output 3. Nutrition EP&R capacities at Greater Yirol, Tonj East and Tonj South county level are enhanced	dewormed: 3,799 P&LW supplemented with macronutrients: 1,640 Community members reached by nutrition messages (IYCF): at least 7,092 (at least 10% men) **<u>For OUTPUT 3</u>:** CHD members capacity built on nutrition surveillance, program planning/implementation/supervision, record keeping: 15	**<u>For OUTPUT 3</u>** -Training reports	
	Activities: *List in a chronological order the key activities to be carried out. Ensure that the key activities will results in the project outputs.* **For OUTPUT 1** **1.1.** Consolidation of Yirol Hospital SC and support of Adior PHCC SC, based on assessed needs (Lakes State). **1.2** Maintain OTPs in PHCC/Us in Greater Yirol; **1.3** Start OTP in up to 2 facilities in Tonj East, 2 facilities in TS; 1 facility in Yirol East, 1 facility in Awerial.	**Inputs:** *What inputs are required to implement these activities, e.g. staff time, equipment, travel, publications costs etc.?* **1.1 Inputs** - Human resources: PM, Procurement Officer - Procurement, contracting and transportation capacities, - Community involvement **1.2 Inputs** - Human resources: PM, Procurement Officer - Procurement, contracting and transportation capacities, - Community involvement **1.3 Inputs** - 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?* **1.1 Assumptions, risks:** -Availability of contractors and construction materials; -Availability of stores **1.2 Assumptions, risks:** -Availability of contractors and construction materials; -Availability of stores **1.3Assumptions, risks:** -Availability of procurement protocols/guidelines; -Suppliers' and transporters' respect of contract timing

	1.4 Procurement and prepositioning and distribution of essential/emergency drugs and nutrition supplies for SAM/MAM treatment and management of the related complications at facility level.	**1.4 Inputs** - Human resources: Procurement Officer - Logistic/procurement capacities - Collaboration with concerned institutions (federal and state MoH, CHD, Commissioner, etc.) - Coordination among partners on the ground		**1.4 Assumptions, risks:** - Road accessibility / freedom of movement - Availability of functioning vehicle - Effective communication network
	1.5 Maintaining coordination (through coordination meetings and MoUs with other IPs: namely Plan/KHI and concerned SMoH) between OTP and STFP services in Greater Yirol counties, when SAM and MAM cases are treated by different partners.	**1.5 Inputs** - Networking and communication capacities; - Access to IT facilities - Close and continuous collaboration with CHD; - Movement capacities		**1.5Assumptions, risks:** - No staff turnover; - Availability of communication means and resouces - Road condition - Effective communication network
	1.6 Maintaining of integrated ANC/PNC and nutrition services for P&LW, including ordinary screening and micronutrient supplementation, in Yirol County Hospital MCH and gradually introducing it in all the PHCC/Us in the whole project catchment area;	**1.6 Inputs** - Human resources: PHC Supervisors - Collaboration with SMoHs to sustain local qualified health staff, - Collaboration with concerned CHD and other stakeholders on the ground - Cultural mediation		**1.6Assumptions, risks:** -No staff turnover; -Availability of nutrition supplies and other pharmaceuticals;
	1.7 Maintaining integrated U5 growth monitoring within EPI/OPD ordinary service provision, including micronutrient/Vitamin A supplementation and deworming, in Yirol County Hospital MCH and gradually introducing it in all the PHCC/Us in the whole project catchment area;	**1.7 Inputs** - Human resources: PHC Supervisors - Collaboration with SMoHs to sustain local qualified health staff, - Collaboration with concerned CHD and other stakeholders on the ground - Cultural mediation		**1.7Assumptions, risks:** -No staff turnover; -Availability of nutrition supplies and other pharmaceuticals
	1.8 Enhancing the emergency referral system through improved coordination among partners/stakeholders.	**1.8 Inputs** -Human resources: PHC Supervisors -Collaboration with SMoHs to sustain local qualified health staff, -Collaboration with concerned CHD and other stakeholders on the ground -Cultural mediation		**1.8 Assumptions, risks:** -Road accessibility / freedom of movement -Availability of functioning ambulance -Effective communication network -Conducive cultural environment

		-Movement capacities		
	1.9 Theoretical / on the job training of health staff on (i) Integrated Management of SAM/MAM, (ii) IYCF and (iv) complicated cases emergency referral.	**1.9 Inputs** -Human resources: trainers -Link with MoH at federal level to ensure continuous update on training strategies, manuals, priorities, etc. -Procurement capacities (training materials)		**1.9 Assumptions, risks:** -Availability of standard IMAM treatment protocols/guidelines; -Collaborative attitude from CHD; -No staff turnover
	1.10 TA and supportive supervision to health staff responsible for nutrition data collection/recording and drug administration	**1.10 Inputs** -Human resources: trainers -Link with MoH at federal level to ensure continuous update on training strategies, manuals, priorities, etc. -Procurement capacities (training materials) -Basic IT capacities		**1.10 Assumptions, risks:** -Availability of standard IMAM treatment protocols/guidelines; -Collaborative attitude from CHD; No staff turnover
	For OUTPUT 2 **2.1** Implementation of weekly outreaches, covering the entire targeted counties and targeting underserved areas, cattle-camps, IDP/returnees camps, marginalized households.	**2.1Inputs** -Human resources: Nutrition Supervisors, -Link with CHD for community involvement -Cultural mediation,		**2.1Assumptions, risks:** - No staff turnover; - Conducive cultural environment
	2.2 Organization of weekly nutrition education sessions (breastfeeding, dietary intake, complementary feeding, food hygiene and preparation, FP and RH etc.) at facility and/or outreach level in all supported hospitals/PHCC/PHCU, targeting caretakers (men and women) and women in childbearing age.	**2.2Inputs** -Human resources: Nutrition Supervisors, -Link with CHD for community involvement -Cultural mediation,		**2.2** Assumptions, risks: -No staff turnover; -Availability of IEC materials; - Road accessibility; - Conducive cultural environment
	2.3 Organization of targeted education sessions on safe nutrition/feeding practices for U5 and P&LWs for opinion leaders and peer-to-peer educators (i.e.	**2.3 Inputs** -Human resources: Nutrition Supervisors / community mobilizers -Link with CHD for community involvement -Cultural mediation		**2.3 Assumptions, risks:** -No staff turnover; -Availability of IEC materials; -Road accessibility; -Conducive cultural environment

	Village Health Committees, Home Health Promoters, religious leaders, community/cattle-camps leaders). For OUTPUT 3 **3.1** Training and TA to concerned CHDs and selected health staff (both male and female) on (i) MoH and Nutrition Cluster reporting tools, (ii) nutrition surveillance and e-warning systems. **3.2** Set up /scale up of joint CHD/implementing partners' supporting supervision mechanism of nutrition-related health facilities performances; **3.3** Effective participation to the Nutrition Cluster coordination mechanism at state and national level. **3.4** Facilitation of inter-cluster coordination system at state and national level (with Health, WaSH and Food Security clusters).	**3.1 Inputs** -Human resources: trainers, -Link with MoH at federal level to ensure continuous update on training strategies, manuals, priorities, etc. -Procurement capacities (training materials), -Cultural mediation, **3.2 Inputs** -Networking and communication capacities; -Close and continuous collaboration with CHD; -Movement capacities **3.3 Inputs** -Networking and communication capacities; -Close and continuous collaboration with CHD; -Movement capacities **3.4 Inputs** -Networking and communication capacities; -Close and continuous collaboration with CHD; -Movement capacities		**3.1 Assumptions, risks:** -Availability of standard IMAM treatment protocols/guidelines; -Collaborative attitude from CHD; -No staff turnover **3.2 Assumptions, risks:** -Road accessibility / freedom of movement -Availability of functioning vehicle **3.3 Assumptions, risks**: -Road accessibility / freedom of movement -Availability of functioning vehicle **3.4 Assumptions, risks:** -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:	01/10/2013	Project end date:	31/03/2014

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
OUPUT 1															
1.1 Consolidation of Yirol Hospital SC and support of Adior PHCC SC, based on assessed needs (Lakes State).				x	x	x	x	x	x						
1.2 Maintain OTPs in PHCC/Us in Greater Yirol;				x	x	x	x	x	x						
1.3 Start OTP in up to 2 facilities in Tonj East, 2 facilities in TS; 1 facility in Yirol East, 1 facility in Awerial.					x	x	x	x	x						
1.4 Procurement and prepositioning and distribution of essential/emergency drugs and nutrition supplies for SAM/MAM treatment and management of the related complications at facility level.						x			x						
1.5 Maintaining coordination (through coordination meetings and MoUs with other IPs: namely Plan/KHI and concerned SMoH) between OTP and STFP services in Greater Yirol counties, when SAM and MAM cases are treated by different partners.				x	x	x	x	x	x						
1.6 Maintaining of integrated ANC/PNC and nutrition services for P&LW, including ordinary screening and micronutrient supplementation, in Yirol County Hospital MCH and gradually introducing it in all the PHCC/Us in the whole project catchment area;				x	x	x	x	x	x						
1.7 Maintaining integrated U5 growth monitoring within EPI/OPD ordinary service provision, including micronutrient/Vitamin A supplementation and deworming, in Yirol County Hospital MCH and gradually introducing it in all the PHCC/Us in the whole project catchment area;				x	x	x	x	x	x						
1.8 Enhancing the emergency referral system through improved coordination among partners/stakeholders.				x	x	x	x	x	x						
1.9 Theoretical / on the job training of health staff on (i) Integrated Management of SAM/MAM, (ii) IYCF and (iv) complicated cases emergency referral.				x	x	x	x	x	x						
1.10 TA and supportive supervision to health staff responsible for nutrition data collection/recording and drug administration				X	X	X	X	X	X						
OUTPUT 2															
2.1 Implementation of a weekly outreaches, covering the entire targeted counties and targeting underserved areas, cattle-camps, IDP/returnees camps, marginalized households.				x	x	x	x	x	x						

Activities	Q3/2013			Q4/2013			Q1/2014			Q2/2014			Q3/2014		
2.2 Organization of weekly nutrition education sessions (breastfeeding, dietary intake, complementary feeding, food hygiene and preparation, FP and RH etc.) at facility and/or outreach level in all supported hospitals/PHCC/PHCU, targeting caretakers (men and women) and women in childbearing age.				x	x	x	x	x	x						
2.3 Organization of targeted education sessions on safe nutrition/feeding practices for U5 and P&LWs for opinion leaders and peer-to-peer educators (i.e. Village Health Committees, Home Health Promoters, religious leaders, community/cattle-camps leaders).						X		X							
OUTPUT 3															
3.1 Training and TA to concerned CHDs and selected health staff (both male and female) on (i) MoH and Nutrition Cluster reporting tools, (ii) nutrition surveillance and e-warning systems.				x	x	x	x	x	x						
3.2 Set up /scale up of joint CHD/implementing partners' supporting supervision mechanism of nutrition-related health facilities performances;						x			x						
3.3 Effective participation to the Nutrition Cluster coordination mechanism at state and national level.				x	x	x	x	x	x						
3.4 Facilitation of inter-cluster coordination system at state and national level (with Health, WaSH and Food Security clusters).				x	x	x	x	x	x						
MONITORING AND EVALUATION															
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						
Recruitment of new staff				x											

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