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)
Malaria Consortium	Achana, Chelkou, Marial Baai, Mayom Akuang Rel and Nyinbouli payams, Aweil West County. Achana, Aroyo, Awoda, Awulic, Bar Mayan, Chel South and Nyalath payams Aweil Centre County, **Northern Bahr el Ghazal State**
Project CAP Code SSD-12\H\46200	
CAP Project Title Addressing emergency nutrition needs of vulnerable groups through community based structures	

Total Project Budget in South Sudan CAP	Amount Requested from CHF	Other Resources Secured
US$ 1,058,705	US$ 300,000	US$ 297,412

Direct Beneficiaries	
Women:	58,538
Men:	2,035
Girls:	29,269
Boys	29,269
Total number of beneficiaries	119,111

Total Indirect Beneficiary

Catchment Population (if applicable)
Total population of Aweil West and Aweil Centre is estimated at 373,152(calculated from Malaria Consortium's population figures from the state wide 2009 mass net distribution. Assumes population growth at a rate of 2.85% and takes into account 24,000 returnees[1]).

[1] Figure gained from SSRRC in Aweil October 2011 and UNHCR

Beneficiary breakdown		
Women	P&LW	0
	Trainees	1,000[2]
	Beneficiaries of IYCF promotion	58,538[3]
	Other vulnerable	0
Men	Trainees	140[4]
	Beneficiaries of IYCF promotion	2,035[5]
	Other - vulnerable	0
Children U5 Yrs	SAM	1,150[6]
	MAM	0
	BSFP	0
	Micronutrient supplementation	43,903[7]
	Deworming	58,538[8]

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

N/A

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

Start Date (mm/dd/yy): June 01, 12[9]

End Date (mm/dd/yy): Dec 31, 12

Address of county Office

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Address: Plot 367, Block 3-K South, First Class Residential Juba

Address of HQ

e-mail desk officer: c.vanderick @malariaconsortium.org

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Address: Plot 25, Upper Naguru East Road, Naguru
PO Box 8045, Kampala, Uganda

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[10]

OCHA identified Northern Bahr el Ghazal (NBeG) as one of the 'hot spots' adversely affected by a combination of shocks resulting in multiple deteriorating humanitarian indicators. Malaria Consortium (MC) is the only permanent nutrition actor in Aweil Centre and already implementing Integrated Community Case Management (ICCM) of malaria, diarrhea and pneumonia aligned to Outpatient Therapeutic Programme (OTP) sites in Aweil West and Aweil Centre.

Nutrition Emergency

In Aweil Centre and West malnutrition rates are well above WHO emergency threshold of 15% GAM. Unless the nutrition situation is addressed, impacts on morbidity and mortality in children under five will be high. MC's 2011 post harvest SMART survey in Aweil Centre showed SAM prevalence of 5.3% and GAM of 17%. Concern Worldwide's 2011 pre harvest survey in Aweil West showed SAM rate of 3.8% and GAM of 24.6%.[11] This is concerning as malnutrition rates are comparable to pre harvest survey results from 2011 and expected to further decline in 2012 moving into the hunger gap.

[2] CDDs trained on screening, referral and IYCF messages
[3] All caregivers who access treatment from the CDD network receive IYCF and health messaging through the BCC campaign
[4] 113 CDD Supervisors / CNWs and 27 Health Facility Staff
[5] Numbers of males targeted through community mobilisation meetings – this will include IYCF messaging as men are key decision makers relating to feeding practices
[6] Calculated based on admissions from 2011 + % increase for newly established OTPs and taking into account increase in malnutrition rates from SMART survey data
[7] Based on U5 population for Aweil West and Aweil Centre and assuming 50% coverage based on an existing 20% coverage for NBeG sate from 2011 LQAS report
[8] Based on U5 population for Aweil West and Aweil Centre and assuming 75% coverage
[9] Malaria Consortium proposes to begin implementation o f the CHF 2012 grant immediately following the no cost extension of CHF 2011 funding. This will assure sustained programming and avoid overlap of activities in the first two quarters of 2012. MC hope's to receive a further NCE to CHF 2011 funding to run until 30th June 2012. We would expect the full 2012 CHF funding to be spent out by end December as originally planned. If this further NCE is not approved, then MC would request that the 2012 funding is brought forward to run from 1st May 2012 until 30th November 2012
[10] 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.
[11] Results still awaiting validation from the South Sudan nutrition cluster

Food insecurity
NBeG's food security status at a 'crisis' level[12]. Following Independence, NBeG has experienced extremely disrupted market supply of essential commodities following the closure of the northern border causing escalation in food prices. It is expected this will be additionally adversely affected by coming austerity measures. These factors combined with failed rains and reduced cereal production, resulted in a 70%[13] food deficit forcing larger numbers into food insecure creating direct impacts on nutritional vulnerability.

Returns
NBeG has the highest number of spontaneous returns over the last year within the country. Of the 69,573[14] returnees, 75%[15] were spontaneous, creating a huge burden on host populations in terms of shelter, sanitation facilities, food and provision of basic health services.

A further 300,000 South Sudanese are expected to return adding pressure to already weak state health systems and straining limited capacity to respond . MC's rapid assessment funded by CHF 2011 showed concerning proxy SAM (8.3%) and GAM (23.2%) from returnees in Apada site, providing strong evidence for continuing support to nutrition programming in NBeG.

Childhood Illness
Data sources[16] indicate that malaria, diarrhoea and pneumonia are the three most common communicable disease contributions to morbidity and mortality in South Sudan and are key underlying causes of malnutrition[17]. MC's 2011 SMART survey in Aweil Centre found these to be the most commonly reported illnesses with 59.5% of children under five years experiencing illness in the past two weeks. During the course of 2011 MC treated 204,813 cases of malaria[18] in the community in children under five across Aweil Centre and West.

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 (**added value would include expertise your agency brings, additional nutrition related activity your agency may be doing in addition to CHF project submission and if you are sole provider of services**)

Supporting Nutrition cluster priorities:
Contribute to cluster objectives 1, 2 &3:

- **Treatment:** 45 community based OTP sites will be strengthened to treat under fives for SAM continuing services established with 2010 & 2011 CHF. The extensive MC network of Community Drug Distributors (CDDs) treat children with malaria, pneumonia and diarrhea following set protocols, routinely screen children under five for malnutrition (using MUAC) and monitoring moderate malnutrition (MAM). This method of community case management ensures common childhood diseases and malnutrition can be treated through community structures, catching diseases they become severe[19]. Complicated cases of SAM are referred to inpatient facilities where feasible; Aweil Civil Hospital or Concern inpatient site. However, scarcity of services and lack of access to functional facilities increases the value of community based treatment structures supporting early treatment.

- **Prevention:** Nutrition education and BCC elements promote good practices in Infant and Young Child Feeding (IYCF) with additional de-worming and Vit A supplementation aligned with MoH EPI to address improving feeding behaviors (breast feeding and weaning) and addressing micronutrient deficiencies. Early detection of SAM and monitoring of MAM cases will reduce risks of serious complications of malnutrition.
- **Emergency Assessment:** Programming will capture data on changing nutritional status through a pre and post harvest SMART survey in Aweil Centre, rapid assessment and ongoing supervisions to CNWs and CDDs and data collection/analysis. Combining routine MUAC screening and treatment of SAM cases with community based treatment of children showing malaria, diarrhea or pneumonia will ensure nutritional trends are captured, addressed and shared with SMoHs and partners.
- **Vulnerable groups:** Trained CNW and CDDs will screen, identify and treat cases of SAM in host and returnees communities of Aweil West and Centre. P&LW will be targeted for information around improved nutrition during pregnancy.
- **Value added:**
  - Ongoing programming and value for money: the project builds on MC's wider ICCM programme allowing savings in overheads. Extensive networks of trained and supervised CDDs provide ongoing detection and referral mechanisms, much wider than could be reached by CNWs. Referring cases of SAM at early stages prevents expensive inpatient care, and high mortality: a considerable cost saving to project and health facility.
  - Organizational Expertise: MC has technical expertise at all programme levels of implementing nutrition programmes in country.
  - Sole provider: MC is the only permanent[20] nutrition service provider in Aweil Centre.

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 purpose of the grant is to address emergency nutrition needs of vulnerable groups through community based structures in two highly affected counties.

Responding to emergencies
Malaria Consortium is an active member of the Nutrition Cluster and will be involved in conducting rapid needs assessment along with other partners when the need arises especially in the areas where there are a high number of returnees and refugees

Maintaining front-line services
In Aweil Centre and Aweil West where many populations (host and returnees) have difficulty in accessing health facilities, Malaria Consortium is providing county wide prevention and treatment interventions for SAM and for malaria, pneumonia and diarrhoea, the 3 leading causes of morbidity and mortality in children under five. Using CHF funding, Malaria Consortium plans to increase the number of OTP sites from 33 to 45 targeting areas with high numbers of returnees and remote communities not reached by other service providers.

Ramping up support for returnees

[12] 2011 Crop and Food Security Mission report
[13] 2011 Crop and Food Security Mission report
[14] IOM figures as of 21st Feb 2012
[15] IOM ERS Weekly update 15 Feb – 21 Feb: 5
[16] Sudan Household Health Survey, Starbase Dataset 2010
[17] South Sudan ANLA 2011
[18] Presumptive treatment on the basis of the presentation of fever. RDTs are not currently being used for community treatments in South Sudan
[19] This programme implementation strategy has shown high quality indicators to date. In NBeG the average cure rate was 93.1%, 2.0% defaulter rate and 1.2% death rate ; all well within the SPHERE Standards
[20] MSF F have a mobile outreach team that will respond in Aweil Centre if necessary but the main purpose of the team is surveillance rather than service provision. ACF USA initiated a mobile OTP in Apada following advocacy work from Malaria Consortium and cluster after the rapid assessment completed in October 2011. ACF have indicated that they do not plan to continue services in Apada in the long term and Malaria Consortium is working on a handover plan with ACF

Screening and adequate treatment and follow–up of severely malnourished children will be carried out for returnees as well as coordination with other actors (health, WASH, Food Security and Education) for support in terms of the needs identified that are not within the response capacity of Malaria Consortium.

ii) Objective

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

To contribute to improved nutritional status of children under 5 through increasing access to community-based therapeutic and preventative nutritional programmes and enhancing capacity building for service provision in Aweil Centre & West, Northern Bahr el Ghazal 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 nuFmber of direct beneficiaries **for each activity.**

Assessments

- SMART survey in Aweil Centre (with malnutrition rates disaggregated for boys and girls) in line with cluster recommendations
- Continued membership of the statewide emergency nutrition assessment team. Particularly carrying out rapid assessments in response to population movements, including returnees
- Rapid MUAC screening assessment of children (6-59 months) to determine areas of high need and the location for new OTP sites within NBeG

Treatment

- Establishing 12 new OTP sites to respond to the nutritional emergency in the returnee population an in remote underserved areas in Aweil Centre
- Treatment of 1,150 boys and girls 6-59 months with Severe Acute Malnutrition through 45 OTP & highly decentralised community nutrition promotion sites Aweil West and Aweil Centre, unserved by other interventions

Prevention, Referral and Behavior Change Communication (BCC)

- Training of 1,700 community volunteers to conduct Nutrition screening (using MUAC and checking for oedema and referrals for treatment of SAM in Aweil West and Aweil Centre
- Conducting mass deworming (children 1-5 years) and Vit A supplementation(children 6-59 months) campaigns alongside mass MUAC screening (with referral) throughout Aweil Centre and Aweil West (58,538 boys and girls 1-5 years given deworming treatment and 43,903 boys and girls 6-59 months given Vitamin A supplementation)
- Treat underlying causes of malnutrition in children under five (both boys and girls) – for malaria, diarrhoea, pneumonia, through a network of 1,700 community volunteers covering throughout the county in Aweil West and Aweil Centre
- BCC campaign including 135 community meetings with a focus on mothers' groups conducted to promote: IYCF promotion /nutrition education for children and pregnant and lactating women & hygiene promotion (including hand washing) in Aweil West and Aweil Centre
    - 3,375 female participants and 2,025 male participants
- 58,538 caregivers receiving health education and IYCF messaging through the network of 1,700 CDD volunteers

Capacity development

- Training and refresher training on management of outpatient SAM and IYCF for Community Nutrition Workers (CNW) in Aweil West and Aweil Centre
- Training to 26 health facility staff on outpaitient SAM treatment and links to referral to health services in Aweil West and Aweil Centre
- Training and sensitisation meetings with SMoH in NBeG, CHDs in Aweil West and Aweil Centre on Malaria Consortium's nutrition programme and links with other health services in the community

Coordination

- Participation and support to the cluster system at the state and national level (including participation in 2 Technical Working Groups and chairing state level health and nutrition cluster meetings)
- In areas where other nutrition actors are working (Concern Worldwide in Aweil West) MC will closely coordinate to ensure that services are complementary and not duplicating (e.g. SMART surveys, location of treatment sites etc.)
- MC will link closely with other nutrition actors that are providing additional services in NBeG; referral of complicated SAM cases (MSF F and Concern Worldwide both provide SCs in Aweil town and Aweil West respectively) and MAM cases to supplementary services where they exist
- Malaria Consortium will document lessons learnt and share experience from implementation

Supervision, Monitoring and Evaluation

- Regular data collection and analysis to feed back to CNWs during supervisory visits
- Completion of nutrition cluster and MoH monthly reporting format with ongoing analysis of nutritional trends
- 2 weekly support supervision visits to all CNWs through OTP Supervisors

iv). Cross Cutting Issues

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

Gender: Pregnant and lactating women will be targeted for education messages on nutrition during pregnancy, breastfeeding, how to prepare nutritious weaning foods from locally available food sources, the gradual introduction of complementary foods to infants, infant and child feeding. If feeding practices are identified as being gender-imbalanced, tailor-made behaviour change communications messages will address this. Focus will also be given to messages on water sanitation and hygiene linking to childhood diseases. The majority of CDDS who will refer SAM cases to the OTPs are women and are recognised as an integral part of the success of the wider programme by the local leaders and the county health departments.

Co-infections with attention to HIV /AIDS

The program will consider the presence of other co- infections related to malnutrition such as TB and HIV focusing on the timing for admission in the OTPs and response to treatment. If children have remained within OPT for duration of treatment without improvement, recognition and referral for other co-infections maybe necessary. These skills will be included in trainings for CNWs.

Environment: The environmental conditions within the project lifespan will be taken into consideration especially in terms of access to services during the rainy season and period of insecurity. By combining supervision visits to the OTP sites with those of other elements of the wider integrated community case management programme, the vehicle usage will be markedly reduced, presenting a financial as well as environmental saving. The programme is otherwise environmentally neutral with the programme field teams in place, reducing the number of national or international flights required to implement the project. Behaviour change communication will include messages on water and sanitation, and messages aim to have improving impact on nutrition status.

v) Expected Results

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.

The overall expected result of this project is to contribute to the reduction in child morbidity and mortality through early identification and treatment of SAM and its underlying diseases.

1. Improved access to nutrition treatment in Aweil Centre and Aweil West through the continuation of services and establishment of an additional 12 OTP sites for the provision of nutrition services and treatment for malaria, diarrhoea and pneumonia in the community level in remote locations with referral for complicated cases to SC, PHCU/Cs.
2. Improved nutrition surveillance in NBeG: by early detection of malnutrition in the community through community mobilisation and mass screening campaigns, completing pre and post SMART surveys in Aweil Centre and conducting rapid assessments with Malaria Consortium and other partners make appropriate responses to the need and emergencies
3. Improved delivery of quality OTP services by the training and supervison of Health and Community Nutrition volunteers
4. Improved access to a routine schedule for de worming (children 1 – 5 years) and Vit A supplementation (6-59 months) for children in Aweil West and Aweil Centre through campaign
5. Enhance community awareness on improved nutrition practices through promotion of messages on Infant and Young Child Feeding (IYCF), nutrition in pregnancy and during illness.
6. Improved coordination and support to the national and state Nutrition Cluster

	Indicator	Target (indicate numbers or percentages)
1	Number of Outpatient Therapeutic Programme (OTP) sites for the treatment of Severely Acutely Malnourished (SAM) children	45 OTP sites (33 existing and 12 additional)
2	Quality of SAM treatment	Overall cure rate >75%, defaulter rate <15%, death rate <10%
3	Number of children de-wormed	58,538 children 1-5 years
4	Number of health and nutrition workers trained (includes facility and community level health workers)	1,840 (1,700 Community Volunteers trained in screening and referral & IYCF, 113 CDD Supervisors / CNWs trained and 27 Health Facility Staff, CHD and SMoH trained in outpatient management of SAM)
5	Number of cluster coordination meetings attended in a quarter	>4 meetings attended per quarter (State and national level)

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.

Given the remote location of the beneficiary communities in NBeG, their low access to lifesaving curative services and urgent need for nutritional care, the aim of this project is to continue to implement a highly decentralised model of outpatient therapeutic programmes (OTP) for eligible children 6-59 months with severe acute malnutrition (SAM) within the community.

The project is working through Malaria Consortium's established network of CDDs and their supervisors. CDDs are volunteer community members trained to provide basic health education messages to communities as well as home-based treatment of common infectious diseases. Each CDD is responsible for 40 households. Supervisors have more public health/clinical experience and are responsible for overseeing the work of 15 CDDs each.

In the scope of this project, CDDs play a role in community mobilisation and creating demand for the curative services provided by the project as well as case identification, health education and follow-up of defaulters. Each CDD is supervised by a supervisor who is literate and cable of data collection and on the job training. Some of these supervisors have been selected to serve as Community Nutrition Workers (CNWs), operating OTPs within the community, mostly out of their homes with some based in health facilities. CDDs are to identify cases of SAM and refer them to CNWs. At the OTP sites, CNWs carry out clinical management of the identified cases according to the modified OTP treatment guidelines (based on the South Sudan Integrated Management of Severe Acute Manutrition (IM-SAM) guidelines) and coordinate follow-up of the cases enrolled in the nutrition program. Prevention activities (deworming and Vit A supplementation) will be further linked to the MoH Immunizations campaigns as a supportive mechanism patients who need referral will be sent to suitable stabilisation centres or to existing functional PHCC/PHCUs.

Community structures will be engaged at every level of implementation of the project especially women groups to promote the health and well-being of boys and girls under five.and P&LW.

Collaboration and coordination will be maintained with partners and the MoH within the project area.

vii) Monitoring Plan

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

Malaria Consortium will provide programmatic and financial updates to donors on a quarterly basis according to the donor`s particular reporting requirements. In addition technical and operational updates will be shared with the cluster on a regular basis through the cluster coordination network. The project will involve the Malaria Consortium team working closely with the local county health departments who will also receive ongoing reports of progress.

There will be two key M&E elements for this project. Discrete activities e.g. trainings or SMART surveys, will be recorded and assessed as they take place, with lessons learned feeding back from the field teams to the wider programme and cluster teams as appropriate. This feedback loop will ensure that the programme has the flexibility to evolve on a micro-operational front to ensure the most effective implementation.

The second element will be to record the treatment numbers and outcomes both for SAM and the underlying diseases. This information will be examined during routine supervision visits by Malaria Consortium and will be analyzed both for data quality and impact, in terms of impact the Sphere indicators on OTP outcomes should provide a minimum guide. The data from each OTP site and the supervisory visits will be an opportunity to reinforce the formal training programme, provide immediate correction of any deficiencies and ensure quality of service provision. Such supportive supervision has been shown to improve the retention and motivation of community based workers

Similar information on the treatment of malaria, pneumonia & diarrhoea will also be collected at a community level, collated on a regular basis, feed back to providers and used both to inform operational decisions and to evaluate the technical impact of the project.

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)
UNICEF (until January 2013)	297,412[21]

[21] Currently under submission with UNICEF – indications are good that this will be approved

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-12\H\46200	**Project title: Addressing emergency nutrition needs of vulnerable groups through community based structures**	**Organisation: Malaria Consortium**

Overall Objective: *What is the overall broader objective, to which the project will contribute? Describe the expected long-term change.* • To contribute to improved nutritional status of children under 5 through increasing access to community-based therapeutic and preventative nutritional programmes and enhancing capacity building for service provision in Aweil Centre & West, Northern Bahr el Ghazal State	**Indicators of progress:** *What are the key indicators related to the overall objective?* • Number of OTP sites established and maintained (33 existing and 12 new sites) • Number of children treated and screened for SAM (1,150 children treated, 58,538 children screened)	**How indicators will be measured:** *What are the sources of information on these indicators?* • Monthly nutrition reports	
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 assess the nutritional status of children in the areas of operation through SMART surveys and rapid assessments • To improve access to quality treatment of SAM for children under 5 at the community level • To contribute to the prevention of malnutrition through micronutrient supplementation, deworming and IYCF promotion	**Indicators of progress:** *What are the quantitative and qualitative indicators showing whether and to what extent the project's specific objectives are achieved?* • Number of SMART surveys conducted (1 in Aweil Centre) • Number of rapid assessments conducted (6 according to emergency need) • Number of Outpatient Therapeutic Programme (OTP) sites for the treatment of Severely Acutely Malnourished (SAM) children (maintain 33 existing sites and establish 12 new OTP sites) • Number of children treated for SAM 1,150 • Cure rate >75% • Defaulter rate <15% • Death rate <10%) • GoW <60 days • LoS >4g/kg/day • Number of children 1-5 years de-wormed (58,538 boys and girls) • Number of children 6-59 months supplemented with Vitamin A (43,903 boys and girls) • Numbers of community meetings conducted to promote IYCF promotion / nutrition education for children and pregnant and lactating women & hygiene promotion (135 meetings) ○ 3,375female participants and 2,025 male participants • Number of caregivers receiving health	**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 survey and rapid assessment report completed and submitted to the cluster • Monthly nutrition reports, OTP treatment registers • Monthly nutrition report + campaign report	**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?* • Access is not hindered to treatment sites by insecurity or seasonal flooding • No stock outs of plumpynut or other supplies provided in kind by UNICEF • Large population movement does not overwhelm existing infrastructure • It will be possible to recruit and retain sufficiently qualified and experienced staff for programme implementation

	education and IYCF messaging through the network of 1,700 CDD volunteers (58,538 caregivers)		
• To strengthen the capacity of community volunteers and health staff for the provision of curative and preventative services	• Number of health and nutrition workers trained (includes facility and community level health workers) 1,840 (1,700 Community Volunteers trained in screening and referral & IYCF, 113 CDD Supervisors / CNWs trained and 27 Health Facility Staff, CHD and SMoH trained in outpatient management of SAM)	• Monthly nutrition report + training report and registers	
• To support the nutrition cluster coordination mechanism at state and national level	• Number of cluster coordination meetings attended in a quarter (4 per quarter state and national level) • Number of Technical Working Groups (TWG) attended (2 TWG)	• Meeting minutes	
• To maintain programme supervision, monitoring and evaluation	• Number of CNW supervisory visits conducted per month by OTP supervisors (2 per month per CNW) • Number of complete and timely reports submitted monthly (2 per month)	• M&E reports • Monthly nutrition report	
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?*
• Improved access to nutrition treatment in Aweil Centre and Aweil West through the continuation of services and establishment of an additional 12 OTP sites for the provision of nutrition services and treatment for malaria, diarrhoea and pneumonia in the community level in remote locations with referral for complicated cases to SC, PHCU/Cs.	• % increase in OTP attendance from previous year's treatment records	• Treatment records and monthly reports	• Beneficiaries will utilise OTP services more readily when they are closer to an OTP site
• Improved nutrition surveillance in NBeG: by early detection of malnutrition in the community through community mobilisation and mass screening campaigns, completing pre and post SMART surveys in Aweil Centre and conducting rapid assessments with Malaria Consortium and other partners make appropriate responses to the need and emergencies	• Number of emergency response activities conducted by partners resulting from assessment / survey information	• OCHA and Nutrition cluster reports on assessments and emergency nutrition response interventions	• Nutrition partners have the resources and capacity to respond to emergencies
• Improved delivery of quality OTP services by the training and supervison of Health and Community	• Number of staff with competence and capacity to deliver services in line with the nutrition treatment protocol	• Training records, performance appraisals, supervision records and treatment records	

Nutrition volunteers • Improved access to a routine schedule for de worming (children 1 – 5 years) and Vit A supplementation (6-59 months) for children in Aweil West and Aweil Centre through campaign • Enhance community awareness on improved nutrition practices through promotion of messages on Infant and Young Child Feeding (IYCF), nutrition in pregnancy and during illness • Improved coordination and support to the national and state Nutrition Cluster.	• % children reached with vitamin A supplementation • % children reached with deworming treatment • Number of people reached through awareness and sensitization campaigns on IYCF, nutrition in pregnancy and during illness • Number of cluster level decisions and activities that Malaria Consortium is involved in or contributes to	• Treatment records and reports for Vitamin A and deworming treatment • Community mobilisation and health education reports • Development of cluster materials • Joint cluster assessments and emergency response reports	• Capacity of staff is sufficient to deliver the programme according to treatment protocol • There will be community acceptance of the mass campaign • Community will be receptive to participating in sensitisation campaigns • Cluster mechanism and TWGs will continue at state and national level
Activities: *What are the key activities to be carried out (**grouped in Workpackages**) and in what sequence in order to produce the expected results?* • Establish 12 new OTP sites (identify new CNWs, procure OTP equipment etc.) • Continuation of treatment of 2,350 boys and girls with SAM • Screening and referral of SAM cases from the ICCM programme to OTP sites • Carry out preharvest SMART survey • Carry out rapid assessments in response to nutritional emergencies • Ongoing treatment data collection and analysis of nutritional trends • Training 1,700 community volunteers on to conduct Nutrition screening (using MUAC and checking for oedema and referrals for treatment of SAM in Aweil West and Aweil Centre • Training and refresher training on management of outpatient SAM and IYCF for Community Nutrition Workers (CNW) in Aweil West and Aweil Centre • Training to 26 health facility staff on outpatient SAM treatment and links to referral to health services in Aweil West and Aweil Centre • Training and sensitisation meetings with SMoH in NBeG, CHDs in Aweil West and Aweil Centre on Malaria Consortium's nutrition programme and links with other health services in the community • 2 weekly support supervision visits to CNWs by OTP Supervisors • Coordinate with partners (SMoH, CHDs, INGOs and	**Inputs:** *What inputs are required to implement these activities, e.g. staff time, equipment, mobilities, publications etc.?* • Nutrition Programme Officer, OTP Supervisors and additional CNWs • Training materials for newly recruited CNWs • Equipment for OTP sites • Supplies for OTP sites • ICCM Nutrition Programme Coordinator, Programme Officer, OTP Supervisor time • Temporary staff to conduct the survey • Hire vehicles • Survey equipment and questionnaires • Training manual • Staff to deliver the training • Training materials		**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?* • It will be possible to access the field locations – the security situation will allow this and areas will not be cut off • Supplies will be available from UNICEF for treatment • HF staff are available to attend the training • OTP supervisors are able to access the OTP sites for supervision visits • Communities will be willing to

NNGOs) on aligning campaign with immunisation campaign • Procurement of campaign supplies • ToT of CNWs and CDD Supervisors on mass campaign • Training of CDDs on mass campaign • Sensitisation of the community and leaders on the mass campaign • Implementation of the mass Vitamin and deworming campaign • Report writing and data collection of the campaign	• Staff time for coordination with partners • Equipment and supplies • Training materials • Time from community volunteers to deliver the distribution		spend time on the distribution
• Rapid BCC assessment on IYCF practices • Development of materials • Conduct community meetings on IYCF based on assessment activity 5.1 • 58,538 caregivers receiving health education and IYCF messaging through the network of 1,700 CDD volunteers	• Staff time for rapid assessment and preparation of materials • Materials and supplies		
• Participation in national level cluster meetings) • Chairing state level health and nutrition cluster • Participation in Nutrition cluster Technical Working Groups • Documenting lessons learnt and share experience from implementation with cluster and partners	• Staff time		

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: Improved access to nutrition treatment in Aweil Centre and Aweil West through the continuation of services and establishment of an additional 12 OTP sites for the provision of nutrition services and treatment for malaria, diarrhoea and pneumonia in the community level in remote locations with referral for complicated cases to SC, PHCU/Cs.															
Activity (1.1) Establish 12 new OTP sites (identify new CNWs, procure OTP equipment etc.)					X	X	X	X							
Activity (1.2) Continuation of treatment of 2,350 boys and girls with SAM				X	X	X	X	X	X	X	X	X			
Activity (1.3) Screening and referral of SAM cases from the ICCM programme to OTP sites				X	X	X	X	X	X	X	X	X			
Result 2: Improved nutrition surveillance in NBeG: by early detection of malnutrition in the community through community mobilisation and mass screening campaigns, completing pre and post SMART surveys in Aweil Centre and conducting rapid assessments with Malaria Consortium and other partners make appropriate responses to the need and emergencies															
Activity (2.1) Carry out preharvest SMART survey				X							X				
Activity (2.1) Carry out rapid assessments in response to nutritional emergencies						X	X	X	X	X			X		
Activity (2.2) Ongoing treatment data collection and analysis of nutritional trends					X	X	X	X	X	X	X	X	X		
Result 3: Improved delivery of quality OTP services by training and supervision of Health and Community Nutrition volunteers															
Activity (3.1) Training 1,700 community volunteers on to conduct Nutrition screening (using MUAC and checking for oedema and referrals for treatment of SAM in Aweil West and Aweil Centre				X	X	X	X	X	X	X	X	X			
Activity (3.2) Training and refresher training on management of outpatient SAM and IYCF for Community Nutrition Workers (CNW) in Aweil West and Aweil Centre						X			X			X			
Activity (3.3) Training to 26 health facility staff on outpatient SAM treatment and links to referral to health services in Aweil West and Aweil Centre				X	X	X	X	X	X	X	X	X			
Activity (3.4) Training and sensitisation meetings with SMoH in NBeG, CHDs in Aweil West and Aweil Centre on Malaria Consortium's nutrition programme and links with other health services in the community				X		X		X		X		X			
Activity (3.5) 2 weekly support supervision visits to CNWs by OTP Supervisors				X	X	X	X	X	X	X	X	X			
Result 4: Improved access to a routine schedule for de worming (children 1 – 5 years) and Vit A supplementation (6-59 months) for children in Aweil West and Aweil Centre through campaign															
Activity (4.1) Coordinate with partners (SMoH, CHDs, INGOs and NNGOs) on aligning campaign with immunisation campaign				X	X	X									
Activity (4.2) Procurement of campaign supplies				X	X	X									
Activity (4.3) ToT of CNWs and CDD Supervisors on mass campaign	To be determined based on activity 4.1														
Activity (4.4) Training of CDDs on mass campaign															
Activity (4.5) Sensitisation of the community and leaders on the mass campaign															
Activity (4.4) Implementation of the mass Vitamin A and deworming campaign															
Activity (4.4) Report writing and data collection of the campaign															
Result 5: Enhance community awareness on improved nutrition practices through promotion of messages on Infant and Young Child Feeding (IYCF), nutrition in pregnancy and during illness.															
Activity (5.1) Rapid BCC assessment on IYCF practices				X	X	X									
Activity (5.2) Development of materials						X	X								
Activity (5.3) Conduct community meetings on IYCF based on assessment activity 5.1							X	X	X	X	X	X			
Activity (5.4) 58,538 caregivers receiving health education and IYCF messaging through the network of 1,700 CDD volunteers				X	X	X	X	X	X	X	X	X			
Result 5: Improved coordination and support to the national and state Nutrition Cluster															
Activity (6.1) Participation in national level cluster meetings)				X	X	X	X	X	X	X	X	X			
(Activity 6.2) Chairing state level health and nutrition cluster				X	X	X	X	X	X	X	X	X			
Activity (6.3) Participation in Nutrition cluster Technical Working Groups				X	X	X	X	X	X	X	X	X			
Activity (6.3) Documenting lessons learnt and share experience from implementation with cluster and partners				X	X	X	X	X	X	X	X	X			