THE EUROPEAN UNION EMERGENCY TRUST FUND FOR STABILITY AND ADDRESSING THE ROOT CAUSES OF IRREGULAR MIGRATION AND DISPLACED PERSONS IN AFRICA

Action Fiche for the implementation of the Horn of Africa Window
EUTF05 - HoA - SD - 12

1. IDENTIFICATION

Title/Number	Strengthening Resilience for IDPs, Returnees and Host Communities in West Darfur
Total cost	Total estimated cost: EUR 7 000 000 Total amount from the EU Trust Fund: EUR 7 000 000
Aid method / Method of implementation	Project Modality: Direct management: grants- direct award
DAC-code	120 Sector Health

2. RATIONALE AND CONTEXT

2.1. Summary of the action and its objectives

The project is based on **EU Trust Fund objective (2)** strengthening resilience of most vulnerable communities" **and is aligned with the Valletta Action Plan priority domains (1)** development benefits of migration and addressing root causes of irregular migration and forced displacement **and (5)** return, readmission and reintegration. The project is also based on the **objectives and indicative intervention priorities of the Short Term Strategy 2016/17** for the implementation of a special support measure in favour of the people of the Republic of Sudan.

The **geographical scope** of the project focuses on 6 localities - Al Geneina, Beida, Sirba, Krenik, Kulbus and Jebel Moon - located in West Darfur, which are deeply affected by ongoing internal displacement and by a sharp increase in the number of IDPs and returnees combined with an already low level of health coverage and poor health indicators.

The breakdown of the population of the concerned beneficiaries includes:

Locality	IDP	Returnees	Host	Total Population
Geneina	119,821	0	35,750*	155,571
Beida	32,938	8,197	87,991	129,126
Sirba	40,282	3,954	18,300	62,536
Krenik	76,070	986	128,916	205,972
Kulbus	12,045	0	16,327*	28,372
Jabel Moon	19,341	0	6,000*	25,341
Total	300,497	13,137	293,284	606,918

The **intervention logic** of the proposed project is based on the assumption that strengthening community resilience through the improvement of access to, and quality of health services, in areas affected by displacement and experiencing returns will ensure that local communities, IDPs and returnees are able to receive adequate health care

and services, which is widely recognised as one of the main push factors of irregular and forced migration.

The overall objective is to improve the living conditions of IDPs, returnees and local communities, and thereby addressing the root causes of irregular and forced migration.

The **specific objective** is to strengthen the local health systems to better deliver basic packages of health services in West Darfur with the final aim of creating a more conducive and sustainable living environment for host communities and displaced populations through: (1) greater access to and quality of primary health care and nutrition services; (2) strengthening the governance capacity of states and local authorities for a well functioning and sustainable health service; and (3) creating a more participatory and inclusive health system.

2.2. Context

2.2.1 Country context

Sudan is at the centre of the Eastern African migration route, towards North Africa and Europe. Hundreds of migrants, asylum-seekers and refugees are transiting through Sudan every month, with only a minority choosing to settle in the country. Traffickers and smugglers are operating in the country. About 3,1 million people are internally displaced (IDPs) and almost 367.000 are refugees and asylum seekers (UNHCR 2015).

Eritreans are the largest group of refugees with 108,075 persons, of which 90,806 are residing in 9 camps in the East of Sudan, in the Kassala and Gedaref region[1]. Around 80 per cent of the Eritreans that are registered by UNHCR move onwards within two months after their arrival, to Khartoum, Libya and possibly to the EU. In fact, the chances of them risking onward migration is increasing due to the fact that the majority of the Eritreans coming to Sudan now are young urban people, who are unwilling to stay in enclosed camps without access to higher education or employment and do not have the same social networks in Sudan as the old generation used to have.

The majority of the IDPs in Sudan are found in conflict-affected areas, with an estimated 2.5 million in Darfur[2], 222,000 in South Kordofan and 176,000 in Blue Nile state.

Sudan is considered a fragile State, suffering long lasting internal conflicts, high social and economic disparities and unequal allocation of public resources. With an annual growth rate of 2.8%, the total population was around 39 million in 2014 (World Bank 2016). Sudan is at the bottom of the UN Human Development Index 2014, ranking 167 out of 188 countries, with about 46,5% of population living below poverty line, while 8% living in extreme poverty. In particular, in the East the population living below the poverty line in Red Sea (57.7%) and Gedaref (50.1%) is higher compared to the national average.

Sudan is a lower middle income country, in a transition period. It has a weak economy with soaring inflation due to steep increase in fuel prices coupled with a high fiscal deficit in the face of continuing sanctions, and the binding domestic and international borrowing constrains. That translates in reduced socio-economic development, worsened by internal conflicts and political tension with South Sudan. Sudan's economy has worsened after South Sudan secession with the loss of the 75% oil revenue, resulting in a significant GDP contraction, more than offsetting the loss of 21% of the population, compounded by lack of external investment, economic and financial sanctions and an unsustainable external debt of over $45 billion.

In particular, significant economic, social and cultural disparities between states are reported, with States in the

[1] South Sudanese represent the largest group of Displaced People (DPs) in Sudan, and a great percentage of them are concentrated in White Nile and Sennar States. They are not considered refugees by the Sudanese Government.
[2] A referendum in Darfur over its territorial division (to remain divided in 5 States or to return to the pre-2012 structure of a single State) will be held on 11-13 April.

Eastern Sudan, Darfur and Kordofan regions being particularly disadvantaged. Access to safe drinking water and basic services in these regions is limited, and extreme poverty is widespread. Moreover, these states do not receive federal resources proportionate to their needs.

2.2.2. Sector context: policies and challenges

A complex set of drivers combined with context-related challenges underpins forced displacement and mixed migration. Among those, the lack of access to basic services, such as health, caused by poor governance, weak institutions and low state capacity is recognised as a "push factor" for displacement in Sudan (UNHCR 2015).

Sudan faces significant challenges to provide adequate health care to its people. The National Health Sector Strategic Plan (NHSSP 2012-2016) developed by the Federal Ministry of Health (FMoH) is the main policy and guiding document for the health sector. Despite its comprehensive nature and the identification of the main health sector challenges in the NHSSP 2012-2016, no effective improvement occurred, resulting in a disproportionally high burden of ill health in the country. The national health sector remains underfunded, inequitable, and inefficient, lacking adequate health care services coverage, basic infrastructures and qualified staff.

Since 1993 a National Health Insurance Fund (NHIF) is operative in the country. The NHIF currently covers about 11,8 million people (about 1/3 of the population) - mainly from the formal wage sector. Health facilities (Hospital and Health Units) are accredited by the NHIF against a set of quality criteria. However, the number of accredited health units is not sufficient to cater for the needs of the population. In addition, despite treatment for children under-five and pregnant women being free of charge, less than 2% of the population receive free care and 92% pay for drugs.

Particularly in Darfur, health outcomes are the lowest in the country:

- *Health status indicators:* In 2010, the Maternal Mortality Ratio (MMR) was estimated at 177 per 100,000 in North Darfur, 334 in South Darfur, and 322 in West Darfur, (Sudan Household and Health Survey: SHHS, 2010). The infant mortality rate was 69 per 1,000 live births in North Darfur, 67 in South Darfur, and 93 in West Darfur (national ratio 60). The under-five mortality rate per 1,000 live births was 95 in North Darfur, 98 in South Darfur, and 138 in West Darfur (national ratio 79).
  Health facilities: The total number of existing primary health facilities in West Darfur is 135, out of which only 102 are functioning, representing 76% of the total facilities. Moreover, 51 out of the 102 functioning health facilities are fully managed and supported by NGOs and UN agencies, while 38 are managed by the State Ministry of Health (SMoH) who also receives support from NGOs (NIDAA, Save the Children -Sweden) and UN agencies. Therefore, there is a high dependency of the local health system on external aid. In addition, according to the Darfur Health Facility Survey 2014, it is estimated that 30% of health facilities in West Darfur may require rehabilitation, which has not been addressed due to under-investment, lack of maintenance capacity, and violence.

- *Medical staff:* There is an overall lack of skilled health staff. Indeed, 34% of the job positions in Primary Health Care and 50% in Basic Health Units are not filled.

- *Health services:* Only 23% (5 out of 22) of Family Health Centres and 37% (19 out of 51) of Family Health Units provide the Basic Package of Primary Health Services, including the treatment of common diseases (for outpatient consultations), and the dispensation of essential drugs, immunizations, nutrition, and a reproductive health package composed of Ante-Natal Care (ANC) and family planning. Due to weak supply chain systems, drug availability at the facility level is predictably poor. The health facility survey report also showed that only 50% of tracer drugs are estimated to be found in clinics. The referral system is also very poor and contributes to the underutilization of health care services.

The already weak health system in West Darfur is under mounting pressure due to the rapidly increasing inflow of IDPs and returnees. The inability of the local health systems to cater for the need of the additional population is

expected to severely affect the health status of the most vulnerable segments of the local population as well as to increase tension and conflict amongst the communities. In 2015, 109,543 new IDPs have been reported throughout Darfur, and a comparable figure has already been reached in the first quarter of 2016. These figures are not expected to drop since the region continues to experience violence.

The unstable security situation, limited availability of livelihood opportunities, lack of infrastructure as well as the poor provision of basic services remain a significant constraint for the improvement of the living conditions of IDPs, returnees and local communities in the region. In fact, health, education and water are identified as the most recurrent lacking services in the return locations.

2.3. Lessons learnt

The project is based on the strong understanding that improved local health systems are central to ensure an adequate and timely response to immediate shocks such as a rapid influx of people and a subsequent increase in the demand for health and nutrition services. In this regard, the project acknowledges that strengthening existing local health systems in resource- constrained environments already characterised by recurrent natural and man-made crisis cannot be obtained by a unilateral humanitarian response but it requires a transition to a more development-based approach. In fact, the proposed project is based on the accepted fact that support to Darfur must break the present *status quo's* cycle of protracted relief and humanitarian aid dependence. The project will therefore be harmonised with other donors' strategies and programmes and it will enhance the ongoing policy dialogue on transitioning from emergency to developmental support and capacity building.
The project also aims to ensure a high degree of sustainability in terms of technical and policy results thanks to the important role that participation of different stakeholders play in the development and implementation of the project. For instance, the participation of local communities, local and state health authorities and local NGOs will guarantee a great degree of ownership.

2.4. Complementary actions

The proposed project will create synergies with the existing projects and other EU and non EU funded projects in the State: e.g. sharing and using standard protocols, methodologies, information and working together to train and build the capacity of local partners. This will also contribute to building the resilience of health systems to absorb shocks that may come due to natural and man-made disasters.

The proposed project will ensure complementarity with other programmes including the:

- Integrated Emergency Health, Nutrition and WASH Services for Conflict Affected Populations in Darfur (Programme implemented by International Medical Corps, funded by USAID/OFDA)
- Integrated Health and Nutrition Humanitarian Assistance to Conflict Affected and Vulnerable Populations of Darfur (Programme implemented by International Medical Corps, funded by ECHO)
- Improve the reproductive health status of vulnerable populations in Darfur, Sudan (Programme implemented by UNICEF, funded by the EC)
- Access to basic education and WASH services for returnees and pastoralist communities in West Darfur (Programme implemented by International Medical Corps, funded by the EC)

In addition, the proposed project is expected to benefit from the new Global Fund grant of about USD 155 million for 3 years (2016-2019), out of which 135 million will be allocated to UNDP for the prevention and control of Malaria, HIV/AIDS and Tuberculosis in all States of Sudan and 20 million will be allocated for the Health System Strengthening component implemented by the Federal Ministry of Health (FMoH). The second component is therefore expected to improve governance and coordination capacities at FMoH level with a foreseeable positive cascade effect on the overall governance and management of the health system.

2.5. Donor co-ordination

There are few donors in Sudan active in the health sector, especially in the three targeted States. The funding is shared between humanitarian and development programs, with a predominance of the humanitarian sector (emergencies and early recovery support), implemented by UN agencies and non-governmental organizations (NGOs). Coordination of the operation of donors activities is under the responsibility of the Humanitarian Affairs Council (HAC). At state level, the project will closely coordinate with the Darfur Regional Authority, or with the regional institution in place after the forthcoming referendum on the administrative status of the Darfur region in April 2016).

Reinforced coordination amongst donors must be seen as part of the on-going broader European Union's dialogue and cooperation with African countries on migration and mobility at bilateral, regional and continental level. At national level, the Migration Working Group composed of the EU, EU Member States, Norway and Switzerland will overseen the implementation of the Action in as much as it aims to address root causes of irregular migration and displacement.

The Action Plan approved at the EU-Africa Valletta Summit on migration and the *EU Emergency Trust Fund for stability and addressing the root causes of irregular migration and displaced persons in Africa* identified domains and priorities which will guide donor coordination and interventions.

The Short Term Strategy 2016/17 for the implementation of a special support measure in favour of the people of the Republic of Sudan provide clear orientations to the EU and the EU Member States on how to better join efforts in order to address more effectively their development cooperation.

At sector level, there is a coordination mechanism since 2011 led by the local World Health Organisation (WHO) office, of which the EU Delegation is a member, among other donors.

At the project level, donor coordination will be ensured through the establishment of State Advisory Committee (SAC).

3. DETAILED DESCRIPTION

3.1 Objectives

The overall objective is to improve the living conditions of IDPs, returnees and local communities, and thereby addressing the root causes of irregular and forced migration.

The **specific objective** is to strengthen the local health systems to better deliver basic packages of health services in West Darfur with the final aim of creating a more conducive and sustainable living environment for host communities and displaced populations through: (1) greater access to and quality of primary health care and nutrition services; (2) strengthening the governance capacity of states and local authorities for a well functioning and sustainable health service; and (3) creating a more participatory and inclusive health system.

3.2. Expected results and main activities

The proposed project is expected to achieve the following results:

Result 1: Access to and quality of primary health care and nutrition services in the 6 targeted localities is improved;

Result 2: Governance capacity of State and Local Health Authorities is improved;

Result 3: A more inclusive and participatory health care management system is adopted.

Result 1: *Access to and quality of primary health care and nutrition services in the 6 targeted localities is improved*

This result will be achieved through a two-tier approach. *On one side*, the project will focus on the rehabilitation and

expansion of health care facilities and infrastructures as well as on the provision of essential equipment in order to ensure that the target health facilities are able
to meet the basic needs of health services of the target population. *On the other side,* the project will aim at improving the skills and competencies of the health workforce. For instance, better trained, motivated, and responsive health workers are key to the provision and management of adequate health and nutrition services.

This result will ensure the provision of minimum primary health care basic packages, which should include reproductive health, immunisation, nutrition prevention and treatment of malnutrition and micronutrient deficiencies, treatment of common diseases and provision of essential drugs. Nutrition and health basic services will be provided in an integrated way in order to contribute to improve overall health outcomes.

The two-tier approach will be targeting the 6 building blocks of the national health system (leadership/governance, health care financing, health workforce, medical products and technologies, information and research, and service delivery).

In order to achieve this result, different activities will be implemented under three main components:

- Infrastructure improvements and supply of essential medical and non-medical equipment:
  - o Conduct the assessment of health facility infrastructure to determine level of need in terms of rehabilitation or potential construction.
  - o Rehabilitate existing health care facilities and/or construct new facilities.
  - o Provide target health facilities with essential medical equipment to meet the basic needs of health services.
  - o Provide target health facilities with essential medicines and supplies.
  - o Provide target health facilities with non-medical supplies which are essential for the running of day to day activities.
- Capacity Building and knowledge transfer:
  - o Support target health facilities in improving their Emergency Obstetric CARE and referral system.
  - o Provide capacity building and technical trainings for local health care workers and targeted health facility staff on financial management, pharmaceuticals and supply chain management.
  - o Provide technical training on the implementation of the Health Management Information System (HMIS) in terms of data collection, analysis and utilisation.
  - o Provide training on health policies, protocols, guidelines and regulations for health facilities personnel.
  - o Provide trainings on Community-Based Management of Acute Malnutrition (CMAM) to enable individual health facilities to effectively respond to spikes in the number of acutely malnourished cases without undermining the routine health everyday services.
  - o Capacity Building of health workers on patient care, service delivery and management through training and mentoring.
- Essential primary health care delivery:
  - o Provide (Out Patient Department) OPD consultations, triage, emergency management, referrals and follow up.
  - o Provide Child health services including Integrated community case management (ICCM) of childhood illnesses and Integrated Management of Neonatal and Childhood Illnesses (IMNCI).
  - o Provide reproductive health services including antenatal care, delivery care, Basic Emergency Obstetric and Newborn Care (BeONC), postnatal care, family planning services, management of Sexually Tranmissible Infections (STIs), testing for HIV/AIDS
  - o Support Expanded Programme of Immunization (EPI) services and tracing defaulters .
  - o Disease surveillance and reporting.
  - o Provide Community outreach services including EPI, referrals and community based health education.

Result 2: *Governance capacity of State and Local Health Authorities is improved*

The enhancement of the governance capacity of the state ministry of health and local authorities in the 6 targeted localities is key to the creation of a well-functioning and sustainable health system both at the local and state level.

The existence of an effective and efficient governance system is central to ensure that resources are effectively used to achieve measurable results. This result will reinforce health policies dialogues and debates through an improved planning and programming capacity based on reliable information on the status quo of health systems, current gaps and needs. Finally, it will ensure that decision-making processes are taken efficiently and effectively in a resource-constrained context.

In order to achieve this result, different activities will be carried out:

- Capacity Building:
  - o Provide Technical Assistance and Capacity building to Local Health Authorities (LHA) to improve planning for results and managerial skills (planning, budgeting, implementing, M&E).
  - o Provide technical support to LHAs and State Ministry of Health (SMoH) to improve coordination and national strategies/policies implementation.
  - o Support to LHAs and SMoH key departments for improving capacities on health needs assessment and local priorities identification.
    Support State training institutions (namely Academy of Health Sciences (AHS) and continuing professional development (CPD)) and LHA/SMoH key departments for better collaboration and capacity on Human Resource for Health development plan.
  - o Train LHAs and SMoH on various Health Care Financing Mechanisms and options.
  - o Support the SMoH to provide quality integrated nutrition and health services for targeted population.
  - o Train LHAs and SMoH in Disaster Health Management.
- Support Management Systems:
  - o Develop management systems including electronic programmes for data management and analysis.
- Material resources:
  - o Provide computers, furniture, stationeries as well as infrastructural interventions to improve LHAs and SMoH offices and facilities.

Result 3 : *A more inclusive and participatory health care management system is adopted*

This result will be achieved through advocacy activities for improving political engagement and support to the health system in West Darfur as well as through the strengthening of community and civil society participation in the health care management system. Increase community participation in the planning and management of health systems will ensure that health services are provided with a people-centred approach; the health services will be focused and organized around the health needs and expectations of people and communities.

Local communities will be directly involved in monitoring the quality of services provided. In this regard, local health services are expected to become more responsive to health needs and inclusive. In particular, the project will ensure that returnees, IDPS and host community members are equally represented in the community and leadership networks in order to avoid conflicts among the different communities and to facilitate different stakeholders' interests to be taken into account. Moreover, the participation of women IDPs and returnees in community networks will ensure that gender issues and cultural barriers are not affecting utilization of health services. The participation of local communities in the management of health systems will also raise community members' awareness of service availability as well as encourage health-seeking behaviours.

In order to achieve this result, different activities will be implemented:

- o Organize advocacy activities through nutrition cluster coordination meetings, regular meetings with government officials and donors to increase budget allocations for West Darfur for integration of health and nutrition services.
- o Conduct the identification and selection of community health volunteers and mother and father support groups with the participation of local leaders, beneficiaries and community organisations.
- o Provide trainings to mother and father support groups and community health volunteers on Infant and Young Child Feeding (IYCF), detection and referral of acutely malnourished children, Pregnant and lactating women (PLW) behavioural change communication techniques and Participatory Cooking Sessions

Programme.

o Establish a community feedback mechanism on the quality of health services provided.

o Establish and support Community Health Committees including IDPs, returnees and local community members.

o Organize community stakeholder coordination meetings.

o Provide capacity building trainings to selected national NGOs.

3.3 Risks and assumptions:

The main risks are as follows:

Risks	Risk level (H/M/L)	Mitigating measures
Institutional: Referendum on the administrative status of Darfur	H	The forthcoming referendum on the permanent status of the Darfur region foreseen for April 2016 might have an impact on the institutional structure of the region. The EU Delegation will ensure that the implementing partners closely and regularly monitor the situation on the ground and react timely and quickly to any change in the governance and administrative system in place in the region. The EU Delegation will also ensure that implementing partners build good working relationships with the local authorities in place after April 2016 referendum.
Conflict and Insecurity	H	Coordination and cooperation with international actors, local NGOs, community groups and leaders, HAC, as well as the Government of Sudan will be ensured on a regular basis. The situation in the intervention areas will be constantly monitored in order to a) guarantee the safety of the implementing partners staff and beneficiaries and b) comply with national security rules and procedures.
Politics: The policy of the Government of Sudan towards International NGOs	M	In the choice of the implementing partners, the EU Delegation will ensure that the selected NGOs have built positive working relationships with the Government of Sudan and HAC in order to allow for a smooth and timely implementation of the project activities
Restricted access to the project areas	M	Government of Sudan security regulations may impede access of the international staff to the target areas. In this regard, the international staff will increase back-up and remote support to the local staff in the field.
Staff recruitment and retention	M	In the choice of the implementing partners, the EU Delegation will ensure that the selected NGOs have good retention policies and invest on building staff capacity and competencies. This will ensure a low turnover risk which could otherwise delay the implementation of the project activities.
Economic crisis	M	In the choice of the implementing partners, the EU Delegation will ensure that regular monitoring of the economic situation as well as mitigation plans are in place in order to ensure the exchange rates fluctuations will not affect the implementation of the project activities.

The main assumptions of the proposed project are as follows:

- SMoH and LHAs will effectively support the project.
- Target communities will effectively support the project.
- Adequate health workforce will be made available to the project in a timely manner.
- Adequate financial resources are allocated for PHC services and LHAs running costs and standard supervision and M&E activities.
- Adequate supply of drugs to target clinics.

- Qualified building companies are available in the region.

3.4. Cross-cutting issues:

The crosscutting issues related to the project are:

- *Climate change:* The project will have no significant bearing upon any climate change and environmental sustainability issues. However, the effective management of the primary health care components will improve water and waste management at the level of local health facilities with a positive spillover effect on the environment. Besides, the rehabilitation of health facilities will be conducted with a sustainable and environmentalsensitive approach.
- *Human rights:* In this regard the project is expected to promote human rights, and in particular the right to access health services for IDPs, refugees and communities hosting them.
- *Gender issues:* This issue will be consistently addressed by the project activities, and they have been endorsed as important components in the project activities. Specific project activities will focus on women including awareness raising activities on gender- segregation in health services as well as on women's specific health needs as regards reproductive health and maternal health. But the project will explicitly ensure that women are involved in community decision making processes and community structures involved in health care management.
- *Social inclusion:* This issue will be consistently mainstreamed and addressed by the project activities. In this regard, the project is expected to facilitate and support the creation of health coordination committees (including host communities, migrants, refugees and IDPs representatives). The health coordination committees will ensure that the needs of the different stakeholders are taken into account, and that potential barriers to the equitable access to health services of vulnerable groups (women, children, disabled and others) are identified and adequately addressed.
- *Good governance:* This issue is addressed by the project activities, in particular at local level, by improving the managerial and organizational structures, the health information system, and by training managers and officers. This is aimed at improving the accountability, efficiency and effectiveness of the health system.
- *Misration:* This issue is clearly mainstreamed in the project; it is expected to contribute to reduce increased pressure posed by migrants on already overstretched locality health systems. In doing that the project will benefit local communities and displaced populations and is expected to reduce one of the main push factors of irregular and forced migration. At the same time, the project is expected to improve migrants well-being by ensuring their access to adequate and available health services.

3.5. Stakeholders

The ultimate beneficiaries will be the populations living in the 6 targeted localities, West Darfur, who will be able to benefit from the strengthening of the health system at the local level but more generally from the creation of a conducive and resilient environment.

Key stakeholders and direct beneficiaries in this intervention will be:

- IDPs, returnees, vulnerable households and host communities in targeted areas;
- The local/district health personnel;
- LHAs and SMoH
- Local NGOs

4. IMPLEMENTATION ISSUES

4.1. Financing Agreement

In order to implement this action, it is not foreseen to conclude a financing agreement with the partner country, referred to in Article 17 of Annex IV to the ACP-EU Partnership Agreement.

4.2. Indicative operational implementation period

The period of implementation of this action, during which the activities described in sections 3.2 and 4.3 will be carried out, will be between 78, whilst the overall execution period (including a closure phase of no more than 24 months) will not exceed 102 months from the date of approval of this Action Document by the Operational Committee of the EU Trust Fund.

Contracts are expected to be signed in September 2016.

4.3. Implementation components and modules

The envisaged implementation modality is **Direct Management**. Two grant contracts will be concluded, one with the NGO International Medical Corps, and another with the NGO CONCERN, in line with the use of flexible procedures. These are the only two nongovernmental organisations supporting health systems in the selected localities of West Darfur. There are other organisations active in the health sector, but more focused on humanitarian support and hence following a different approach to that pursued by this project.

The actions undertaken by the grants will implement all actions foreseen under this programme as stated under results 1, 2 and 3

4.4 Indicative budget

Component	**Amount in EUR**
Direct management - result 1- Access to and quality of health and nutrition services in the 6 targeted localities is improved	4 700 000
Direct management - result 2 - Governance capacity of State and Local Health Authorities is improved	1 400 000
Direct management - result 3 - A more inclusive and participatory health care management system is adopted	820 000
Communication and visibility	20 000
Audit, Monitoring and Evaluation	60 000
Total	**7 000 000**

4.5. Monitoring, Evaluation and audit

It is important to establish monitoring and evaluation arrangements that can measure progress towards the intended results in a consistent and regular manner. Efforts will be made to set up a single monitoring & evaluation and lessons learned framework for all EUTF-funded projects in the Horn of Africa. Each of the projects in the Horn of Africa will pool resources by setting aside 1.5-2% of their EU Trust Fund allocations to establish a single monitoring and evaluation framework with a dedicated team of experts. The single M&E

framework will help ensure consistency in progress reporting by using the project baselines and undertaking regular monitoring, evaluation and reviews of on-going projects in the region. It will also serve as a tool for compiling documentation and sharing experience in a structured manner.

Ad hoc audits or expenditure verification assignments could be contracted by the European Commission. Audits and expenditure verification assignments will be carried out in conformity with the risk analysis in the frame of the yearly Audit Plan exercise conducted by the European Commission. Evaluation and audit assignments will be implemented through service contracts; making use of one of the Commission's dedicated framework contracts or alternatively through the competitive negotiated procedure or the single tender procedure.

4.6. Communication and visibility

Communication and visibility of the EU is a legal obligation for all external actions funded by the EU. This action shall contain communication and visibility measures which shall be based on a specific Communication and Visibility Plan of the Action. Appropriate contractual obligations shall be included in the procurement contracts. The Communication and Visibility Manual for European Union External Action shall be used to establish the Communication and Visibility Plan and the appropriate contractual obligations.

EU Trust Fund Strategy	Valletta Action Plan	United Nations Sustainable Development Goals
Four main areas of intervention	**Five priority domains, and 16 initiatives**	**17 goals**
1) Greater economic and employment opportunities 2) Strengthening resilience of communities and in particular the most vulnerable, as well as refugees and displaced people 3) Improved migration management in countries of origin and transit 4) Improved governance and conflict prevention, and reduction of forced displacement and irregular migration	1) Development benefits of migration and addressing root causes of irregular migration and forced displacement 1. enhance employment opportunities and revenue-generating activities 2. link relief, rehabilitation and development in peripheral and most vulnerable areas 3. operationalise the African Institute on Remittances 4. facilitate responsible private investment and boost trade 2) Legal migration and mobility 5. double the number of Erasmus scholarships 6. pool offers for legal migration 7. organise workshops on visa facilitation 3) Protection and asylum 8. Regional Development and Protection Programmes 9. improve the quality of the asylum process 10. improve resilience, safety and self-reliance of refugees in camps and host communities 4) Prevention of and fight against irregular migration, migrant smuggling and trafficking of human beings 11. national and regional anti-smuggling and anti-trafficking legislation, policies and action plans 12. strengthen institutional capacity to fight smuggling and trafficking 13. pilot project in Niger 14. information campaigns 5) Return, readmission and reintegration 15. strengthen capacity of countries of origin to respond to readmission applications 16. support reintegration of returnees into their communities	1. End poverty in all its forms everywhere 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture 3. Ensure healthy lives and promote well-being for all at all ages 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all 5. Achieve gender equality and empower all women and girls 6. Ensure availability and sustainable management of water and sanitation for all 7. Ensure access to affordable, reliable, sustainable and modern energy for all 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all 9. Build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation 10. Reduce inequality within and among countries 11. Make cities and human settlements inclusive, safe, resilient and sustainable 12. Ensure sustainable consumption and production patterns 13. Take urgent action to combat climate change and its impacts 14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development 15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels 17. Strengthen the means of implementation and revitalise the global partnership for sustainable development

Appendix I: Indicative Logical Framework

During the contracting phase, implementing partners will be requested to provide baseline information as available. A full survey is planned to be done in each component/project during its initial phase. This will also provide elements for a more refined definition of quantitative targets to be included in the log-frame

HIERARCHY OF OBJECTIVES	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
OVERALL OBJECTIVE			
To address the root causes of forced displacement and irregular migration	Reduction in % of Infant mortality rate Reduction in % of maternal mortality ratio Reduction in % of under-five mortality	-National statistics/ survey -Reports from WHO/UNICEF -Reports from the relevant Sudanese Ministry	
SPECIFIC OBJECTIVE			
To improve the provision of basic health and nutrition services for vulnerable populations in West Darfur.	1. Increase in % of beneficiaries that can access PHC basic services: facility utilization rate, ANC 1st and 4th visit coverage, deliveries attended by skilled staff vs expected deliveries 2. Increase in % of number of health facilities functional and operational in the target areas 3. Increase in % of health care workers in the target areas	-Baseline vs. end surveys; -HeRAMS3 quarterly reports -Health facilities monthly reports -Outputs of cluster/sector coordination meetings for health and nutrition	Peace prevails and security is maintained No major natural and man-made disasters

Health Resources Availability Mapping System, Federal Ministry of Health and World Health Organization

RESULTS			
R1. Access to and aualitv of primary health care and nutrition services in the 6 targeted localities is improved	1. Increase in% of population attendance (including disaggregated data on women, children, IDPs and returnees) 2. N. of rehabilitated/refurnished health service facilities 3. N. of health facilities that have introduced and applied CMAM 4. Increase in % of health care workers that have improved knowledge on financial management, pharmaceuticals and supply chain management 5. Increase in % of health care workers that have improved knowledge and attitudes towards patients	- Baseline vs. end surveys Needs assessment reports about conditions of the health facilities - Regular reports from target health services -Reports from regular supervision visits -Reports from monitoring vis its by donor and stakeholders - Photos documentation	SMoH and LHAs will effectively support the project. Target communities will effectively support the project Adequate health workforce will be made available to the project in a timely manner. Adequate financial resources are allocated for PHC services and LHAs running costs and standard supervision and M&E activities. Adequate supply of drugs to target clinics Qualified building companies available in the region Health facilities are accessible for most of the year (rain, insecurity) Monitoring mechanisms are working effectively GoS does not restrict community participation
R2. Governance capacity of State and Local Health authorities is improved	1. Monitoring and evaluation mechanisms are in place 2. Improved accountability of LHAs and SMoH 3. Improved maintenance system of health facilities 4. N. of health policies and guidelines developed and applied 5. Improved health information gathering and analysis system	- Reports from MoH - Reports from regular - monitoring visits to SMoH - by partners and donor - Needs assessment reports - Training' reports including pre and post test results, training monitoring and training manuals - Participants' post training feedback forms - Program's financial records - Reports retrieved from the national health information management system - Program's photo gallery	
R3. A more inclusive and participatory health care management system is adopted	1. Community participatory mechanisms are in place 2. Increased awareness of service availability 3. Increased cultural acceptability of health care services provided 4. Increased demand of health services 5. Reduction of social tensions among different communities 6. Improved levels of funding for the health sector	- Program reports - Reports from structured community interviews and focus group discussions (FGDs) done at regular interval on elected sites. - Reports from partner and stakeholder monitoring visits - LHAs and SMoH Budgets - Reports from donors	

ACTIVITIES			
A 1.1 Conduct the assessment of health facility infrastructure to determine level of need in terms of rehabilitation or potential construction A 1.2 Rehabilitate existing health care facilities and/or construct new facilities A.1.3 Provide target health facilities with essential medical equipment to meet the basic needs of health services A.1.4 Provide target health facilities with essential medicines and supplies A.1.5 Provide target health facilities with nonmedical supplies which are essential for the running of day to day activities A.1.6 Support target health facilities in improving their Emergency Obstetric CARE and referral system A.1.7 Provide capacity building and technical trainings for local health care workers and targeted health facility staff on financial management, pharmaceuticals and supply chain management, A 1.8 Provide technical training on the implementation of the Health Management Information System (HMIS) in terms of data collection, analysis and utilization A1.9 Provide health staff training on health policies, protocols, guidelines and regulations A 1.10 Provide trainings on Community-Based Management of Acute Malnutrition (CMAM) A.1.11 Capacity building of health worker on patient care, service delivery and management through training and mentoring A.1.12 Provide OPD consultations, triage, emergency management, referrals and follow up A.1.13 Provide Child health services including Integrated case management of childhood illnesses (ICCM) and IMNCI A.1.14 Provide reproductive health services including antenatal care, delivery care, BeOMNC, postnatal care, family planning services, management of STIs, testing for HIV/AIDS A.1.15 Support EPI services and tracing defaulters A.1.16 Disease surveillance and reporting		- Progress Monitoring Reports prepared by the implementing Agencies - The tentative budget is Approximately 7 MEUR	Assumption - Agreements are signed between the EUD and the implementing agencies - The political and security situations are stable - Economic situation is stable - Adequate human resources are made available - Funds are made available for the project activities. Risks: - The security situation deteriorates limiting access to target communities

A.1.17 Provide Community outreach services including EPI, referrals and community based health education A. 2.1 Provide Technical Assistance and Capacity building to LHAs to improve planning for results and managerial skills (planning, budgeting, implementing, M&E) A.2.2 Provide technical support to LHA and SMoH to improve coordination and national strategies/policies implementation A.2.3 Support to LHA and SMoH key departments for improving capacities on health needs assessment and local priorities identification A.2.4 Support State training institutions (namely AHS and ¿PD) and LHA/SMoH key departments for better collaboration and capacity on Human Resource for Health development plan A. 2.5 Train LHAs and SMoH on various Health Care Financing Mechanisms and options (such as community Insurance, Revolving Drug Fund) A. 2.6 Support the SMoH to provide quality integrated nutrition and health services for targeted population. A.2.7 Train LHAs and SMoH in Disaster Health Management A.2.8 Develop management systems including electronic programmes for data management and analysis A.2.9 Provide computers, furniture, stationeries as well as infrastructural interventions to improve LHAs and SMoH offices and facilities A.3.1 Organize advocacy activities through nutrition cluster coordination meetings, regular meetings with government officials and donors to increase budget allocations for West Darfur for integration of health and nutrition services; A.3.2 Conduct the identification and selection of community health volunteers and mothers and fathers support groups with the participation of local leaders, beneficiaries and community organisations A.3.3 Provide trainings to mother and father support groups and community health volunteers on Infant and Young Child Feeding (IYCF), detection and referral of acutely malnourished children, Pregnant and lactating women (PLW) behavioural change			

communication techniques and Participatory Cooking Sessions Programme A.3.4 Establish a community feedback mechanism on the quality of health services provided A.3.5 Establish and support Community Health Committees A.3.6 Organize community stakeholder coordination meetings A.3.7 Provide capacity building trainings to selected national NGOs			