South Sudan
2012 CHF Standard Allocation Project Proposal

Proposal for CHF funding against Consolidated Appeal

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 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 proposal should explain and justify the activities for which CHF funding is requested and it 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. 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. Partners should also fill and submit to cluster coordinator/ co-coordinator the CHF Allocation Matrix (Excel template).

SECTION I:

CAP Cluster	Nutrition

CHF Cluster Priorities for 2012 First Round Standard Allocation
This section should be filled by the cluster Coordinators/Co-coordinators before sending to cluster partners. Provide a brief articulation of Cluster priority activities and geographic priorities that the cluster will recommend for funding from the CHF.

Cluster Priority Activities	Cluster Geographic Priorities
Cluster objectives and activities as outlined in CAP **Treatment services** for Severe Acute Malnutrition and Moderate Acute Malnutrition in children under 5 years, P&LW and other vulnerable groups, through SCs, OTPs and TSFPs - including training of staff **Prevention services** for children under 5 years and P&LW through - micronutrient supplementation U5 & P&LW, community screening (MUAC) and referral of U5, blanket supplementary feeding in hunger gap and in acute emergency 3-36mths, promotion and support of IYCF; includes training health workers, MSGs and CBOs **Strengthen Nutrition emergency preparedness and response capacity -** Cluster coordination, Management and analysis of nutrition information, Rapid assessments and SMART surveys in line with cluster standards, Capacity building of CBOs, MSGs, NNGOs and CHD & SMOH on emergency preparedness and response.	Hot spot areas in high priority states will be prioritized

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

Requesting Organization	Project Location(s) (list State, County and if possible Payam where CHF activities will be implemented)
TEARFUND	Jonglei state, Uror County, Motot, Pulchuol and Pieri Payams, Modit and Karam payams. (100%)
Project CAP Code	
SSD-12/H/46153/5157	
CAP Project Title	
Tearefund's Provision of Life Saving Services to Highly Vulnerable populations suffering from Malnutrition	

Total Project Budget in South Sudan CAP	Amount Requested from CHF	Other Resources Secured
$422,850	US$ 200,000	0

Direct Beneficiaries	
Women:	7489
Men:	2521
Girls:	8059
Boys	8059

Total Indirect Beneficiary
57088
Catchment Population (if applicable)
The population will be from the payams of Motot, Pulchuol and Pieri, Modit and Karam, including the returnees who have joined the community.

Beneficiary breakdown		
Women	P&LW	2854
	Trainees	85
	Beneficiaries of IYCF promotion	4550
	Other vulnerable	
Men	Trainees	71
	Beneficiaries of IYCF promotion	2450
	Other - vulnerable	
Children U5 Yrs	SAM	500
	MAM	
	BSFP	
	Micronutrient supplementation	8220
	Deworming	7398

Implementing Partners (Indicate partners who will be sub-contracted if applicable and corresponding sub-grant amounts)

Tearfund will implement the programme

Project Duration (max. of 12 months, starting from allocation date)

Start Date (mm/dd/yy): 03/10/12

End Date (mm/dd/yy): 01/09/13

Address of Country Office

Project Focal Person: Dr Chol

Email & Tel: dmt-motot@tearfund.org

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Address:
Tearfund, ECS Compound, Hai Malakal, PO Box 94, Juba, South Sudan

Address of HQ

e-mail desk officer: dmt-southsudan-ha@tearfund.org

e-mail finance officer: dmt-southsudan-gic@tearfund.org

Address: Tearfund, ECS Compound, Hai Malakal, PO Box 94, Juba, South Sudan

SECTION II

A. Humanitarian Context Analysis

Briefly describe (in no more than 500 words) the current humanitarian situation in the specific locations where CHF supported activities will be implemented. Provide evidence of needs by referencing assessments and key data, including the number and type of the affected population[1]

Uror County has been plagued by intertribal fighting between the Lou Nuer and Murle tribes throughout 2011, significantly disrupting populations in the programme area. The latest massacre in August 2011 affected Motot, Pulchuol and Pieri payams specifically, with 600 deaths reported, 850 wounded, 200 children kidnapped, 7,900 houses burnt and up to 26,000 people displaced during the period between 19-26 August (UNCHR, Reliefweb, 26 Aug 2011). Tearfund was central to the humanitarian response in Uror County, enabling transport to secondary care of more than 30 severely wounded. In Jonglei over 208 conflict incidents have occurred, resulting in the displacement of 90,046 (OCHA 31122011). There are also a recorded 638 returnees that have returned to settle in the county following the independence process in July 2011 (OCHA records 31 Jan 2012). This insecurity and instability not only results in thousands displaced, but heavy loss of livestock and livelihoods with significant food insecurity, malnutrition, disease, and an increased number of female headed households (who have the most difficulty accessing resources). Annual flooding, poor education and limited understanding as to the causes of ill health and malnutrition, also combine to make the population of Uror County extremely vulnerable. Furthermore, it is expected that there will be a high number of returnees to Jonglei State throughout 2012 due to deteriorating political relations between North and South Sudan, potentially further exacerbating food security and increasing the likelihood of SAM in children under 5 in the area.

Tearfund's SMART Survey of March 2011 in Uror County reported SAM rates at 2.6% (95% C.I: 1.1 – 4.0%), (above the WHO emergency threshold), and GAM rates of 14.6 % (11.9 - 17.3 95% C.I.), down from 22.4% (19.3 - 25.9) in 2010. However, clinic records have shown a high defaulter rate on the Outpatient Therapeutic Programme (OTP) since the inter-tribal conflict in August, and it is assumed that the food insecurity experienced by the 26,000 people displaced by this conflict will have negatively affected malnutrition rates since the 2011 SMART Survey was conducted. The Crude Mortality Rate (CMR) was 0.66 deaths /10,000/ day, higher than the average baseline for sub-Saharan Africa at 0.44 deaths /10,000/ day. Only 12% of the sampled boys and girls had received Vitamin A in the last 6 months. A Tearfund KAP survey of the area in December 2010, showed that exclusive breastfeeding rates are extremely low at only 6.2%. The average HDDS was found to be 2.66, classified as low and inadequate dietary diversity.

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

Uror County exemplifies the health care needs of the State, with the population of 178,519 served by only 4 PHCUs (Census 2008). Diarrhoea, malaria and measles are all known to impact malnutrition rates and a Tearfund FGD (Uror County, Dec 2010) focusing on hand-washing to prevent diarrhoea, and the use of mosquito nets to prevent malaria, showed that rates for both were poor across all groups (16.9% and 37% respectively). Only 54.4% of children aged 0-12 months have been immunised against measles, which is below the SPHERE standard of 95% (Tearfund SMART survey March 2011).

B. Grant Request Justification

Briefly describe (in no more than 500 words) how proposed activities support the agreed cluster priorities and the value added by your organization

Tearfund will provide services in the areas of assessment, treatment, prevention, capacity building, coordination and emergency response, in line with cluster guidelines. These are outlined as follows:

Assessment: The project will conduct two SMART nutrition surveys, pre and post-harvest to determine and assess the nutrition trends. Information on the agreed cluster indicators for WASH, Food Security and IYCF will also be collected. The team are also equipped with the tools ready to do a Rapid MUAC assessment should returnees number >500 in the project area. All SMART surveys will be done in conjunction with the MoH.

Treatment: Tearfund is already running and will continue to run 4 OTP sites: two static OTP sites for SAM children aged 6-59 months in Motot and Pulchuol payams, and two outreach OTPs in Karam and Modit payams. OTP services are provided in line with MoH IM-SAM guidelines.

Prevention: All health care contacts under five years in the payam population will be screened for malnutrition using MUAC with referral to OTP as necessary. All healthcare workers, including EPI, curative, CHD, BHC and maternal care staff will be trained on MUAC, IYCF and referral procedures. Micronutrient supplements in the form of Vitamin A will be given to all children aged 6-59 months as per WHO guidelines, and deworming tablets will be given to all those aged 12-59 months (including all non OTP children). All pregnant and lactating mothers will also be given micronutrient supplements in the form of iron and folate. The health education programme (including a primary focus on IYCF messages) targets school children, traditional healers, church leaders, health clinic attendees, market traders, women's groups and village leaders.

Capacity Building: CHD health staff will be trained on nutrition protocols and management of SAM, as per IMSAM guidelines. Tearfund is capacity building the CHD nutrition department on the management of SAM so that they can take over the running of the two outreach centers within their PHCUs in Modit and Karam. Tearfund is also running a SMART training for all health staff, to capacity build knowledge and experience in this area, and participates in the nutrition in emergencies training coordinated by the cluster. Staff training will also occur as documented in the prevention section.

Coordination and preparedness: Tearfund participates in nutrition cluster coordination meetings at county, state and national level. MoH will be informed and invited for all surveys and assessments. Monthly nutrition cluster reporting forms are sent to all stakeholders. SMART and Rapid MUAC assessments are done in line with cluster standards. CHD staff will be invited to participate in SMART training. Tearfund is fully integrated onto the IDSR, EWARN, DHIS and HMIS government systems. Tearfund works closely to mobilise BHCs on malnutrition care. Emergency preparedness and response will ensure that all Plumpy nut and micronutrients are delivered in advance of the rains, documented systems are in place for remote management during insecurity, and referral guidelines for emergency SAM cases are in place, with access to vehicular ambulance services.

Tearfund will be the sole implementer of these services.

The health advisor for the project is a medical doctor and brings this needed expertise to the project. There is an experienced and SMART trained nutrition manager and nutrition officer in charge of the project at field level.

C. Project Description (For CHF Component only)

i) Purpose of the grant

Briefly describe how CHF funding will be used to support core humanitarian activities

The grant will be used for the direct costs of the entire nutrition project described above, including but not limited to nutrition staff salaries, procurement of programme supplies, transportation of GIK supplies from UNICEF to the programme site, nutrition surveillance, warehousing, training and support for local running of the programme.

ii) Objective

State the objective/s of the project. Objective/s should be specific, measurable, achievable, relevant and time-bound (SMART)

To reduce mortality and morbidity from malnutrition among highly vulnerable populations in the extremely underserved area of Uror County, by providing malnutrition services for children under five and pregnant and lactating women in the areas of assessment, prevention and treatment of acute malnutrition, capacity building and emergency preparedness.

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.

All activities will take place in Uror County, in the payams of Motot, Pulchuol, Pieri, Modit and Karam.

Assessment:

- Conduct pre and post-harvest SMART surveys in targeted payams of Uror County, Jonglei State, in line with nutrition cluster standards (May 2012, November 2012: 57088 target population for random sampling).
- Prepare teams and conduct MUAC rapid assessments wherever returnees number >500 in all project areas. (500 returnees)

- Disaggregate all needs assessment data for gender, including training courses and BHC committee lists.

Treatment:

- Treat SAM in boys and girls by delivering OTP at 4 sites, 2 mobile and 2 static, using SPHERE standards and IM-SAM guidelines. Direct beneficiaries 591.
- Ensure proper secondary care referral pathways for all SAM children with complications. Referrals will be to IMC Walgak and MSF-H Lankien PHCC for further specialized management.
- Improve defaulter and non-responder rates. Defaulter rates are high in the project area due to pastoralist movements and insecurity. The defaulter tracing procedure includes a visit by a nutrition extension worker to the defaulter's home; an assessment is done and the parents are then encouraged to return the child to the programme. If children fail to meet the discharge criteria, they are readmitted to the OTP element following a comprehensive investigation.
- All admission data collection is disaggregated for gender.

Prevention:

- Screen all health care contacts aged 6-59m with MUAC (including all U5 EPI, nutrition and curative care attendances). Direct beneficiaries 14774.
- Administer Vitamin A to all health care contacts aged 6-59m according to WHO guidelines. Direct beneficiaries 14,774.
- Administer deworming tablets to all health care contacts aged 12-59m. Direct beneficiaries 13,132.
- Administer iron and folate to all pregnant women attending for antenatal care. Direct beneficiaries: 2854. Pregnant women are at risk of anaemia and the needs assessments show child spacing is extremely poor in the communities targeted.
- Educate all pregnant and lactating women on exclusive breastfeeding. Promote appropriate IYCF. Direct beneficiaries 9854 (including those targeted by the health education programmes).
- Educate women's groups on what constitutes a nutritious diet, using local products, including the use of demonstration sessions. Direct beneficiaries 1000.
- Train healthcare workers, including EPI, curative, CHD, BHC and maternal care staff on MUAC, IYCF and referral procedures. Direct beneficiaries 85.

- **Capacity building:**
- Train all nutrition staff and CHWs on IM-SAM guidelines. Direct beneficiaries: 30
- Promote the 5 key health messages at all staff trainings. (Including exclusive breastfeeding and IYCF). Direct beneficiaries: 200.
- Train nutrition staff in all aspects of emergency response. Direct beneficiaries: 10 trained.
- Ensure all trainings are open to both men and women. Strongly encourage BHC committees to be at least one third female.
- Train healthcare workers, including EPI, curative, CHD, BHC and maternal care staff on MUAC, IYCF and referral procedures. Direct beneficiaries 85 (as above).
- SMART training. Direct beneficiaries 8.

- **Coordination, emergency preparedness and emergency response:**
- Ensure data collection procedures allow monitoring to continue when movement and access to outreach centres is reduced.
- Pre-position supplies before the rains.
- Improve access to underserved areas using mobile nutrition teams.
- Record and monitor supply stock outs with proper analysis for future prevention.
- Submit timely monthly reports and nutrition surveys to cluster.
- Train all nutrition teams on emergency nutrition procedures for returnees, to ensure emergency preparedness for humanitarian crisis.
- Improve pipeline management.
- Ensure secondary care referral pathways are documented and in place.
- Carry out monitoring and evaluation with regular clinic and feeding center supervision.
- Establish improved data collection procedures to ensure continuous monitoring.
- Conduct focus group discussions with the beneficiaries annually to improve coordination and gain a qualitative understanding of the project's impact.

iv). Cross Cutting Issues

Briefly describe how cross-cutting issues are taken into consideration (i.e. gender, environment, HIV/AIDS)

Gender

Gender is one of the quality standards by which Tearfund's projects are internally assessed. Tearfund actively promotes gender issues, including encouraging women to take roles in the management of the clinics and all village committees, (e.g. BHC and WASH) with the aim that women comprise at least a third of representatives. The main programme beneficiaries are women and children so this improves sustainability and encourages a sense of ownership for the project services. There are also gender considerations in staffing; where possible female staff are given special consideration. Mothers are allowed all maternity leave

benefits and breastfeeding access. Interventions and projects are designed to ensure participation of both women and men, taking into consideration the different needs of each. Feedback is sought from gender specific groups for triangulation during surveys. Every effort is made to ensure that assistance is inclusive and provided in a way that does not create or exacerbate tensions within communities. The communities themselves are directly consulted regarding beneficiary selection criteria. Women and children are emphasised as project beneficiaries, whilst ensuring that both women and men have equal access to services provided. Gender focus group discussions are conducted at all sites annually, to assess gender needs, for example on issues such as the age of marriage and child spacing. Poor child spacing links to anaemia in pregnant women and in turn malnutrition. Maternal labour directly links to child/mother contact time, feeding time and rates of malnutrition. Findings are used to impact the design of the projects. All needs assessment data is disaggregated for gender, including training courses and BHC committee lists. At each site a community empowerment officer is employed specifically to promote gender equality. All trainings are open to both men and women. This year gender based violence referral pathways are being written for all clinics, with rape and PEP kits in place, provided by UNFPA.

Environment

Assessing impact on the environment is also a Tearfund quality standard. Areas of waste disposal at clinics are clearly demarcated and health officers monitor clinic staff to ensure that waste is being correctly incinerated on a daily basis, buried and disposed of properly. Flooding in the area affects the project seasonally. Sites for outreach and static facilities are carefully chosen to minimise the negative impact of this environmental disturbance. Caretakers of children in the programme are encouraged to bring back Plumpy nut sachets for verification that they were used as intended, for the malnourished children, rather than sold in the market or exchanged. After the feeding session all the sachets are collected together and burnt in the incinerator at the PHCU.

HIV/AIDS

In addition to its HIV-focused health activities, Tearfund mainstreams HIV in all its disaster management programmes both internally and externally. Currently, Tearfund has an HIV workplace policy in all sites. PEP kits are procured and HIV training is conducted for staff. This ensures that staff are aware of HIV and are supported if affected or infected. Tearfund staff in Uror County have been trained on how to incorporate HIV into relief projects by reshaping and redesigning core sectors to reduce beneficiaries' vulnerability to HIV and help them better cope with its impact. Food assistance programmes have HIV prevention and awareness activities incorporated into them. Condoms are available at health clinics as well as other HIV prevention services. HIV testing is promoted, and detection and treatment of STIs is carried out in the health facilities. All staff are trained in universal precautions and there is capacity building of local spear masters to reduce harmful practices. All of these activities are monitored by Tearfund's Health advisor who is based in Juba and regularly travels to field sites.

Disaster Risk Reduction

While it is essential to respond to emergency relief needs, Tearfund believes that there must be more emphasis put on strengthening people's capacity to anticipate, cope with and recover from disasters, as an integral part of relief and development programmes. This can reduce the impact of disasters. Tearfund aims to build the capacities of the communities they are working with by supporting them to identify solutions to their own problems and where necessary, provision of support and expertise to implement their plans. Community empowerment officers are specifically tasked with capacity building communities in mobilisation and disaster risk reduction.

v) Expected Result/s

List below the results you expect to have at the end of the CHF grant period, and provide no more than five indicators you will use to measure the extent to which those results will have been achieved. At least three of the indicators should be out of the cluster defined Standard Output Indicators.

	Indicator	Target (indicate numbers or percentages)
1.	Child healthcare contacts aged 6-59 months are screened for malnutrition with MUAC (including EPI and curative children).	>5006 (80%) of the total children aged 6-59 months attending health care clinics or EPI are screened.
2.	Improved malnutrition prevention with supplements, defined as; children aged 6-59 months attending the health facility receive Vitamin A supplementation, and children aged 12-59 months attending the health facility receive de-worming tablets as per WHO guidelines.	>5006 (80%) of children aged 6-59 months attending the health facility receive Vitamin A supplementation >4450 (80%) of children aged 12-59 months attending the health facility receive de-worming tablets as per WHO guidelines.
3.	All OTP programmes provide quality SAM treatment with results in line with SPHERE standards.	4 OTP sites operating The proportion of exits from therapeutic care who have died is <10%, recovered is >75% and defaulted is <15%.
4	>70% of staff are appropriately trained in nutrition protocols. This is defined as: >70% WHMs, BHC members, CHWs, MCHWs, EPI and CHD staff trained in MUAC screening, IYCF and referral, and >70% of nutrition staff and CHWs trained in IM-SAM protocols.	85 health and nutrition staff, including those from the CHD, trained on nutrition and IYCF protocols.
5.	High quality coordination with punctual and complete nutrition forms submitted to the cluster.	Minimum of 4 nutrition meetings attended >80% of nutrition cluster reports completed and submitted to

		the cluster on time during the project cycle.

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.

Tearfund is the direct implementer of this project and does not have any implementing partners relating to this project. Tearfund is the sole NGO working in nutrition in these payams. However, Tearfund receives gifts in kind and nutrition supplies from UNICEF to enable us to implement the project objectives.

1. Conduct SMART nutrition survey pre and post hunger gap, coordinating with SMoH / CHD and Cluster

The nutrition cluster has standardized the timings for nutrition surveys pre-harvest in March-May and post-harvest in Oct-Nov. Tearfund will conduct the pre-harvest survey in May 2012 and the post-harvest survey in November 2012. The teams will undertake UNICEF SMART training in April 2011, to which the CHD will also be invited. In conjunction with the coordination of the CHD and SMOH, the surveys will be conducted by Tearfund staff internally. The results of the survey will be disseminated to NGOs, UN agencies including WFP, local authorities and donors operating in Southern Sudan. The information will also be relevant for advocacy if other interventions are necessary to address underlying food insecurity or nutrition issues in the community.

2. Deliver OTP from decentralized and mobile sites using UNICEF GIK.

Tearfund will continue to implement the nutrition strategy in line with current WHO, UNICEF and RoSS MOH recommendations and practice. Plumpy Nut will be obtained as gift in kind through the UNICEF PCA agreement. A nutrition manager and a nutrition officer will oversee the project directly at field level, with a health and nutrition advisor at Juba level for technical support.
OTP children will be attended through the PHCU by the CHWs and nutrition extension workers. All children admitted to the nutrition programme will receive de-worming medication, micronutrient supplements and measles vaccinations in accordance with SPHERE standards.

3. Prevention (Screening, micronutrients) with internal trainings

Screening of all children under 5 in the targeted payams will be conducted at community level by the WHMs, BHC, EPI vaccinators and nutrition extension workers. Health staff working in the health facility and MCH will also screen all children under 5 years during consultations and MCH sessions. All children with MUAC <115mm and / or oedema will be referred to OTP for treatment of acute malnutrition.
All health care workers coming into contact with children under five and pregnant women will be trained internally by Tearfund to recognise, screen and appropriately refer cases of malnutrition, and administer appropriate micronutrients (deworming and vitamin A).

4. Referrals to Secondary Care, to neighbouring areas

Severely malnourished children with complications will be referred to IMC Walgak stabilization center or MSF-H Lankien PHCC for further management using Tearfund vehicles. Once their condition has stabilized they will be transferred back to the OTP center to complete their treatment.

5. Coordination

Tearfund will attend the monthly Juba nutrition cluster meetings. State cluster meetings in Bor will also be attended regularly, to strengthen coordination between Tearfund with the cluster and Ministry. Monthly reports will be submitted to all levels and stakeholders through existing reporting mechanisms between Tearfund and the cluster.

6. Promote health education including IYCF.

Women's groups, school groups, market traders, church groups and traditional healers are targeted by Community Health Educators (CHE) workers for health promotion across targeted payams. There are 5 key messages taught across the whole programme, all of which have the potential to impact on malnutrition rates. The messages are as follows:

· Use only safe water from the borehole for drinking
· Immunize all pregnant women and children below one year to prevent disease
· Eat more vegetables and fruit to be healthy
· Give only breast milk for the first 6 months to prevent sickness
· Wash your hands after defecation and before handling food to prevent diarrhoea.

These five health messages have been translated into Nuer, the local tribal language, along with several other health promotion resources, such as the Motot health promotion manual.
Varied and diverse feeding practices and IYCF promotion (especially exclusive breastfeeding) are encouraged among the above groups. The UNICEF IYCF package of resources is used, along with Tearfund's own pack of resources on exclusive breastfeeding, including the use of breastfeeding messages on T-shirts, banners for the clinics, posters for community areas, flip charts for trainings and training DVDs and manuals for maternal care workers.
Tearfund Nutrition and CHE extension workers attend each feeding session to deliver these key messages. Sharing sessions, demonstrations, support and counseling mothers will be the components of education for community women's groups. Voluntary small groups are formed to support special mothers with different infant feeding needs. Good feeding practices and messages on complementary feeding will be taught, with demonstrations on the type of local nutritious food to use when feeding young children. Feedback will be obtained from the community groups via the community empowerment officer, for purposes of quality improvement and accountability.
Breastfeeding messages are not only passed to mothers but also to men, village and church leaders, and others with decision making powers within the communities.

7. Capacity building and training health and nutrition staff on IYCF guidelines and MoH SAM protocols.

CHWs, MCHWs, WHMs, BHC, EPI workers, nutrition extension workers, CHE, CHD and all health staff will be trained internally by

Tearfund on MUAC screening, IYCF and referral of malnutrition cases. All nutrition extension workers, supervisors and CHWs will be internally trained on IM-SAM protocols using the MoH guidelines, with training done by the nutrition manager. Tearfund will specifically train all CHD staff in the nutrition department at Modit and Karam payams on CMAM and IM-SAM so that they will be able to fully integrate nutrition services in their PHCUs.

A UNICEF representative has been identified to provide an external training on SMART surveys and up to 8 members will attend this in Juba, including those from the CHD.

8. Emergency Preparedness

All supplies will be delivered in advance of the rains. Plumpy nut will be obtained via the Tearfund / UNICEF PCA agreement, mosquito nets will be obtained through the current agreement with PSI, and drugs will be obtained from the MoH drug kits, supplemented by Tearfund's own pharmaceutical procurement. The Tearfund health advisor, using guidelines from the gender and GBV clusters, will ensure that GBV referral pathways and procedures are in place at each clinic, along with referral guidelines in place for SAM cases with complications and EmOnc. The health advisor also coordinates the DHIS training for staff, to ensure proper reporting, and with the help of the nutrition and health managers, will ensure a proper system for remote management during periods of insecurity is documented and in place. All drug stock outs are thoroughly investigated during monthly reporting, so that future episodes can be prevented.

vii) Monitoring Plan

Describe how you will monitor progress and achievements of the project.

- Clinic data in the form of monthly Ministry of Health DHIS reports and internal Tearfund DHIS reports will measure accurately the number of child healthcare contacts aged 6-59 months screened for malnutrition with MUAC, given Vitamin A, and deworming tablets and demonstrate progress.
- Clinic data in the form of Ministry of Health DHIS reports and internal Tearfund DHIS reports will measure accurately the number of pregnant and lactating women given micronutrients in the form of iron and folate.
- Monthly Tearfund health and nutrition narrative reports will record and document progress made with teaching communities nutritious recipes, and the numbers reached in IYCF health education.
- Pre and post SMART survey reports will monitor and assess the impact of the project on IYCF, SAM and GAM rates, measles and hand washing rates, morbidity and mortality, and the impact of the health education programme on community behavior.
- OTP admission data, cluster reporting and DHIS systems will monitor the OTP programme quality for SPHERE standards.
- Computer and advisor report records will assess the punctuality and completeness of Tearfund's submitted cluster reports.
- Monthly HR training reports will document the number of staff trained, including females and different cadres.
- Quarterly quantified supervisory checklists will be carried out in conjunction with the CHD at clinic sites.
- Monthly Tearfund clinic assessments will be performed by health project officers, with written reports to Juba, to assess quality of services at clinic level, as permitted by insecurity challenges.

E. Committed funding

Please add details of committed funds for the project from other sources including in-kind supports in monetary terms (USD)

Source/donor and date (month, year)	**Amount** (USD)

SECTION III:

This section is NOT required at the first submission of a proposal to the cluster coordinator/co-coordinator. However it is required to be filled for proposals recommended for funding by the Advisory Board.

LOGFRAME			
CHF ref. Code: SSD-12H4153/5157	**Project title: Provision of Life Saving Services to Highly Vulnerable Populations suffering from Malnutrition.**		**Organisation: Tearfund.**
Overall Objective: *What is the overall broader objective, to which the project will contribute? Describe the expected long-term change.* • To improve nutrition and health in conflict affected Wuror County	**Indicators of progress:** *What are the key indicators related to the overall objective?* N/A	**How indicators will be measured:** *What are the sources of information on these indicators?* N/A	
Specific Project Objective/s: *What are the specific objectives, which the project shall achieve? These relate to the immediate effect of the intervention measured at the end of the project.* • To reduce mortality and morbidity from malnutrition among highly vulnerable populations in the extremely underserved area of Uror County.	**Indicators of progress:** *What are the quantitative and qualitative indicators showing whether and to what extent the project's specific objectives are achieved?* • Overall mortality and morbidity rates remain below current levels (CMR 0.66%, U5MR 0.46%, U5 morbidity 48.6%) during project period') • Severe acute malnutrition rate among children under 5 is reduced by 0.5% within targeted Payams by December 2012	**How indicators will be measured:** *What are the sources of information that exist and can be collected? What are the methods required to get this information?* • SMART Nutrition survey • Clinic records on morbidity and mortality • Rapid Assessments Monthly nutrition reports	**Assumptions & risks:** *What are the factors and conditions not under the direct control of the project, which are necessary to achieve these objectives? What risks have to be considered?* • Political and social stability • Absence of large scale humanitarian crisis or disasters • Normal climatic conditions • Security in the target areas remains sufficiently stable to allow access to conduct humanitarian activities • On-going support and willing participation of South Sudan Relief and Rehabilitation Commission (SSRRC) counterpart, local authorities, MoH and beneficiaries • Absence of extreme price or exchange rate shifts. • Localised conflict or emergencies do not result

			in inability to remotely monitor programme • Appropriate funding is received
Results - Outputs (tangible) and Outcomes (intangible): • *Please provide the list of concrete DELIVERABLES - outputs/outcomes (**grouped in Workpackages**), leading to the specific objective/s:*	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged results and effects?*	**How indicators will be measured:** *What are the sources of information on these indicators?*	**Assumptions & risks:** *What external factors and conditions must be realised to obtain the expected outcomes and results on schedule?*
1. Assessment of acute malnutrition • Assessment surveys conducted.	• Two SMART surveys to be conducted per year, pre and post harvest, in line with cluster recommendations.	• SMART Survey report • Admission / discharge statistics • Feeding centre records • Training records • Distribution records • Assessment questionnaires • Nutrition survey • Training attendance list • KAP survey • Monthly nutrition reports • PHCU and EPI records • Monthly/quarterly coordination meetings attended. • Cluster monthly reports • Monthly nutrition reports, monthly programme reports, monthly health promotion reports, final evaluation report. • Final evaluation report. Monthly programme reports.	• Availability of SMART training sessions for staff. • No disease outbreaks • Able to recruit and retain skilled staff • Support from local authorities and community • No population movements due to insecurity and drought • Gifts in Kind (GIK) sourced and provided in required quantities in a timely manner from partners • No adverse limitations in access during rainy season • Existence and cooperation of a County Health Department (CHD) in Wuror County • Community are able to access services freely (no limitations due to insecurity) • Community willing to access services
2. Treatment of acute malnutrition • Children treated for SAM • OTP sites operating • OTP programmes provide quality SAM treatment with results inline with Sphere standards	• Number of children treated for SAM • Number of OTP sites operating • The proportion of exits from therapeutic care in line with Sphere standards; % who have died is <10%, recovered is >75% and defaulted is <15%		
3.Prevention of acute malnutrition • Improved malnutrition prevention with supplements • Children aged 6-59 months attending health facility receive Vitamin A supplementation • Children aged 12-59 months attending health facility receive de-worming tables as per WHO guidelines	• 5006 (80%) of the total children aged 6-59 months attending health care clinics or EPI are screened. • Improved malnutrition prevention with supplements, defined as: 5006 (>80%) of children aged 6-59 months attending the health facility will receive Vitamin A supplementation, 4450 (>80%) of children health care contacts aged 12-59 months will receive deworming tablets as per WHO guidelines.		
4.Improved capacity building • Improved capacity for local staff and CHD on management of Severe acute malnutrition	• >15% children aged 0-6 months are exclusively breastfeed. • >70% of staff appropriately trained in nutrition protocols. Defined as: >70% WHMs, BHC members, CHWs, MCHWs, EPI staff, CHD staff are trained in MUAC		

5. Improved coordination, emergency preparedness and emergency response • Improved Emergency preparedness responses in the project area.	screening, IYCF and referral. >70% Nutrition staff and CHWs trained in SAM protocols. • >80% of nutrition cluster reports completed and submitted to the cluster on time during the project cycle. • Minimum of 4 state nutrition meetings attended.		
Activities: *What are the key activities to be carried out (**grouped in Workpackages**) and in what sequence in order to produce the expected results?* **1. Assessment of acute malnutrition:** 1.1 Conduct pre and post-harvest SMART surveys in targeted payams of Uror County, Jonglei State, in line with nutrition cluster standards (May 2012, November 2012: 57088 target population for random sampling). 1.2 Prepare teams and conduct MUAC rapid assessments wherever returnees number >500 in all project areas. (500 returnees) 1.3 Disaggregate all needs assessment data for gender, including training courses and BHC committee lists. **2.Treatment of acute malnutrition:** 2.1 Treat SAM in boys and girls by delivering OTP at 4 sites, 2 mobile and 2 static, using SPHERE standards and IM-SAM guidelines. Direct beneficiaries 591. 2.2 Ensure proper secondary care referral pathways for all SAM children with complications. Referrals will be to IMC Walgak and MSF-H Lankien PHCC for further specialized management. 2.3 Improve defaulter and non-responder rates. Defaulter rates are high in the project	**Inputs:** *What inputs are required to implement these activities, e.g. staff time, equipment, mobilities, publications etc.?* • Trainable staff to undertake programme activities • Anthropometry equipment's • SMART training • CHD staff who are ready to be trained and participate in nutrition activities • GIK • Micronutrients supplements • Referral mechanism and availability of transport • Air transport to State headquarters • IYCF Materials, posters • Training materials (IMSAM, IYCF protocols) • Procurement and delivery of supplies (GIK) early for pre-positioning. • Tracks for transporting supplies to project sites • The defaulter tracing procedure includes a visit by a nutrition extension worker to the defaulter's home; assumes access.		**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?* • Stable security • Accessibility, rainy season does not start earlier than the usual pattern • Political and social stability • Localised conflict and emergency. • Peaceful disarmament • Transport contractors willing to transport GIK and other supplies amidst anticipated Jonglei disarmament • Women groups willing to be trained on IYCF and implement the new objectives • Absence of large scale humanitarian crisis or disasters

area due to pastoralist movements and insecurity. 2.4 All admission data collection is disaggregated for gender. **3.Prevention of acute malnutrition:** 3.1 Screen all health care contacts aged 6-59m with MUAC (including all U5 EPI, nutrition and curative care attendances). Direct beneficiaries 14774. 3.2 Administer Vitamin A to all health care contacts aged 6-59m according to WHO guidelines. Direct beneficiaries 14,774. 3.3 Administer deworming tablets to all health care contacts aged 12-59m. Direct beneficiaries 13,132. 3.4 Administer iron and folate to all pregnant women attending for antenatal care. Direct beneficiaries: 2854. 3.5 Educate all pregnant and lactating women on exclusive breastfeeding. Promote appropriate IYCF. Direct beneficiaries 9854 (including those targeted by the health education programmes). 3.6 Educate women's groups on what constitutes a nutritious diet, using local products, including the use of demonstration sessions. Direct beneficiaries 1000. 3.7 Train healthcare workers, including EPI, curative, CHD, BHC and maternal care staff on MUAC, IYCF and referral procedures. Direct beneficiaries 85. **4. Improved Capacity building:** 4.1 Train all nutrition staff and CHWs on IM-SAM guidelines. Direct beneficiaries: 30 4.2 Promote the 5 key health messages at all staff trainings. (Including exclusive breastfeeding and IYCF). Direct beneficiaries: 200. 4.3 Train nutrition staff in all aspects of			

emergency response. Direct beneficiaries: 10 trained. 4.4 Train healthcare workers, including EPI, curative, CHD, BHC and maternal care staff on MUAC, IYCF and referral procedures. Direct beneficiaries 85 (as above). 4.5 SMART training. Direct beneficiaries 8 **5. Improved coordination, emergency preparedness and emergency response:** 5.1 Ensure data collection procedures allow monitoring to continue when movement and access to outreach centres is reduced. 5.2 Pre-position supplies before the rains. 5.3 Record and monitor supply stock outs with proper analysis for future prevention. 5.4 Submit timely monthly reports and nutrition surveys to cluster. 5.5 Improve pipeline management. 5.6 Ensure secondary care referral pathways are documented and in place. 5.7 Carry out monitoring and evaluation with regular clinic and feeding center supervision. 5.8 Establish improved data collection procedures to ensure continuous monitoring. 5.9 Conduct focus group discussions with the beneficiaries annually to improve coordination and gain a qualitative understanding of the projects impact.			

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.

Activity	**Q1 / 2012**			**Q2 / 2012**			**Q3 / 2012**			**Q4 / 2012**			**Q1. / 2013**		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Result 1. Assessment of acute malnutrition:															
1.1 Conduct pre and post-harvest SMART surveys in targeted payams of Uror County, Jonglei State, in line with nutrition cluster standards					X						X				
1.2 Prepare teams and conduct MUAC rapid assessments wherever returnees number >500 in all project areas.			X	X	X	X	X	X	X	X	X	X			
1.3 Disaggregate all needs assessment data for gender, including training courses and BHC committee lists.					X	X	X	X	X	X	X				
2.Treatment of acute malnutrition:															
2.1 Treat SAM in boys and girls by delivering OTP at 4 sites, 2 mobile and 2 static, using SPHERE standards and IM-SAM guidelines.			X	X	X	X	X	X	X	X	X	X			
2.2 Ensure proper secondary care referral pathways for all SAM children with complications. Referrals will be to IMC Walgak and MSF-H Lankien PHCC for further specialized management.			X	X	X	X	X	X	X	X	X	X			
2.3 Improve defaulter and non-responder rates. Defaulter rates are high in the project area due to pastoralist movements and insecurity.			X	X	X	X	X	X	X	X	X	X			
3.Prevention of acute malnutrition:															
3.1 Screen all health care contacts aged 6-59m with MUAC (including all U5 EPI, nutrition and curative care attendances).			X	X	X	X	X	X	X	X	X	X			
3.2 Administer Vitamin A to all health care contacts aged 6-59m according to WHO guidelines.			X	X	X	X	X	X	X	X	X	X			
3.3 Administer deworming tablets to all health care contacts aged 12-59m.			X	X	X	X	X	X	X	X	X	X			
3.4 Administer iron and folate to all pregnant women attending for antenatal care. Direct beneficiaries: 2854.			X	X	X	X	X	X	X	X	X	X			
3.5 Educate all pregnant and lactating women on exclusive breastfeeding. Promote appropriate IYCF.			X	X	X	X	X	X	X	X	X	X			
3.6 Educate women's groups on what constitutes a nutritious diet, using local products, including the use of demonstration sessions.			X	X	X	X	X	X	X	X	X	X			
3.7 Train healthcare workers, including EPI, curative, CHD, BHC and maternal care staff on MUAC, IYCF and referral procedures.			X	X	X	X	X	X	X	X	X	X			
4. Improved Capacity building:															
4.1 Train all nutrition staff and CHWs on IM-SAM guidelines.						X		X		X					
4.2 Promote the 5 key health messages at all staff trainings. (Including exclusive breastfeeding and IYCF).			X	X	X	X	X	X	X	X	X	X			
4.3 Train nutrition staff in all aspects of emergency response.							X								
4.4 Train healthcare workers, including EPI, curative, CHD, BHC and maternal care staff on MUAC, IYCF and referral procedures.						X		X		X					
4.5 SMART training.					X						X				
5. Improved coordination, emergency preparedness and emergency response:															

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.

Activity	**Q1 / 2012**			**Q2 / 2012**			**Q3 / 2012**			**Q4 / 2012**			**Q1. / 2013**		
5.1 Ensure data collection procedures allow monitoring to continue when movement and access to outreach centres is reduced.			X	X	X	X	X	X	X	X	X	X			
5.2 Pre-position supplies before the rains.				X	X	X									
5.3 Record and monitor supply stock outs with proper analysis for future prevention.			X	X	X	X	X	X	X	X	X	X			
5.4 Submit timely monthly reports and nutrition surveys to cluster.			X	X	X	X	X	X	X	X	X	X			
5.5 Improve pipeline management.			X	X	X	X	X	X	X	X	X	X			
5.6 Ensure secondary care referral pathways are documented and in place.			X	X	X	X	X	X	X	X	X	X			
5.7 Carry out monitoring and evaluation with regular clinic and feeding center supervision.			X	X	X	X	X	X	X	X	X	X			
5.8 Establish improved data collection procedures to ensure continuous monitoring.			X	X	X	X	X	X	X	X	X	X			
5.9 Conduct focus group discussions with the beneficiaries annually to improve coordination and gain a qualitative understanding of the projects impact.			X									X			

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