Republic of Sudan
Higher Council for Decentralized Governance

REPUBLIC OF SUDAN

STUDY ON DETAILED PLAN FOR PROJECT FOR HUMAN RESOURCES DEVELOPMENT FOR DARFUR PHASE-II

FINAL REPORT: APPENDIX-1

SECTOR PLAN: HEALTH

July 2014

Japan International Cooperation Agency
System Science Consultants Inc.
Earth System Science Co. Ltd.

Exchange Rate

Currency	As of June, 2014	Sudan Pound (SDG)
Exchange Rate***	As of June, 2014	USD 1=JPY 101.68 USD 1= SDG 5.669 JPY 1 = SDG 0.055754 SDG 1=JPY 17.936

*** JICA Rate（June, 2014）

Abbreviations

AHV	Assistant Health Visitor
CHP	Community Health Promoter
CHW	Community Health Worker
C/P	Counterpart
DRA	Darfur Regional Authority
EPI	Expanded Program on Immunization
HCDG	Higher Council for Decentralised Governance
HV	Health Visitor
IDP	Internally Displaced Persons
IMCI	Integrated Management of Childhood Illness
IOM	International Migration Organization
JCC	Joint Coordinating Committee
JICA	Japan International Cooperation Agency
M/M	Minute of Meeting
MMR	Maternal Mortality Ratio
NGO	Non-governmental Organization
PDM	Project Design Matrix
PDCA	Plan-Do-Check-Act
PHC	Primary Health Care
PMC	（State）Project Management Committee
PNC	Postpartum Care/Postnatal Maternal Care
PO	Plan of Operations
RH	Reproductive Health
SDG	Sudanese Genaih (Pound)
SM	Sector Meeting
SMAP	Project on Human Resources Development in Darfur
SMOH	State Ministry of Health
TBA	Traditional Birth Attendant
TOT	Training of Trainers
UNFPA	United Nation population Fund
UNICEF	United Nations Children’s Fund
VMW	Village Midwife
WHO	World Health Organisation

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1. Overview of the Component 1

Following the Village Midwifes (VMWs) in-service training conducted in Phase 1, supportive supervision for VMWs as pilot project is expected to strengthen the capacity of VMWs and improve the current Maternal and Child Health (MCH) services. In addition, community mobilization activities aim to enhance the problem-solving skills of community people in order to be able to manage their health. These supportive supervision and community mobilization activities will be provided as package to the total 15 communities in each state (3 communities in the 1st year, 4 communities in the 2nd-4th year).

During supportive supervision, Health Visitors (HVs) visit individual VMW at home as well as provide group training to VMWs in their closest health facility. Also, community people's behaviour is expected to change through health education and promotion focusing on reproductive health, nutrition, Expanded Program on Immunization (EPI), Integrated Management of Childhood Illness (IMCI) and other important health topics such as malaria and HIV in the Primary Health Care (PHC) package of the Federal Ministry of Health (FMOH). Community mobilization also promotes community group activities to improve the health and sanitation condition by organizing community groups, especially women's groups, with small financial assistance provided for the activity.

For the capacity building of the State Ministry of Health (SMOH), training will be provided to enhance skills and knowledge necessary for the implementation of pilot projects. Lessons learned through the pilot project will be shared at regular Project Technical Committee meetings, and eventually compiled into a case manual.

2. Background

(1) Background

The MCH-related indicators of Darfur are extremely poor in comparison with those of the national average. The Maternal Mortality Ratio per 100,000 (MMR) in West Darfur, South Darfur, and North Darfur are 335, 332, and 280 respectively (SHHS 2010). The average rate of women who attended Antenatal care (ANC) more than four times is also low, ranging between 33 and 46% (SHHS 2010). Infant Mortality Rate (per 1,000) ranges between 104 and 133 in the three Darfur states where more than one third of children faces the underweight (SHHS 2010). While the limited access to the essential MCH services is one of the factors that explain this poor situation, 1) high poverty rate, 2) limited access to the health facility, and 3) insufficient basic health knowledge are also deeply related.

Poverty is largely related to the access to health services. The poverty rate of Darfur region is 63%. One of the reasons behind the use of TBA by more than 60% of women in West Darfur is said to be the low service fee. Many people (42% in West Darfur, 35% in South Darfur, 25.5% in North Darfur), who are not covered by Health Facility within 5 KM, do not have easy access to health services. Moreover, the majority of women in three Darfur states are illiterate and do not have basic health knowledge. Such insufficient health knowledge is considered to

be partially attributable to the delay in recognizing the danger sign (WHO, 2012). The traditional socio-cultural belief that prevents some people from believing the modern medicine also hinders access to health services.

On the other hand, the Government health expenditure per capita in the Darfur region is less than a half of the national average. This can be explained by the large proportion of financial assistance received from development partners and NGOs. Due to such limited government budget, the government may face challenges in gradually restoring the service provision from emergency and humanitarian aid.

The prevention and early detection are believed to play a significant role in the Darfur region, which are highlighted by the high poverty rate, the limited access to health facilities, the poor health knowledge, and the limited health budget. Since 2012, the FMOH has been encouraging the health promotion activities by community people as well as the utilization of health services through community mobilization and health promotion through PHC Expansion Plan.

For health promotion, Village Midwife (VMW), Community Health Promoter (CHP), and Community Health Worker (CHW) are expected to facilitate the community participation. While the State Ministry of Health started project-base activities with assistance from UNICEF/WHO and NGOs in the Darfur region, there is a large room to improve the current situation where there is no standardized plan, no clear demarcation between Health Promotion Directorate and Reproductive Health Department, and the variance in the interpretation of health promotion among people.

In addition, the continuous capacity development of VMWs who are the key players in providing MCH service in the community is very important. Although 60-80%[1] of VMWs in the Darfur region already received in-service training during Phase I, the ANC coverage is still low despite its improvement. While the supervision for VMWs is yet to be strengthened, it is still questionable whether the in-service training has an effect to solve the MCH issues. The supervision by SMOH needs to be strengthened in order to sustain the positive outcome and its effect yielded during the Phase I.

(2) Relevance

1) Relevance to Sudanese development needs

The health situation of the Darfur region has not been well in comparison to the Sudan national average. For example, the maternal mortality rate of North Darfur state, South Darfur state and West Darfur State is 280, 335 and 332 per 100,000 live births respectively. These numbers are relatively higher than 216 per 100,000 births of national average. There are various reasons behind this challenging situation; fragile health system with a shortage of health service facilities, high turnover of the government staff and limited accessibility to

[1] Although the terminal evaluation report of the Phase 1 reported that the coverage of VMW in-service training had achieved nearly 100%, the current coverage is lowered because the number of VMWs at the time of calculation was from 2009 and the number of VMWs have been annually increased.

health service facilities, political challenges such as repeated policy and institutional changes in the decentralization, delay in being referred from community to health facilities partly because of the people's hesitation to the refer, challenges in community mobilization and health seeking behaviors such as low acceptance to antenatal cares.

2) Relevance to Sudanese development plan and strategy

The health strategy of Interim Poverty Reduction Strategy Papers (IPRPS) (2012) aims at the expansion of PHC services and the improvement quality of services by improving the coverage of basic health services and the equity in terms of the coverage area, the access, and the output. In addition, IPRPS prioritizes such activities that are focused not only on the morbidity and mortality of mother and child but also on the initiative for safe motherhood. The strategic objectives of the National Health Sector Strategy Plan II 2012-2016 developed by the FMOH are: 1) Equal access and use of health services, and 2) Effective Health system that meets people's expectation and needs. With a strong focus on the improvement of health status of socially vulnerable people, FMOH aims to strategically expand the comprehensive PHC services that include community participation and empowerment in order to improve the MCH and nutrition.

The Darfur Development Strategy (2013) similarly aims at the improvement of access to the comprehensive health and nutrition services as well as the expansion of use of these services. Health, nutrition and reproductive health services are included in the basic package whose access should be guaranteed to promote the immunization, ANC by health workers, and birth attended by the Skilled Birth Attendant (SBA).

As mentioned above, the Sudanese national health policy focusing on the equity in consideration of socially vulnerable people including those affected by conflict is highly relevant to SMAP-2 in terms of the strategic direction and priority areas since both aim at the expansion of access to the PHC services including MCH services, nutrition, and reproductive health.

(3) Lessons learned from similar projects

１）Degree of community participation in community mobilization

In community mobilization, the degree of community participation ranges from 1) participation in the benefits of the program, 2) participation in program activity, 3) participation in implementing health program, 4) participation in monitoring and evaluation, and to 5) participation in planning programs (WHO, 1990). The Warmi project in Bolivia and Nepal shows the significant change in the ANC attendance, delivery at facility, delivery assisted by SBA, and clean care, with the intervention of action learning cycle where women's groups identify their own problems, think about possible solutions, and carry out the activity through regular meetings. In this project, it is necessary to consider the effective method that encourages community people to participate not only in the program activity but also in the program implementation and planning as community health committee members.

２）Diverse target of community mobilization

In the "Capacity Development Project for the Provision of Services for Basic Human Needs in

Kassala State", VMW Festival and the health promotion activity including mobile cinema were conducted. Based on the recognition that men's participation is important, they arranged to start the drama play in the evening so that men could also attend. Since the health issues facing in Darfur are not only limited to mother and child, it is important to target at community people as a whole including the youth and men in order for the community to increase the knowledge for prevention of common diseases. In addition, the community mobilization should be effective by targeting not only the individual level but also by involving special groups such as women's group or youth group or diversifying the target groups.

3) Strengthening of linkage between VMW and health facility

In the "Frontline Maternal and Child Health Empowerment Project Phase 2," VMWs monthly gather in the closest health facility to receive technical advice and replace some equipment. This has resulted in strengthening the linkage between VMWs and other health workers in the health facility. Currently, outcomes such as 1) continuous and sustainable technical follow-up opportunities, 2) the strengthened linkage with the facility, and 3) technical advice available from medical doctors in the facility have been observed. SMAP-2 has a plan of supportive supervision of HVs and AHVs either visiting VMWs at home or gathering a group of VMWs in the closest health facility, depending on the access to the facility and the number of available supervisors. No matter which method is taken, it is important to consider how the linkage between VWMs and the health facility can be strengthened in order to make the smooth referral from the community to the facility.

4) Modification of training method in accordance with Darfur situation

The lessons learned from the VMW in-service training in Phase 1 recommend the utilization of visual aids in consideration of illiteracy of VMWs, ensuring the availability of trainers who can speak local languages, and strengthening of training management by SMOH. In this project, state-level core trainers are expected to be the trainers in the pilot communities after being trained in Khartoum through Training of Trainers (TOT) such as Core Trainer Refresher Training in health promotion. Since the cascading method decreases the training effect, it is important to revise training methods in consideration of education background of trainees and the circumstances facing Darfur.

3. Planning Framework

- **Response to the multiple community health issues→ Provision of services that meet the community needs**

  While it is a fact that the MMR in Darfur is remarkably poor compared with the national average, health issues facing the community people especially women and child are not only the safe delivery. They are rather diverse, ranging from sanitation, infectious disease to nutrition, which are closely related to the extreme poverty and conflict. Therefore, services that respond to the overall PHC issues are desired to meet the community needs.

- **Pilot project as learning opportunity for the community people→ Provision of services that meet the community needs**

  In Darfur, the literacy rate of women is really low, and they lack basic health and sanitation knowledge because of the limited education opportunities available for women. Therefore, pilot projects are expected to be an opportunity for these women not only to be the health service recipient but also to be a learner to acquire the minimum information and knowledge necessary for health life.

- **Pilot projects in line with FMOH policy and strategy→Transparent services**

  Pilot projects will be selected and implemented in line with the FMOH policy and strategy. Ensuring the transparency of the provided services, the consistency between pilot projects and the national policy is expected to transform the pilot project to the ordinary public services. On the other hand, national strategy and policy may not be always applicable to the unique circumstances in Darfur. Therefore, the feedback system from the Darfur region to the FMOH should be considered so that the relevance of national policy and strategy and the applicability of national guidelines are verified through pilot project.

- **Information sharing and building cooperative relationship with major development partners→Effective and equal service provision**

  Since it is difficult for Japanese experts to provide direct technical assistance on the ground in this project, taking the ordinary technical assistance approach based on the rich experience of the past Japanese cooperation may not necessarily yield the effectiveness in the end. Rather, building cooperative relationships with existing aid agencies and NGOs under the same direction will achieve the effective assistance. In this manner, the duplication of activities will be avoided and more equal delivery of assistance in the overall health sector in Sudan is expected.

- **Utilization of existing resources→Provision of efficient services**

  JICA has implemented MCH projects in other states in addition to the Phase 1 in Darfur. The outputs of these past projects such as manual and training materials, human resources such as trained VMW, HV, and AHVs, established network with development partners, and good practice and lessons learned will be fully utilized.

- **Strengthening of Management Capacity of FMOH and SMOH→Transparent services**

  When pilot projects are implemented, capacity building of frontline service providers in the community as well as SMOH personnel will be considered. Since SMOH depends on

financial and technical assistance from development partners to a great degree, project management system based on the PDCA cycle is still missing. The project aims to improve the transparency of provided services by strengthening the management capacity of FMOH and SMOH.

- **Recovery of self-identity through community activity → Consideration of peace-building**

  People in Darfur are feeling that they have lost their role and identity in the community where they had lived due to the influence of the conflict. In consideration of peace-building, pilot projects are expected to become not only the place to provide quality public service but also the opportunity for community people to recover their lost self-identity and dignity by activity participating in the community activity including planning and problem-solving.

4. Basic Information of the Health Sector Plan

(1) Project Title

The Project for Strengthening Peace through the Improvement of Public Services in Three Darfur States (SMAP2)

Sector Sub-title

Together for Health and Peace in Darfur

(2) Project Period

January 2015-December 2018 (48 months)

(3) Target States

Target states of SMAP-2 are North Darfur, West Darfur, and South Darfur.

(4) Beneficiaries

1) Direct Beneficiaries

Around 90,400 persons of target community people and government officials are expected to be direct beneficiaries of the project as the following breakdown shows.

Table-1 : Breakdown of Direct Beneficiaries

Component	Beneficiary	Number	Content
Component 1 : Health	Community people	About 90,000*	Health service users/Training participants
	Government staff (Mainly SMOH, VMW, CHWs)	About 400	Training participants

*90,000=2,000 persons/community x 15 communities/state x 3 states

2) Indirect Beneficiaries

Population of 3 Darfur states who receive improved health services (approximately 7.25 million*)
(*According to 2013 SMOH statistics: North Darfur 2,688,220, West Darfur 1,201,539, South Darfur: 3,367,831)

(5) Implementing Agency

State Ministry of Health is the implementing agency of Component 1.

State	Name of Institution	Responsible person
North Darfur	SMOH RH Department and Health Promotion Department	Director General
South Darfur	SMOH RH Department and Health Promotion Department	Director General
West Darfur	SMOH RH Department and Health Promotion Department	Director General

5. Purposes

(1) Super goal (Common to all sectors)

Strengthening peace and stability of three Darfur states through improvement of quality of life of people in three Darfur States

(2) Overall Goal

Public well-being is enhanced in three Darfur States

(Well-being is defined as conditions where public services are fulfilled for the people as well as people feel happiness)

【Indicators】

- [Common indicators among four components] Public happiness is increased
- [Common indicators among four components] Public trust/public image on the

government is increased

- [Common indicators among four components] Satisfaction on public services is increased
- Number of ANC provided by VMWs is increased in three Darfur states
- Number of births attended by skilled-birth attendant (including VMWs) is increased in three Darfur states
- Number of community referral is increased in three Darfur States
- Healthy behavior (XXXXXXX etc.) is promoted in three Darfur states[2]

(3) Project Purpose

Public services considering public needs are inclusively provided in pilot projects area and institutional capacity (planning, implementation, monitoring and evaluation) of the State Governments in the provision of public services is strengthened

【Indicators】

- [Common among all components] Selection process of the pilot areas become inclusive (include the most conflict-affected people and community, etc. into target groups with consideration for coexistence)
- [Common among all components] Recognition of implementing agencies on public needs is improved (Contacts with community is increased, attitude of implementing agencies to community people become responsive from neglective, etc.)
- [Common among all components] Capacity (to make the services efficient, transparent and peace promotion) of service providers perceived by stakeholders is improved
- Public satisfaction on selected health services is increased in pilot areas
- Number of ANC provided by VMWs is increased in pilot areas
- Number of births attended by skilled-birth attendant (including VMWs) is increased in pilot areas
- Number of community referral is increased in pilot areas
- Healthy behaviour (XXXXXXX etc.) is promoted in pilot areas
- Pilot Projects are repeatedly implemented as planned

6. Expected Outputs

In Component 1, institutional capacity of SMOH in three areas of 1) planning, 2) knowledge and skills, and 3) operation is expected to be strengthened through pilot projects.

1) Planning and coordination skills necessary to conduct pilot projects (community mobilization/Supportive supervision of VMWs) in consideration of public needs and equity are improved

【Indicators】

- Pilot projects plan is prepared in consideration of public needs and equity.

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[2] The healthy behavior to be monitored (e.g. hand washing) will be selected once the activity is started.

- Overall annual plan of pilot projects is prepared every year and is reviewed more than X times a year

2) Skills and knowledge of SMOHs on the management of the pilot projects with awareness for public needs and equity are improved.

【Indicators】

- More than XX RH coordinators/HVs/AHVs/MA/SMOH(Health Promotion) receive technical training
- More than XX VMW/CHW/CHP receive training
- Number of VMWs who receive regular supervision is increased (at least XX times a year)
- Satisfaction of VMWs who receive supervision is increased
- Community Health Committee organize meetings more than XX times a year
- Community mobilization activities are implemented more than XX times a year
- More than XX persons participate in the activity
- Skills, knowledge and awareness of SMOHs staff are improved

3) Operational procedure of pilot projects in SMOHs (supportive supervision and community mobilization) is improved for public needs and equity

【Indicators】

- Good practice and lessons learned of pilot projects are compiled as a case manual in each state.
- State Community mobilization strategy is developed in each state
- Supportive supervision improvement plan is developed in each state

7. Activities

(Output 1)

1.1 Establish Pilot Project Management Team at SMOH

SMOH establishes Pilot Project Management Team that consists of staff from RH department and Health Promotion Department, and clarifies the role and responsibility of the Management Team.

1.2 Select pilot areas in consultation with stakeholders including State Water Cooperation

Final selection of pilot communities will be made based on the shortlist which has been already submitted by each SMOH, considering the following selection criteria. Once one target locality is selected, several pilot communities are selected surrounding the existing Family Health Centre located in the locality in order to promote the community referral. While total 15 communities are expected to be selected in each state throughout the four years, three communities where implementation, management and monitoring can be easily done will be

selected in the first year, adding four communities every year in each state from the 2nd year and on.

- Target states: North, South, and West Darfur
- Total 15 communities per state where a day return trip from the state capital can be made
- Minimum one community in the state capital where Japanese/Sudanese team member can visit
- Two to three communities of/close to IDP camps/settlement area of returnees
- Two to three communities where SMAP2 water sector also works

Dimension	Points to check
Suitability	• Do the local government and community people agree with the selection result?
Equity	• Are the selected areas only focused in some specific geographical areas? Ethnic groups? Religious groups? Or any other specific groups? • Are the selected communities already receiving similar assistance from other donors/NGOs? •
Feasibility	• Is the implementation feasible in terms of transportation, communication, capacities of VMWs and CHWs?
Community participation	• Are the community people willing to cooperate in the implementation of pilot activities such as community health committee?
Security management	• Is there any security concern for the implementation?
Conflict mitigation	• Is there any possibility that pilot activity itself could cause instability within community and with other communities? • Are the areas/people severely affected by conflict considered?
Coordination with implementing agencies	• Are there communities where the SMAP2 water and sanitation sector can work together?
Coordination with other aid agencies/NGOs	• Are there any aid agencies and/or NGOs which can cooperate with SMOH for implementation and monitoring? • Are there any duplication of similar activities supported by existing other aid agencies and NGOs?

Areas to be excluded

- ➢ Areas where security is not maintained
- ➢ Areas with conflict among residents
- ➢ Areas where only specific groups/persons become beneficiaries
- ➢ Areas where no VMW and CHW is working
- ➢ Areas where existing VMWs have not received any in-service training
- ➢ Areas where communities are not committed to work on the project activities

1.3 Conduct baseline study and situational analysis of community health (especially on MCH) activities and VMW supportive supervision

Pilot Project Management Team carries out the baseline study on the health activities and

supportive supervision in target communities and analyses the result. The items to be collected, target, and methodology are tentatively summarized as follows:

Baseline Survey Items (Draft)

Main Items	Details	target			method				PDM indicators
		SMOH	Community	Donors etc.	Questionnaire /Interview	Observation	Group Discussion	Data document	
1) Community Social Environment									
(1) Population	Population and household number		●		●			●	
	Number of women and infant		●		●			●	
(2) Economic activity	Main economic activities (income sources)		●		●				
(3) Community activity	Existence of community groups/members/activity and frequency		●		●				
2) PHC system									
(1) Access to health facility	Existence of Family Health Unit/Center	●						●	
	Distance/time to the closest facility If there is no FHU/FHC		●		●				
(2) Human resources	Type and number of staff	●						●	
	Number of VMW working in the community, number of in-service training participants	●						●	
	Number of CHWs	●						●	
(3) Equipment at health facility	Water supply, type and number of equipment at FHU/FHC	●			●	●			
3) MCH services									
(1) MCH indicators	Number of delivery/Delivery at facility/assisted by VMW, TBA	●						●	●
	ANC・PNC (facility・VMW・TBA・others)	●						●	●
	Number of referral cases	●						●	●
	Number of mortality of pregnant women/newborn infant	●						●	
(2) Satisfaction with service	Utilization of VMW services (content/frequency), people's satisfaction		●				●	●	●
	Utilization of CHW services (content/frequency), people's satisfaction		●				●	●	●
	Utilization of services at FHU/FHC (content/frequency), people's satisfaction		●				●	●	●
4) Health issues and behavior									
(1) Health issues	Common health issues	●	●		●			●	
	Number of child with diarrhea	●						●	
	Number of child with ARI	●						●	
(2) Knowledge and behavior for prevention	Situation of hand washing (Frequency, method etc.)		●				●		●
	Method for diarrhea prevention		●				●		
	Community Health Committee (Establishment, Function and role, meetings, activity, members)		●				●		●
	Community mobilization activity (Content, frequency, target, participants)		●				●		●
	Existence of referral to FHC and means for referral (transportation)		●				●		●
5) Supportive supervision for VMW (SSV)									
(1) Current situation	Number of HV/AHV conducting SSV	●			●			●	
	Number of VMWs receiving SSV							●	
	Content, frequency, place, transportation of SSV				●	●		●	●
(2) Satisfaction with supervision	VMW's satisfaction with SSV	●			●				●
	Training needs for supervisors	●			●				
6) Assistance from other donor/NGOs									
(1) Current situation	Organizations supporting the community, content, assistance plan		●	●	●				

*Some information will be collected through Socio-Economic Survey which is expected to be carried out prior to the project

1.4 Prepare and review Community Mobilization Action Plan for MCH with Community Health Committee and supportive supervision implementation plan in discussion with stakeholders including FMOH

Pilot Project Management Team develops the Annual Work Plan (Implementation plan of community mobilization and supportive supervision) based on the result of situational analysis through discussions with stakeholders.

(Output 2)

2.1 Based on activity 1.3, identify the training needs

Training needs are identified by clarifying knowledge and skills necessary for SMOH staff to carry out and manage pilot projects based on the baseline study and situational analysis in Output 1.

2.2 Check the available training programs and existing guidelines and manuals and develop a training plan.

The availability of training program, guidelines, and manuals is checked at MCH department and Health Promotion Department of FMOH. Availability of assistance from existing trainers and possibility of joint training in collaboration with other development partners working in this field will be also considered.

2.3 Conduct training courses for capacity development of SMOH personnel （TOT training for RH coordinator/HV/AHV on Supportive Supervision, ToT for SMOH on Health Promotion, training for Capacity development of health staff in Health Centers）.

TOT Refresher Training of Community Mobilization will be conducted for State Core Trainer Team members (7 members per state) who have been already trained by FMOH Health Promotion Department in Khartoum (5 days). The training content covers following topics of the existing training manual named “CHW/CHP for MCH in the community”, communication skills and management of Community Health Committee.

Topics covered in “CHW/CHP for MCH in the community”

1. Communication	12. Home treatment of sick child
2. Breastfeeding	13. Health of pregnant women
3. Complementary feeding	14. Delivery plan
4. Continuous growth	15. Danger signs during pregnancy
5. Nutrition and sickness	16. Cases to be delivered to hospital
6. Malnutrition	17. Danger signs during delivery
7. Vaccination	18. Danger signs after delivery
8. Diarrhoea prevention	19. Maternal Death Review
9. Management of Acute Respiratory Infection	20. Health of breastfeeding-mother and baby
10. Management of Ear infection	21. Family Planning
11. Malaria	

Regarding Supportive Supervision, State RH coordinator and Health Visitors as well as Assistant Health Visitors (North and South Darfur: 20 x 2 states and West Darfur: 10) received Supportive Supervision Supervisor Training based on the latest guideline developed by FMOH (5 days).

2.4 Provide Community mobilization training (Training for CHW/VMW, Training for community health committees' core members).

State Core Trainers who have received the above training (Activity 2.3) conduct Community Mobilization Basic Training for CHWs, VMWs, Medical Assistants and nurses working in the Health Facility (Total 20 per state: 10 days). The trained VMWs and CHWs conduct Basic Training for Community Health Committee Core members (30 members per state: 10 days). For the basic training targeting at community people, exiting manual will be simplified. From the 2nd year and on, additional training are conducted to strengthen the capacity necessary to promote activities and solve issues and challenges faced through the implementation of pilot activities (e.g.: Activity reporting, Material development, Planning, Specific disease) (Total 20 participants/year/state, 3 days).

2.5 Improve the functions of Community Health Committees in pilot areas in order to implement community mobilization activities (health education on MCH, community referral fund, etc.)

Vision and functions of Community Health Committee, the role of each member, and expected activity are clarified. Community Health Committees are also expected to strengthen their functions in planning, implementation, and monitoring through regular meetings.

2.6 Implement activities with Community Health Committee based on the Community Mobilization Action Plan

Community Mobilization activities are implemented based on the action plan developed with Community Health Committees. Effective methods will be adopted in consideration of socio-economic circumstances, characteristics of community, and institutional capacity of each Committee.

Purpose	Improvement of community people's basic health knowledge, Change of wrong perception and behaviour
Target	Individual level: Community people as a whole Group level: School, Women's group, Youth group
Topics	Comprehensive PHC topics focused on Reproductive Health, Nutrition, EPI, IMCI （Topics covered in "CHW/CHP for MCH in the community"）
Method	Message through religious leaders, Utilization of TV and radio, Group discussion, Lecture, Home Visit, Mobile theatre, Traditional Media（Hkmat）, IEC materials (Posters, brochure, picture show etc.)

2.7 Conduct necessary trainings (In-service training for VMW etc.)
The 12-day in-service training is conducted, targeting at 20 VMWs in each state who have not received the training yet from the 2nd year and on (12 days per year). In addition, Health Visitors carry out the complementary skills development training for VMWs in order to

strengthen their clinical skills once the skill gap is identified through baseline survey and supportive supervision (3 day per year).

2.8 Conduct supervision for VMWs by supervisors
Health Visitors and Assistant Health Visitors who have received the Supportive Supervision Supervisor Training conduct supportive supervision for VMWs based on the FMOH guideline. Depending on the situation of each state, they either visit each VMW at home as specified in the FMOH guideline or call for VMWs to the closest Health Centre for supervision.

2.9 Prepare activity reports of community mobilization and supportive supervision, and organize regular meeting.

RH coordinator in the Pilot Project Management Team is responsible for the monthly activity report of community mobilization and supportive supervision. The Pilot Project Management Team monthly checks the progress of activities as well as activities planned for the next month based on this activity report.

2.10 Procure necessary equipment for management and PHC centers
Equipment necessary for community mobilization and supportive supervision are procured in accordance with the annual work plan of pilot projects. After the status of infrastructure such as water and electricity supply is checked, the minimum requirement of equipment as defined by FMOH is procured at Family Health Unit in the pilot communities.

2.11 Evaluate pilot projects
The effect of pilot projects are examined with the PDM indicators of each output as well as such outcome indictors as reported cases of diarrhoea, ARI, and infant mortality.

(Output 3)

3.1 Develop a case manual of good practice of community mobilization and share it with other stakeholders
Good practice and lessons learned of community mobilization are shared quarterly at Health Sector Technical Committee and compiled into a case manual in the end of the project year. These manuals will be finally materialized as community mobilization practice manual.

3.2 Review current supportive supervision system and develop the improvement plan
The RH coordinator of each SMOH reviews the system of supportive supervision (e.g. implementation method, frequency, and monitoring method) based on the result of supportive supervision activity in Output 2, and develops the improvement plan in the end of every year.

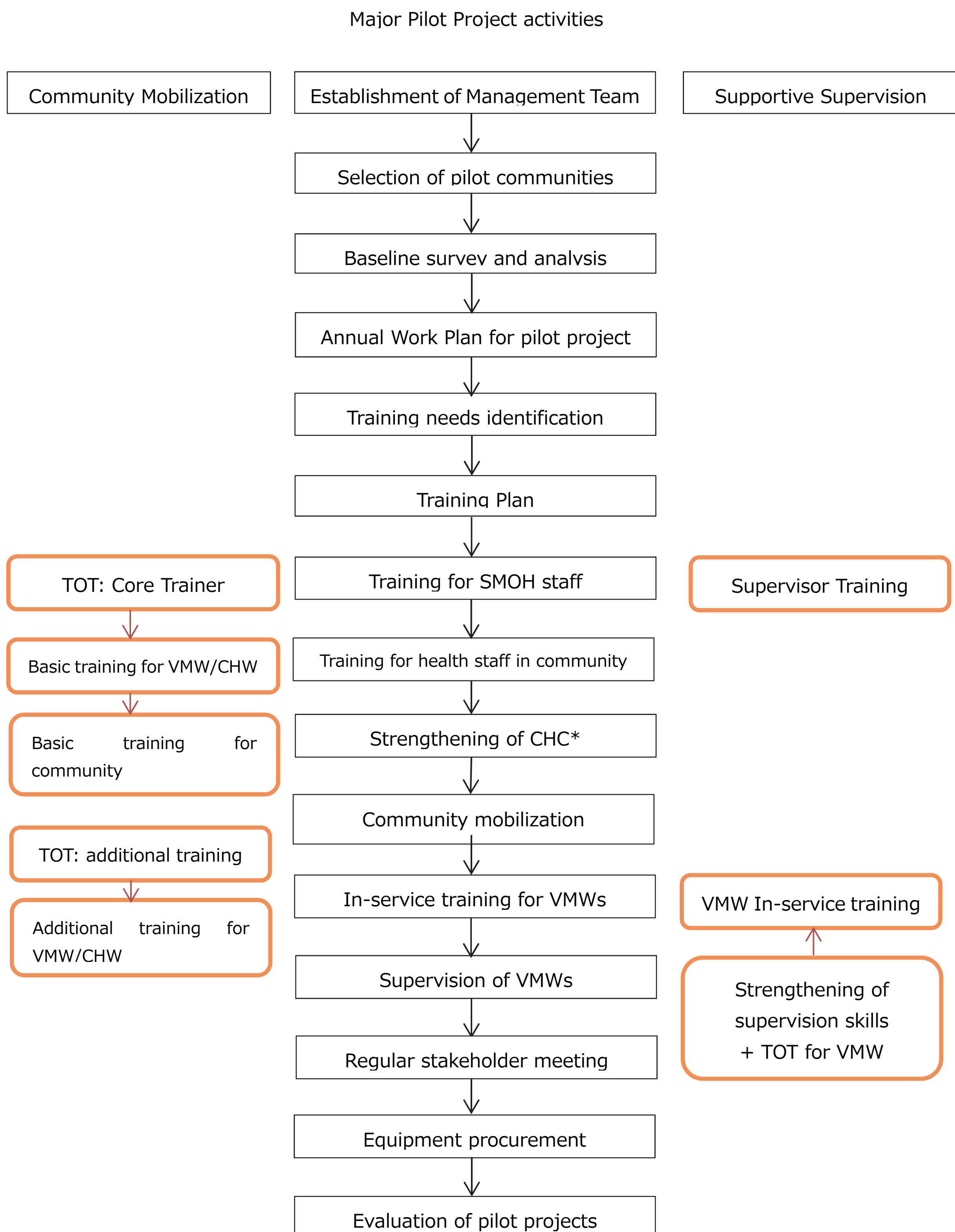
3.3 Develop state Community mobilization strategy
Pilot Project Management Team develops the state community mobilization strategy, considering the dissemination of pilot activities across the state (end of 4th year).

8. Training Course

(1) Purpose

The Sudanese counterpart is expected to play a major role in planning, implementation and operation, and monitoring and evaluation of pilot projects in each state. Therefore, training aimed at strengthening the capacity of Pilot Project Management Team (State Government staff) and Pilot Project Implementation Team is provided. In addition, training aimed at filling the gap of specific skills and knowledge is continuously provided for the improvement of public services.

(2) Training Flow



*CHC: Community Health Committee

(3) Type

1) Group Training in Khartoum

Training in Khartoum is aimed to train trainers (state core trainers) for Pilot Project Implementation Team. FMOH national trainers and Japanese experts conduct TOT to improve knowledge and skill for pilot projects as well as teaching/training method.

2) Group Training in each state

Pilot Project Implementation Team learns basic knowledge and skills necessary for pilot projects from core trainers who receive TOT. Further training for capacity building is provided to respond to the needs and issues identified though pilot projects from 2nd year and on.

(4) Content

【Group Training in Khartoum】

<table>
<tr><th>Name</th><th>Period</th><th>Participant</th><th>Number</th><th>Implementing Agency</th></tr>
<tr><td rowspan="3">State Core Trainer Refresher Training (TOT)</td><td>2015 (5 days)</td><td>State Health Promotion core trainer</td><td>7/state × 3 states = 21 persons</td><td>FMOH/JICA expert</td></tr>
<tr><td>Topics :</td><td colspan="3">21 topics covered in the manual “CHW/CHP for MCH in the community”, communication skills, management of Community Health Committee</td></tr>
<tr><td>Remark :</td><td colspan="3">Conducted in Khartoum/Training material is available at FMOH</td></tr>
<tr><td rowspan="3">Additional Training of Community Mobilization (TOT)</td><td>2015-2018 : once/year (3 days)</td><td>State Health Promotion core trainer</td><td>7/state × 3 states = 21 persons</td><td>FMOH/JICA expert</td></tr>
<tr><td>Topics :</td><td colspan="3">Topics that are necessary to strengthen the community mobilization and community referral (e.g. record writing, material development, planning, specific disease common in the community)[3]</td></tr>
<tr><td>Remark :</td><td colspan="3">Conducted in Khartoum</td></tr>
<tr><td rowspan="3">Supportive Supervision Supervisor Training</td><td>2015 : once/year (5 days)</td><td>State RH coordinator/HV/AHV</td><td>10/state x 3 states = 30 persons</td><td>FMOH/JICA expert</td></tr>
<tr><td>Topics :</td><td colspan="3">Vision and purpose of supportive supervision, implementation method and monitoring based on the FMOH guideline</td></tr>
<tr><td>Remark :</td><td colspan="3">Conducted in Khartoum</td></tr>
</table>

[3] Issues in the implementation of community mobilization activities will be identified though monitoring, submitted records, and the disease tendency

【Group Training in each state】

Name	Period	Participant	Number	Implementing Agency
Community Mobilization Basic Training (VMW/CHW)	2015-2018 : once/year (10 days)	VMW/CHW in pilot communities	20/state×3 states	Core trainers who received TOT
	Topic :	21 topics covered in the manual “CHW/CHP for MCH in the community”, communication skills, management of Community Health Committee		
	Remark :	Core Trainers provide training in each locality		
Community Mobilization Basic Training (Community)	2015-2018 : once/year (10 days)	Community leader and residents/Community Health Committee members	30/state×3 states	VMW/CHW who receive the above training
	Topics :	21 topics covered in the manual “CHW/CHP for MCH in the community”, communication skills, management of Community Health Committee		
	Remark :	VMW/CHW in community become trainers for community people/Check the necessity of simplified version of exiting manual		
Community Mobilization Additional Training	2015-2018 : once/year (3 days)	VMW/CHW in pilot community	20/batch/state × 3 states＝60	Core trainers who receive TOT training
	Topics :	Topics that are necessary to strengthen the community mobilization and community referral (e.g. record writing, material development, planning, specific disease common in the community)		
	Remark :	Core Trainers provide training in each locality		
Supervision skill strengthening +TOT for VMW in-service training	2015-2017 : Once/year	HV/AHV in each state	North/South each 20+West 10＝50	FMOH/JICA experts /RH coordinator
	Topics :	TOT for strengthening of skills and technique of VMWs based on the supportive supervision result/Strengthening of supervision skills		
	Remark :	Conducted at each state capital		
VMW in-service training	2016-2018 Once/year (12 days)	VMWs in pilot area	20/state/year × 3 states	HV/AHV who receive the above TOT
	Topics :	12-day in-service training		
	Remark :	Midwifery school in pilot areas and/or health facility		
VMW skills development training	2015-2017: Once/year (3 days)	VMWs in pilot area	15/batch/state × 3 states＝60	HV/AHV who receive the above TOT
	Topics :	Clinical skills of VMWs to be strengthened based on the supportive supervision result		
	Remark :	Midwifery school in pilot areas and/or health facility		

(5) Schedule

Training schedule is presented as below.

<1st year>

Type of training	2015 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2-3 Training courses for capacity development of SMOH personnel				CM refresher	SSV supervisor					CM additional	SSV skill	
2-4 Provide Community mobilization training					CM/VMW・CHW		CM/community				CM additonal	
2-7 In-service training for VMW											skills development	

<2nd year>

Type of training	2016 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2-3 Training courses for capacity development of SMOH personnel					SSV skill			SSV skill	CM additional			
2-4 Provide Community mobilization training					CM/VMW・CHW, CM/community					CM additional		
2-7 In-service training for VMW								inservice			skills development	

<3rd year>

Type of training	2017 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2-3 Training courses for capacity development of SMOH personnel					SSV skill			SSV skill	CM additional			
2-4 Provide Community mobilization training					CM/VMW・C, CM/community					CM additional		
2-7 In-service training for VMW								inservice			skills development	

<4th year>

Type of training	2018 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2-3 Training courses for capacity development of SMOH personnel								SSV skill	CM additional			
2-4 Provide Community mobilization training					CM/VMW・CHW	CM/community				CM additional		
2-7 In-service training for VMW									inservice			

(6) Evaluation

The effect of training conducted in this project is regularly monitored and evaluated in order to verify its significance. Several monitoring items related to the improvement of management and institutional capacity will be selected to measure before and after the training. Various evaluation methods including the questionnaire for training participants and interviews with co-workers will be considered and determined though discussion among stakeholders.

9. Implementation Structure and Roles of Relevant Institutions

(1) Overall Management by SMAP Project Office

SMAP Project Office located in HCDG (Khartoum) manages 9 pilot projects, training of staff of implementing agencies, various workshop for system improvement, and regular meetings.

(2) Responsible personnel of SMAP

As the project of Sudanese government, responsible personnel of SMAP are as follows:

- Project Director : HCDG General Rapporteur
- Project General Manager : Secretary General of North, South, and West Darfur States
- Project Manager: Director General of North, South, and West Darfur State Ministry of Finance

(3) Committees

Joint Coordinating Committee, State Project Management Committee, and Sector Technical Committee are established in SMAP for the overall project management, state-level management, and technical management.

1) JCC/Joint Coordinating Committee

Joint Coordinating Committee (JCC), composition of members listed in Table 2 below, will meet at least once in every six (6) month and whenever the necessity arises during the project.

Table-2: Outline of JCC

Chairperson	General Rapporteur, HCDG
Members	Core members are representatives of implementing agencies of SMAP 2. In addition, Line Ministries of Federal Government will participate as observers (refer Table below).
Secretariat	HCDG
Function	a) To monitor the overall progress and the achievements of the project b) To review measures taken by JICA on i. Dispatch of Japanese experts ii. Acceptance of counterpart personnel in Japan or third country for

	training iii. Utilization and administration of machinery and equipment procured by the project c) To make recommendations to the Government of Republic of Sudan on: i. Budgetary matters ii. Recruitment and appointment of counterpart personnel iii. Selection and effective utilization of machinery and equipment d) To make decisions and recommendations relevant to the overall strategy and management of the project.
Meetings	At least once in every six months

2) SPMC/State Project Management Committee

State Coordinating Committee (SPMC) has the function of overseeing the project activities in Component 1, 2, 3 and 4 within the State. Therefore, three SPMC will be set up in North, South and West Darfur respectively. SPMC will be composed of 6 members who will be representative of organisations implementing the Pilot projects and members will meet at least once in every three (3) months and whenever the necessity arises during the project.

Table-3: Outline of SPMC

Committees	1) North Darfur State Project Management Committee (ND-SPMC) 2) South Darfur State Project Management Committee (ND-SPMC) 3) West Darfur State Project Management Committee (ND-SPMC)
Chairperson	Director General (DG), State Ministry of Finance
Members	Representative of; 1) State Ministries of Finance 2) State Ministries of Health 3) State Water Cooperation 4) State Ministries of Education 5) State Employment and Entrepreneurship Promotion Committees 6) Secretary General Office (Secretary) 7) Others appointed by Chairperson
Function	• To review the progress of the project in each state • To exchange opinion on major issues that arise during the implementation of the project, and take steps necessary to resolve issues • To approve annual project budget (local component) • To promote Publicity regarding to SMAP • To report the results of the discussion to Project Director and General

	Manager
Meetings	Quarterly meeting will be held at State Ministry of Finance

3) STC/Sector Technical Committee

Sector Technical Committee (STC) is the most important M&E tools and monitors the Pilot projects and training programme in technical view point. STC will be set by sector, namely Health STC, Water & Sanitation STC and Employment STC. Outline of these STCs are shown in the Table-4 below.

Table-4: Outline of Health STC

Chairperson	Chairperson will be elected by members every year.
Members	Federal Government Representatives of Ministry of Health (PHC Department and Health Promotion Department) State Government Representatives of; 1) Ministry of Health, North Darfur 2) Ministry of Health, South Darfur 3) Ministry of Health, West Darfur Above representatives will include at least Director General, RH Coordinator and Director of Health Promotion. Others 4) Representatives of JICA Project Team 5) Key development partners (e.g. UNICEF, UNFPA, etc.) 6) Others appointed by Chairperson
Function	• To monitor progress of the Pilot projects and training programme • To identify the problems and its solution to be taken by implementing agencies • To develop annual sector plan and its cost estimation • To share lessons learned, good practices and updated information • To develop common guideline/manual for supportive supervision and community mobilization
Meetings	Quarterly meeting will be held at Federal Ministry of Health, Khartoum

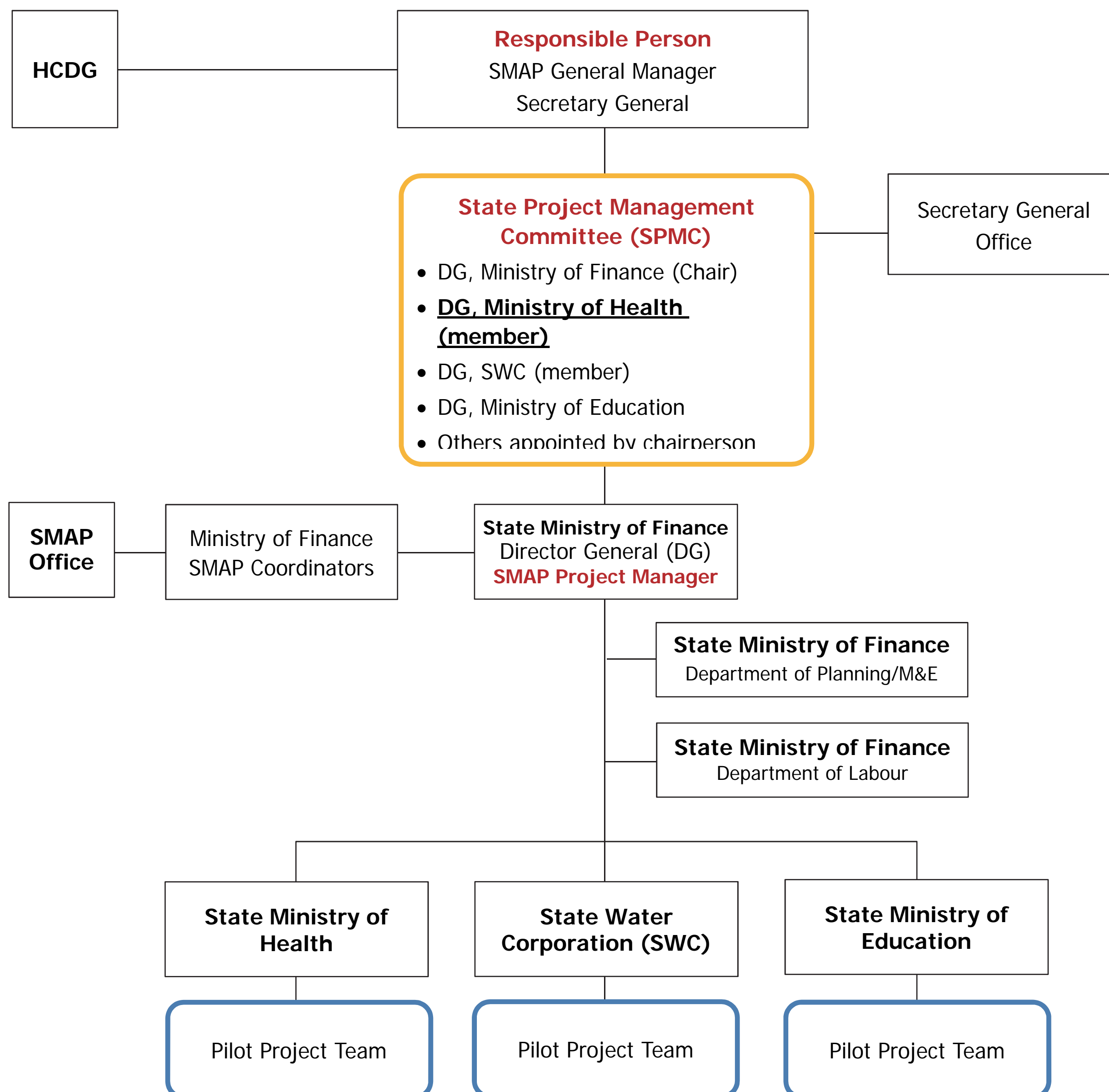


Figure 1： Implementation structure at state level

(4) SMOH Project Team

Health Promotion Team will be organized that consists of RH Department, Health Promotion Directorate, and Locality Health Office for the implementation of Component 1 activities.

1) Project Manager

Director General of SMOH will be the responsible person for Component 1. The responsibility includes overall management of pilot project activities, decision making and instructions on the significant matter, and responsive measures for risk mitigation.

2) Pilot Project Management Team

Pilot Project Management Team, consisting of staff from SMOH RH department and Health Promotion Directorate, is responsible for pilot project planning, instruction and contact with Pilot Project Implementation Team, assistance for pilot project implementation and monitoring, and consultation and reporting to FMOH.

3) Pilot Project Implementation Team

Pilot Project Implementation Team will consist of members of Community Health Committee (health personnel working in the health facility, VMW, CHW, community leader, CHP etc.) who are directly involved in the pilot project activities. The team will carry out the planned activity in the community and report to the Pilot Project Management Team.

(5) Responsibility and Role of the Relevant Institutions

1) HCDG

HCDG is responsible for monitoring the progress of the project activities in accordance with the plan through regular report submitted by the state government, regular meetings including JCC, and pilot project site visit as the responsible body of the project. If the purpose is not achieved, the implementation is delayed, or the activity is changed, HCDG also considers and recommends the necessary countermeasures to the state-level implanting agency.

2) FMOH

FMOH assists SMOH by providing training materials for community mobilization and revised supportive supervision guideline and checklist as well as TOT training through national trainers for the pilot project implementation. In response to the regular update from SMOH Pilot Project Management Team, FMOH provides necessary advice to SMOH. Especially in Health Sector Technical Committee, FMOH is expected to play a role in checking the progress, identifying the issues, and proposing the possible countermeasure from a point of national strategy and policy.

3) Academy of Health Science

AHS responsible for basic training is not directly related to in-service training conducted in

SMAP2. On the other hand, it is expected for the project to cooperate with AHS in developing such training program that aims to strengthen VMW's technique and skills by applying the existing basic training content, incorporating teaching method into the training for supervisors, and dispatching experienced trainers.

4) Midwifery school

Midwifery school provides basic training for VMWs. There are two in North Darfur and one each in South and West Darfur states. The cooperation with these midwifery schools is expected in sending trainers for in-service training for VMWs and providing space for training.

5) Locality/Community Health Committee

While the current situation of Community Health Committee (CHC) and its functions are different from one state to another, CHC as Pilot Project Implementation Team is responsible for carrying out health education and raising awareness to community people based on the community mobilization implementation plan. As it is important to strengthen the capacity of locality in bridging state to community, locality is expected to play a role in monitoring the activity of CHC once necessary human resources become available in the later period of the project so that CHC at locality level can be established and strengthened.

(6) Collaboration with other organizations

1) SWC

SMOH will collaborate with SWC to select common target communities where both health and water sectors jointly work. Examples of possible joint activities to be performed by SMOH and SWC are summarised:

- Hygiene education including maintenance of clean water sources, hand washing and safe water use, prevention of water-borne diseases
- Joint test and monitoring of water quality
- Training to Water Committee on health education
- Joint campaigning

2) Humanitarian Aid Commission (HAC)

SMOH will share information with HAC during the implementation of pilot project to keep the relevance of the project activity with the government policy. Extreme caution will be paid to the assistance to IDP camps and returnee communities. SPMC, Project General Manager (State Secretary General), and HCDG will provide assistance for the coordination with HAC if necessary.

3) Darfur Regional Authority (DRA)

DRA checks the progress of the project at the quarterly committee meetings as JCC members. In addition, the information related to DRA activities will be shared to consider the possible

collaboration and avoid duplication of similar activities.

4) Other development partners

- UNICEF

The project will periodically share the information with UNICEF, which has provided training on community mobilization and assisted supportive supervision for VMWs in North Darfur in the past. If SMOH Pilot Project Implementation Team finds it impossible to implement and manage training, UNCEF might be contracted for the training provision and monitoring based on the past assistance provided by UNICEF in VMW in-service training in Phase 1.

- UNFPA

As the major aid organization that has widely provided assistance in the MCH area, UNFPA has experience in awareness raising through drama, youth outreach, assistance and monitoring of supportive supervision for VMWs. As their activities are overlapped in SMAP2, project information will be regularly shared with UNFPA. In addition, subcontracting with UNFPA that has a wide network of many NGOs might be considered in the implementation and monitoring of community mobilization if necessary

- IOM

IOM conducts comprehensive assessment by registering refugees, IDPs, and returnees, monitoring the movement of these populations, checking the availability of minimum services such as water, health and education at village level and livelihood. In addition to the experience in this comprehensive village assessment, IOM has many staffs that are able to carry out the survey in the community. Considering these experience and availability of human resources, IOM could be subcontracted for the project evaluation and/or pilot project management.

- Others

Approximately 50% of health personnel and 40% of health facility are currently managed by UN agencies and NGOs. Nevertheless, there are several health facilities that had to be closed down due to the stagnated management by SMOH. Considering this situation, if it is found that NGOs are providing assistance in the target community, the project will ask for the cooperation for community mobilization and information sharing as well as arrange the human resources at community level so that activities are sustained even after the termination of their activities.

- Donor meeting

Donor meeting in the area of reproductive health and MCH are regularly organized both at federal and state level. On the other hand, as there is no donor meeting specifically focused on the area of health promotion, SMOH Health Promotion staff is strongly encouraged to attend the RH/MCH donor meeting to report and share the information with other development partners and NGOs.

Figure 2: Implementation Structure of Component 1 (Health)

10. Monitoring & Evaluation

Monitoring and evaluation (M&E) will be conducted according to the M&E plan, to be developed in SMAP-2. Khartoum-based JICA team and states-based C/Ps will cooperatively implement pilot activities and thus M&E is indispensable because of the remote management, more than conventional project.

(1) Objectives of M&E

Objectives of M&E of SMAP2 are as follows

- To verify if the public services are appropriately and steadily implemented according to the pilot activity plan (from the view point of effectiveness, efficiency, equity, accountability and consideration to the conflict prevention)
- To seek for cost efficient service provision through M&E on the public expenditure
- To fulfil accountability of pilot activities (public services)
- To enhance communication with the community people through M&E, and to promote service provision that meets the needs of the community.
- To minimize delay of operation process and aggravation of problems so as to achieve the outputs of the pilot activities.
- To sort out the lessons learned and recommendations recognized through M&E, with the intention of utilising the data as basis for development of guidelines and state development strategy.

(2) M&E Approaches

- Monthly Report

Pilot activity management team leader of the C/P will prepare monthly report, by sorting out information (such as activity record) provided by the pilot activity implementation team. Monthly report will be the most fundamental tool to understand the progress of the pilot activities. Team leader will submit the monthly report to the SMoF and SMAP office (JICA team and HCDG), and then the SMAP office shall share with the relevant organisations.

- Team Meeting

Pilot activity management team of the C/P will hold monthly meeting inviting the team members and other stakeholders when appropriate, to share the progress of the activities. Monthly report explained in the above section will be used as meeting handouts, which could be updated where necessary. Team leader is requested to make effort for better daily communication among the members including pilot activity implementation team, not limited to the meetings set officially.

- Quarterly Monitoring & Evaluation Sheet

M&E team of the SMoF will make quarterly report, based on the monthly reports submitted by the implementing agencies and discussion record of SPMC and JCC. Quarterly report is to

figure out the status of the evaluation indicators, and to suggest for improvement. Implementing agencies should receive feedback from the SMoF-M&E team.

- JCC, SPMC and STC

As detailed in the previous section, periodical meetings will monitor, analyse and evaluate the data collected by the C/P.

- Site Visit

SMAP Office will visit the Darfur region quarterly, and monitor the progress and achievements of pilot activities through observation and discussion with the C/P, project team, and community people. SMoF should also participate in such study.

- Evaluation Study

When the data is not available from the pilot activity records, C/P will conduct simple surveys such as interview to stakeholders.

- Annual Evaluation Study

Prior to the annual activity/budget planning, achievement status of pilot activities will be studied (June-July every year). The study will be conducted based on the evaluation indicators, using various survey methods such as questionnaire survey, focus group discussion, and 360 degree survey with questionnaire. Evaluation should be conducted by third party (SMAP2 JICA team will outsource a study team) and C/P shall cooperate to the survey.

Table-5 : Component 1 Indicators and Means of Verification

Overall Goal	Indicator	Means of Verification
Public well-being is enhanced in three Darfur States (*Well-being is defined as conditions where public happiness, public trust and public services are fulfilled for the people)	[Common indicator] Public happiness is increased	Questionnaire survey/ focus group discussion
	[Common indicator] Public trust on the government is promoted	Ditto
	[Common indicator] Satisfaction on public services is increased	Ditto
	Number of ANC provided by VMWs is increased in three Darfur states	Records/statistics of SMoHs
	Number of births attended by skilled-birth attendant (including VMWs) is increased in three Darfur states	Ditto
	Number of community referral is increased in three Darfur States	Baseline survey/endline survey Records/statistics of SMOHs
	Healthy behaviour is promoted in three Darfur states	Records/statistics of SMoHs

Project Purpose	Indicator	Means of Verification
Community-based maternal and child health services considering public needs are inclusively provided in pilot project area and institutional capacity of the State Ministry of Health (SMoHs) in the provision of community-based maternal and child health services is strengthened	[Common indicator] Selection process of the pilot areas become inclusive (include the most conflict-affected people and community, etc. into target groups with consideration for coexistence)	360 degree survey with questionnaire Most Significant Change method
	[Common indicator] Recognition of implementing agencies on public needs is improved (Contacts with community is increased, attitude of implementing agencies to community people become responsive from neglective, etc.)	Ditto
	[Common indicator] Capacity (to make the services efficient, transparent and peace promotion) of service providers perceived by stakeholders is improved	Ditto
	Public satisfaction on selected health services is increased in pilot areas	Baseline survey/endline survey
	Number of ANC provided by VMWs is increased in pilot areas	Records/statistics of SMoHs
	Number of births attended by skilled-birth attendant (including VMWs) is increased in pilot areas	Ditto
	Number of community referral is increased in pilot areas	Baseline survey/endline survey Records/statistics of SMOHs
	Healthy behaviour is promoted in pilot areas	Survey
	Pilot Projects are repeatedly implemented as planned	Pilot Project Plan
Output	**Indicator**	**Means of Verification**
Planning and coordination skills necessary to conduct pilot projects (community mobilization and supportive supervision of VMW) in consideration of public needs and inclusiveness are improved	Pilot Projects plan is prepared in consideration of public needs and inclusiveness	Project records
	Overall annual plan of pilot projects is prepared every year and is reviewed more than XXX times a year	Ditto
Skills and knowledge	More than XXX persons of RH	Training records of SMoHs

of SMOHs on the management of the pilot projects with awareness for public needs and inclusiveness are improved	coordinators/HVs/AHVs/MA/SMOH(Health Promotion) receive technical training	
	More than XXX persons of VMW/CHW/CHP receive training	Supportive supervision record of SMoHs
	Number of VMWs who receive regular supervision is increased (at least XXX times a year)	Training records of SMoHs
	Satisfaction of VMWs who receive supervision is increased	Questionnaire survey/ Training evaluation report of SMoHs
	Community Health Committee organize meetings more than XXX times a year	Health promotion activity records of SMoHs
	Community mobilization activities are implemented more than XXX times a year	Ditto
	More than XXX persons participate in the activity	Ditto
	Skills, knowledge and awareness of SMOHs staff are improved	Interview with SMoH staff
Operational procedure of pilot projects in SMOHs (supportive supervision and community mobilization) is improved for public needs and inclusiveness	Good practice and lessons learned of pilot projects are compiled as a case manual in each state	Developed case manual
	State Community mobilization strategy is developed in each state	Developed state community mobilization strategy
	Supportive supervision improvement plan is developed in each state	Developed supportive supervision improvement plan

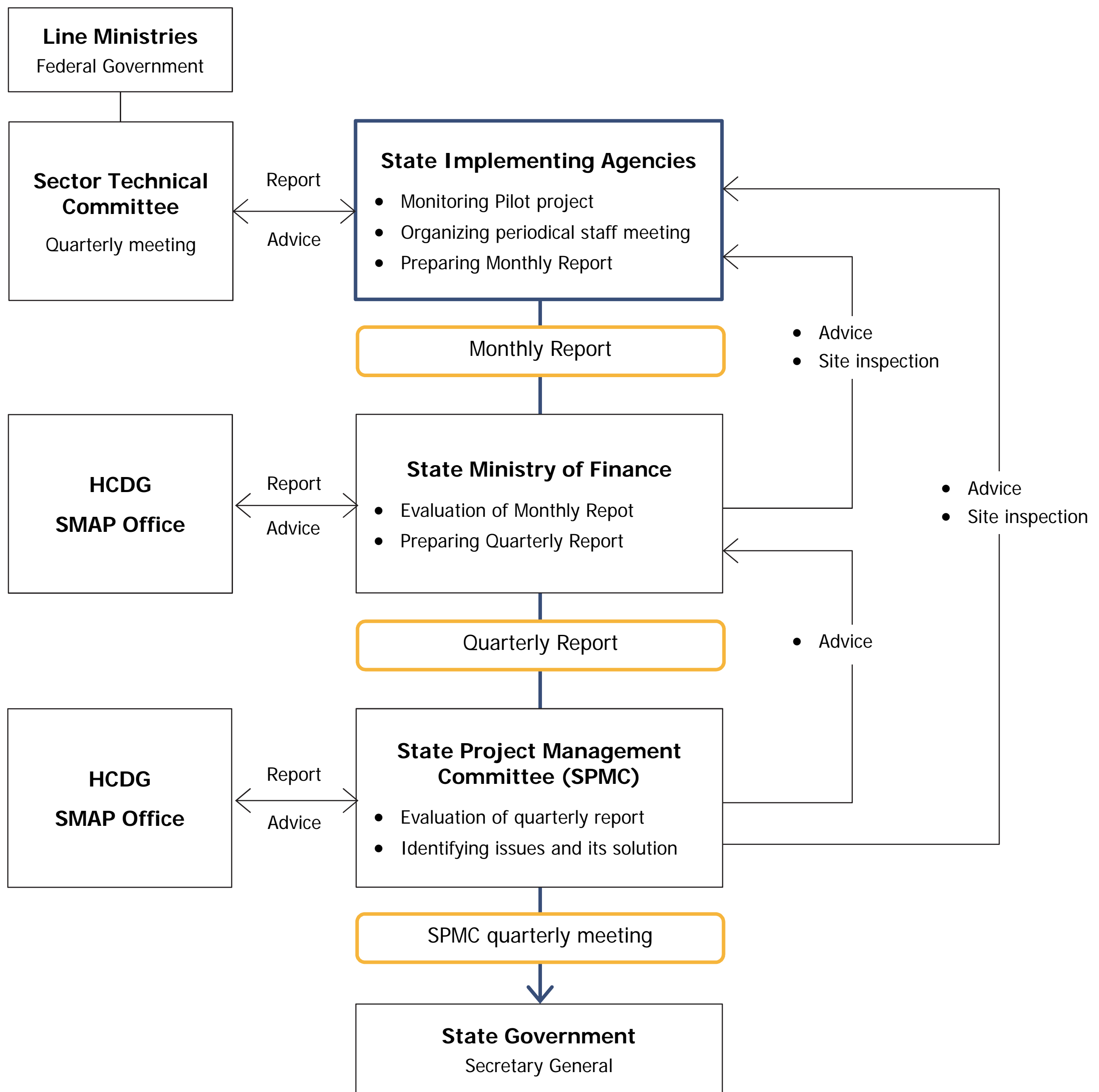


Figure 3: M&E Structure for Pilot Projects

11. Procurement

(1) Basic principle for equipment procurement

The type and quantity of equipment for effective in-service training are found insufficient because some equipment were already damaged and a half of the training equipment distributed to West Darfur and South Darfur were transferred to the East Darfur and Central Darfur at the time of the separation of these states. Infrastructure is not in place as perennial power failure and water failure still occur frequently. In this circumstance, many existing Family Health Units and Family Health Centers are not fully equipped to meet the specification regulated by FMOH. In addition, the allocated budget is limited to replace some parts and consumables. In consideration of these conditions, the equipment will be selected and procured based on the following principle.

1) Equipment can be used for basic practice
2) Equipment does not require any special knowledge and operation
3) Equipment maintenance is easy

There is no company that manufactures medical equipment in Sudan. In other words, all the equipment is imported from abroad. However, the third-country procurement takes longer time and the procedure becomes complicated as it needs to go through all the steps, including transportation from the country of origin, customs clearance, domestic transportation, exporting to Sudan etc. Therefore, equipment for this project will be locally procured.

(2) Content

In addition to many VMW kits provided after the in-service training, maternity/child models were provided to the midwifery school in Phase 1. However, as some were damaged and a half were transferred to Central and East Darfur states, practical training at midwifery school has become difficult due to the shortage of equipment for practice. In SMAP-2, the necessary equipment will be procured to improve the effectiveness of in-service training so that the awareness of hygiene is improved and that the measurement of vital signs of pregnant women can be fully exercised. In the emergency case, patients are currently sent to the Family Health Unit/Center whereas many of these facilities are not fully equipped. Therefore, necessary equipment including basic furniture such as tables and chairs for waiting patients will be procured in Family Health Units/Family Health Centers located in the target community.

(3) Procurement method

The equipment will be procured in accordance with the JICA procurement guideline.

(4) SMOH's responsibility for equipment maintenance

The person in charge of equipment maintenance in SMOH will take full responsibility for the inspection and maintenance of the procured equipment. Due to the security concern, it is

difficulty for Japanese experts to attend the inspection. Therefore, all the necessary inspection procedures to check the quantity, exterior, and operation will be carried out at the presence of Japanese experts before they are transferred to the three Darfur states by air. Once the equipment is delivered to the site, the quantity and operation will be checked by the contractor and the responsible person in the site, and the delivery will be completed with the signed inspection document. Unlike SMOH, there may not be a logbook of equipment available in the recipient site. In this case, equipment maintenance staff at SMOH is expected to instruct the each site on the use of equipment logbook and its update.

12. Cost Estimation and Sharing Expenses

Note: The following cost estimation is tentatively proposed by consultants based on the discussion made during the planning workshop, and not officially approved by JICA.

(1) Cost estimation

The expenses for Component 1 (Pilot project, training, manual development etc.) will be USD 843,425, including USD 481,624 for pilot projects which accounts for 57% of the Component 1 total expenses. All the activities for Component 1 will be commonly carried out in each state, and consequently the cost is estimated equally among all three states.

(2) Sharing Expenses

Expenses for pilot projects will be shared both by JICA and the Sudanese government (State Government). The portion which the State Government will bear increases from 10% in the first year, to 15% in the 2nd year, 20% in the 3rd year, and 25% in the fourth year.

Table-6 : Sharing Expenses by JICA and the State Government

Institutions	Items to be shared
JICA	• Travel expenses for JICA experts, Expenses spent in Japan • Administration cost • Expenses for C/P training • Expenses for information system improvement, development of guideline and manuals
State Government/SMOH	• A part of pilot project expenses（The rate of sharing is set at 10% in the 1st year and increases by 5% every year to be 25% in the 4th year.）
Others（Federal Government ）	• Subsidies for training conducted in the government training center

Table-7 : Annual expenses for Component 1 and expenses sharing by the State Government

Unit : US$

	PY-1	PY-2	PY-3	PY-4	Total*
Pilot Project	107,240	113,811	138,030	122,543	481,624
Training	106,930	94,352	100,512	57,957	359,751
Development of Guidelines etc.	150	350	550	1,000	2,050
Total (A)	214,320	208,513	239,092	181,500	843,425
Amount of Activity Cost Shared by JICA (B)	203,586	191,425	212,356	151,059	758,426
Amount of Activity Cost Shared by 3 State Governments (C)	10,734	17,088	26,736	30,441	84,999
Ratio (C/A)	5%	8%	11%	17%	

13. Assumption and Risk Management

11-1. Assumption

(1) Precondition to the Implement the Project

- Security of project sites (including Khartoum) is not extremely worsened. (State Governments can implement activities)

(2) Assumption to Achieve Overall Goal

- Each state makes use of lessons learned and recommendation of pilot projects
- Each state makes use of the operational framework and its relevant documents developed or amended through project activities
- Pilot project, the operational framework and its relevant documents are consistent with federal and state policies
- Contents of pilot projects, the operation framework and its relevant documents are approved by State Governments
- Resources of State Governments or other development partners (budget/ equipment/ human resources, etc.) are continuously provided.

(3) Assumption to Achieve Project Purpose

- Experiences from project activities are accumulated as organizational knowledge.

(4) Assumption to Achieve Project Outputs

- The Federal government does not change development policy.
- Drastic organizational reform and personnel transfer do not occur.
-

11-2. Risk Management

In some parts of the target area of SMAP, armed conflict has been continuing and the security situation is very fluid. In this situation, the dispatch of Japanese experts to the project area is restricted and project is basically managed with remote communication. Thus, early detection of problems and prompt action to solve them is a key point of the successful project management. Otherwise, the problem could be more serious and prolonged. In practice, it is essential to assume predictable risks and decide countermeasures as well as to share the information and the decision with people concerned including counterparts.

As of 2014, the expected risks and countermeasures are listed in the next pages. However, such risk management is needed to be update during the project implementation.

Table-8: Risks and Countermeasures in SMAP

<Risks on Achievement of Overall Goal, Other Impacts and Ripple Effects (Common Issues among All Components)>

Categories	Risks	Responses
Human Resources	After the completion of the project, the activities supported by the project are at a standstill because of the personnel transfer, etc.	A. During the project period, the situation of personnel transfers in implementing organization is monitored. As a result of monitoring, the exit strategies and action plans in the next years after the project are developed, considering the human resources in the organization at the end of the project.
Organizational Structure	After the end of the project, the activities supported by the project are at a standstill because of the organizational transform or changes of implementing agencies.	A. During the project period, the situation of organizational transformation is monitored. As a result of monitoring, the exit strategies and action plans in the next years after the project are developed, considering the organizational structure after the end of the project.
Financing	After the end of the project, the activities supported by the project are at a standstill because of a shortage of financial resources including the change of budget allocation by the change of policy priority area.	A. During the four year project period, portion of Sudanese local component on total expenses for pilot projects is increased gradually. B. The possibility of collaboration with other development partners is sought. C. Exit strategies are developed by the end of the project in order to alleviate the negative influence of change of budget allocation by the policy change
Deterioration of security/ stability of political situation	Well–being (availability of public services, happiness of people living in Darfur, etc.) is reduced by deterioration of security and instability of political situation	Impossible to response
Negative impacts	Negative impacts on the natural environment are occurred.	A. It is examined in SMPC and JCC whether any concern is arisen or not. If confirmed, countermeasures are discussed in SMPC and JCC.
	Negative impacts on the social environment (land acquisition/ displacement of inhabitant) are occurred.	A. It is examined in SMPC and JCC whether any concern is arisen or not. If confirmed, countermeasures are discussed in SMPC and JCC.
	Negative impacts on well-being of people living in Darfur	A. It is examined in SMPC and JCC whether any concern is arisen or

	including the process of peace building and conflict prevention are occurred	not. If confirmed, countermeasures are discussed in SMPC and JCC.
Others	In spite of the fact that overall goal is achieved, the causal relationship between the project purpose and overall goal is not clarified.	A. During the project period, achievement, outcome, direct and indirect impacts are proactively documented and visualized.

<Risks on Achievement of Project Purposes (Common Issues among All Components)>

Categories	Risks	Responses
Peace Building & Conflict Prevention	Some groups of inhabitants complain of the project activities such as "the activities are not inclusive", "the activities do not take the peoples' needs into consideration", "the service is provided only to a certain group", etc.	A. It is examined in SPMC and JCC whether any complaints are reported among people in Darfur. If confirmed, appropriate measures such as change, amendment, or cancellation of activities are considered after the reason behind such complaint and dissatisfaction among inhabitants is analysed.
Change of Development Priority	Capacity development is excluded from development policy priorities.	Least likely to occur
	Federal or state governments establish a different definition of "capacity of the government" from the one defined by the project in federal or state development plan or strategies.	A. During the project period, the definition of "capacity" in federal or state development plan and strategies are monitored.
	Other development partner conducts a similar project and it causes confusion of the definition of "capacity of the government"	A. During the project period, the movement of other development partners is monitored with monthly report, SMPC and JCC. If necessary, consultation with other partners is conducted for the definition of "the capacity of the government" through the state governments.
Non-achievements of Project Purpose (Refer to the below for the issues of target of indicators)	Because planned outputs are not generated, the project purpose is not achieved. (Implementation failure)	*For risks in outputs, refer to the next page.
	In spite of the fact that planned outputs are generated, the project purpose is not achieved. (Theory failure)	A. Logic of PDM is re-examined. If necessary, the change or addition of the activities and inputs is made.
Target of Indicators for the Project Purposes	Before the end of project, it becomes clear that the achievement of project purpose is difficult. (It is recognized that target of indicators of project purpose is beyond the achievable level.)	A. The adequacy of indicators and their targets is re-examined. If indicators or their targets are found inadequate, they are amended. B. In the case that there is influence of unexpected factors on non-attainment of the project purposes, change of targets and addition of inputs and activities are discussed.
	Before the end of the project, the project purpose is achieved. (It is recognized that the target of indicators of the project purpose is too	A. The adequacy of indicators and their targets is re-examined. If indicators or their targets are found inadequate, they are

	low.”)	amended. B. In the case that there is influence of unexpected factors on achievement of the project purposes, change of targets and addition of inputs and activities are discussed.
Others	In spite of the fact that all outputs and project purpose are achieved, the causal relationship is not clarified.	

<Risks on Achievement of Outputs (Common Issues among All Components)>

Categories	Risks	Reponses
Deterioration of security and instable political situation	Activities or function of implementing agencies are stopped or declined due to the deterioration of security in state capital. (Deterioration of pre-condition of project implementation)	A. JCC is organized in three months if problems are identified, and countermeasures are discussed. The activities in state where the problems are happened can be cancelled with approval from JICA. B. Activities can be limited to the training of staff of implementing agencies, if necessary.
	Pilot projects are cancelled or delayed due to the deterioration of security in pilot sites.	A. SMPC is organized in three months after problems are recognized and it is discussed whether activities in certain sites are cancelled or not. If possible, alternative sites are selected in order to achieve planned outputs.
	Visiting state capital by Japanese experts becomes impossible due to the deterioration of security in the state capital. It becomes impossible for Japanese experts to directly provide guidance and training to implementing organizations.	A. Plan is developed based on the assumption that Japanese experts do not go to the State capital since the beginning. B. A field office is placed in the state capital and full-time staff is appointed for activity management. In addition, the capacity of the full-time staff is strengthened in order to substitute the role of Japanese experts.
	Visiting state capital by Japanese experts is limited due to the social dislocations after the presidential election in 2015 such as demonstration, etc.	A. If activities are delayed, plan of operation is amended as soon as possible and is shared with STC, SPMC, etc. B. Management skills and knowledge of local staff are trained so that they can manage activities in State
Occurrence of natural disaster such as draught, flood, etc.	Activities are cancelled or delayed due to the limited access to pilot sites or due to the change in the prioritization on the emergency relief beyond project activities.	A. SMPC is organized in three months if problems are identified, and it is discussed whether activities in certain sites should be cancelled or not. If possible, alternative sites are selected in order to achieve planned outputs.
	Activities are influenced by irregular rainy seasons. (Access to some pilot sites may be impossible in rainy season.)	A. The influence of rainy season on the activity is taken into consideration at the planning stage. (However, as for accessible pilot sites, plan includes activities that will be implemented during rainy seasons.(water sector)) B. The beginning and ending of rainy season are grasped and plan of operation is amended promptly, if necessary.
Theft of vehicle and equipment	Activities are stopped because of the theft of equipment and vehicles necessary for the activities.	

Communication	The lack of timely reporting and underreporting from implementing agencies to SMAP Project office due to the remote communication results in worsening the identified problem or delaying further in the project activity.	A. Developing monthly reports is ensured. The format of monthly reports is designed to be simple enough to easily fill out with essential information.
	Remote communication limits opportunities/ frequency of contact among States, and between implementing organizations and SMAP project office. As a result, understandings and consensus on the project scope can be diversified or fragmented, and then, a part of project activities can be delayed.	A. Project scope is confirmed repeatedly in SMPC and JCC. B. Project plan, rules, and other document related to the project scope are documented and shared among implementing agencies.
	Communication between SMAP project office and state implementing organization becomes excessively dependent on management staffs/ executive staff. As a result, the information is not flowed to the practical members. It makes the activities delayed and/or ineffective.	A. The periodical meeting in state implementing organization is conducted thoroughly. In each state capital, SMAP Field Coordinator is allocated to support the implementation of periodical meeting.
	Activities are delayed because of the gap between project activities and federal government policy in terms of implementation methods and contents.	A. Participation of Federal organizations in quarterly SPMC is ensured. Or, during the period of SPMC, the opportunity of the consultation with federal organizations is provided in order to secure the information sharing
Organizational structure	Activities are stopped or delayed due to the administrational reform, organizational change, personnel transfer of implementing organizations, etc.	A. Information about organizational change and personnel transfer is collected through monthly report for early detection. In a case that the transfer of a core member of activities occurs, the orientation for a new comer is provided by SMAP project office as soon as possible.
	Activities are delayed because of lack of coordination among relevant organizations (e.g. Waiting for approval, etc.) In particular, it might take more time for coordination in IDP camps.	A. Activities are adjusted based on the discussion not only with implementing agencies concerned, but also with different discussion channels such as SPMC, etc.
	In a case that implementation of a part of pilot project activities is outsourced to UN agencies, NGO, etc., activities or its effects are delayed or reduced due to the insufficient performance of outsourced organization.	A. The problem is solved at the early stage through the discussion between SMAP project office and the outsourced organization B. Plan of operation is amended if delayed.
Procurement of local contractor	The activities are delayed and its effects are reduced because of the shortage of skilled local contractors. (e.g. Construction of boreholes)	A. The inspection on procured equipment is conducted every year. In addition, training on procurement is provided in order to prevent problems.
Maintenance of	The activities are stopped or delayed because the repair of equipment	A. Equipment that can be locally maintained is selected.

procured equipment	and procurement of spare parts are not practiced timely with appropriate costs (e.g. the camera/ transceiver for borehole, etc.).	B. SMAP-2 supports the repair.
	Implementing organizations are not capable of fully utilizing procured equipment due to the lack of sufficient skills.	A. At the time of delivery, the training on the equipment use and maintenance is provided.
	The non-use of equipment lowers the effect because unnecessary equipment, or equipment with different specification, or damaged equipment due to the inappropriate inspection is procured.	A. Equipment that can be locally maintained is selected. B. SMAP-2 supports the repair.
Financial issues	Activities are delayed due to the delay in disbursing the budget.	A. The State Ministries of Finance are consulted for the early projection of disbursement timing.. B. SMAP project office lends the expenses temporarily.
	Activities are delayed and/or incomplete due to the shortage of budget of implementing organizations. (Facility or equipment)	A. The amount shared by implementing organizations is decided first, considering such possibility that the State Ministries of Finance cannot prepare a certain amount of local expenses all at once.
	Effects of training and efficiency of activities are reduced by low motivation of staff of implementing organizations that is induced by the delay of salary payment or the stop of salary increase.	A. Change of operation plan

<Risks and possible countermeasures in Component 1(Health)>

Category	Risk	Countermeasure
Not attaining the Project Purpose	The behaviour is not changed (Project Purpose) even though the activities are implemented as planned.	Activities will be reviewed and revised through regular monitoring and analysing the obstacles
Change in health issues	Delay in the progress of project activity due to the change in health issues as a result of worsening hygiene environment and security situation	Both FMOH and SMOH urgently check the situation. If the change in the priority of health issue is confirmed, the topics of community mobilization are reviewed and modified accordingly.
Communication	Delay in the progress of project activity due to the lack of smooth communication between SMOH Health Promotion Directorate and Reproductive Health Department	Communication method within the State will be reviewed and improved under the supervision of DG.
Organization structure	Delay in the progress of project activity because the Community Health Committee is wrongly abused for the political purpose	If any activity beyond the project purpose is confirmed through regular monitoring, Health Sector Technical Committee will have discussion with community leader and Community Health Committee to modify the objective of the activity. If there is no improvement seen, the activity will exclude strengthening of the function of Committee, only focused on the community mobilization activity done by VMW and CHWs or the target community might be changed.
	Community needs are not appropriately reflected into the activity because members of Community Health Committee are not inclusively selected	The minimum qualification to be the member of the committee will be determined in consideration of inclusiveness, and the composition of selected member will be reviewed once selection is made. If the unequal composition from a point of gender and ethnic balance is found, the re-selection will be recommended.
	Low functioning of Community Health Committee due to the internal conflict within the community	Under the supervision of DG, Pilot Project Management Team will check the situation with the community leader. If there is no improvement seen in the conflict, the activity will exclude strengthening of the function of Committee, only focused on the community mobilization activity done by VMW and CHWs or the target community might be changed.
Environment	Health Facility in the pilot community is closed down after the assistance from development partner/NGOs working in the community ends	If the possibility of closure is confirmed, the project will consult with SMOH to examine the possibility of management by SMOH and arrange necessary human resources. The cost sharing will be also discussed with the Community Health Committee to enable the maintenance of the facility.

Implementation structure	Ineffective implementation and monitoring of pilot projects as the assistance from other development partners becomes concentrated to SMOH Health Promotion and/or RH department.	The project will carefully assign the workload to avoid concentrating only on a part of the Pilot Project Management Team members under the supervision of DG. The duplication of activity will be avoided through information sharing with other development partners.

14. Work Plan and Deliverables

(1) Work Plan

The project activities in Component 1 will be implemented for the period of four years (Each project year starts in January and ends in December). The work schedule is as follows:

Work Plan

Project Implementation Period: Januay 2015～December 2018

Output	Activity	2015 (Jan–Dec)	2016 (Jan–Dec)	2017 (Jan–Dec)	2018 (Jan–Dec)
1	1-1 Establish Pilot Project Management Team at SMOH				
	1-2 Select pilot areas in consultation with stakeholders				
	1-3 Baseline survey and situational analysis of Pilot Projects				
	1-4 Prepare and review Community Mobilization Action Plan				
2	2-1 Identify training needs of SMOH				
	2-2 Develop a training program				
	2-3 Conduct training courses for capacity development of SMOH personnel				
	2-4 Provide Community mobilization training				
	2-5 Improve the functions of Community Health Committees in pilot areas				
	2-6 Implement activities with Community Health Committee				
	2-7 In-service training for VMW				
	2-8 Supportive supervision for VMW				
	2-9 Prepare activity reports, and organize regular meeting				
	2-10 Procure necessary equipment for management and PHC centers				
	2-11 Evaluate pilot projects				
3	3-1 Develop a case manual of good practice of community mobilization and sharing				
	3-2 Review current supportive supervision system and develop the improvement plan				
	3-3 Develop state Community mobilization strategy				
Training	2-3 Training courses for capacity development of SMOH personnel	CM refresher; SSV supervisor; CM additional; SSV skill	SSV skill; SSV skill; CM additional	SSV skill; SSV skill; CM additional	SSV skill; CM additional
	2-4 Provide Community mobilization training	CM/VMW・CHW; CM/community; CM additional	CM/VMW・CHW; CM/community; CM additional	CM/VMW・CI CM/community; CM additional	CM/VMW・CHW; CM/community; CM additional
	2-7 In-service training for VMW	skills development	inservice; skills development	inservice; skills development	inservice
Sector Technical Committee	Health Sector				
Expert	Project Management：Health(1)				
	Project Management：Health (2)				
	Community Mobilization／IEC material development				
Equipment	Community mobilization equipment				
	Supportive Supervision/VMW in-service training				
	PHCC center equipment				

(2) Deliverables

The schedule of final outputs and others made during the implementation period will be as follows:

Table-9 : Deliverables and Timing

Deliverables	Timing	Responsible person
Community mobilization materials (e.g. posters, drama, picture show etc.)	Every year	SMOH Health Promotion Director
Community mobilization operation manual	Every year	SMOH Health Promotion Director
State Community Mobilization Strategy	End of 4th year	SMOH Pilot Project Management Team
Supportive Supervision improvement plan	Every year	SMOH RH coordinator

15. Sustainability of Pilot Project

(1) Policy

The NHSPPII (2012-2016) developed based on the IPRSP (2012) aims at the PHC expansion including the community participation and empowerment, with the strategic objective of improving MCH and nutrition services. Darfur Development Strategy similarly aims at the improvement of access to the comprehensive health and nutrition services as well as the expansion of its use. The sustainability of the project can be considered as high at the policy level as the public services provided in SMAP-2 and the capacity building of government staff are highly related to the priority issues in the significant strategy of each sector (Health, water, and employment).

(2) Organization Structure of Implementing Agency

Not only the HCDG at federal level but also the Secretary General of three Darfur states, SMOH, SWC, SoME, and SMoF play a crucial role in this project. It is highly unlikely that these institutions get dissolved, considering the fact that they are the fundamental administrative organizations both at federal and state levels. Also, the drastic change within the responsible organization that provides universal public services through pilot projects, as well as the operational structure and the function of Community Health Committee at community level, are unlikely to occur. Therefore, the organization structure of the implementation agency is expected to be sustained even after the project, ensuring the utilization of the strengthened skills and knowledge.

(3) Capacity

SMAP2 conducts the training in parallel with pilot projects and the monitoring of training to make sure the necessary skills are effectively acquired. The areas of skills focused in SMAP-2,

namely planning, implementation, monitoring and evaluation, are highly versatile. In other words, these skills can be utilized in the improvement of various public services after the project. In addition, development of guideline and manuals by compiling the knowledge and lessons learned from the pilot projects is expected to ensure the continuity of knowledge and skills as organizational knowledge even if the transfer or resignation of the staff occurs.

(4) Finance

The Federal Government of Sudan is currently administrating the ultra-austerity budget. This has resulted in a huge decrease in the Development budget and the local allocation, whereas the Darfur region largely depends on the local allocation from the Federal Government and the financial assistance from the aid agencies (80-90%). As the improvement of this situation is beyond the scope of this project, the provision of public services using the state budget might not be financially possible. However, in response to this issue of financial sustainability, SMAP-2 focuses on the strengthening of budgeting and accounting capacity of the implementing agency so that the cost-effective services can be provided. In addition, the project evaluation and public finance management of SMoF is also included in the training so that the necessary expenses can be allocated to the important service despite the limited state budget. In this manner, it is expected that the implementing agencies can secure a certain amount of budget to effectively provide services after the end of the project.

Furthermore, it is necessary to consider the collaboration with other development partners, considering the continuity of service provision using the financial resources of other donors in order to maximize the effect of the project. As some of the pilot project activities are in common with those planned by other development partners and Darfur Development Strategy. Therefore, such coordination that considers the continuity between the pilot projects and the project of other development partners is important.

Appendices

1. JCC member list
2. Equipment procurement list
3. PDM of Component 1 (Health)
4. Shortlist of Pilot communities

Appendix-1. JCC member list

Joint Coordination Committee Composition (Tentative)

a) Chair person
   General Rapporteur, HCDG

b) Members
   Representative of Higher Council for Decentralized Governance
   Representative of State Ministries of Finance
   Representative of State Ministries of Health
   Representatives of State Water Cooperation
   Representative of State Ministries of Education
   Representative of State Employment and Entrepreneurship Promotion Committees
   Representatives of JICA Sudan Office
   Japanese experts for the project

c) Observers
   Representative of Federal Ministry of Finance and National Economy
   Representative of Federal Ministry of Health
   Representative of Drinking Water and Sanitation Unit
   Representative of Federal Ministry of General Education
   Representative of National Council for Technical and Technological Education
   Representative of Supreme Council for Vocational Training and Apprenticeship
   Representative of Darfur Regional Authority
   Representative of Embassy of Japan
   Representatives of Other Development Partners
   Others appointed by the Chairman

d) Japan Desk/ Secretariat of the Committee
   Higher Council for Decentralized Governance will assign appropriate number of staffs as Secretariat of the Committee. The Secretariat will coordinate matters pertaining to the administration of the Committee.

Appendix-2. Equipment Procurement List

No	Name	Quantity			
		North Darfur	West Darfur	South Darfur	Total
Midwifery school					
1	Stainless bowl	20	24	20	64
2	Thermometer	20	24	20	64
3	Fetalscope	20	24	20	64
4	Trousers for weight scale	10	12	10	32
5	Sphygmomanometer	10	12	10	32
6	Stethoscope (single)	10	12	10	32
7	Tape measure	10	12	10	32
8	Delivery Table	1	1	1	3
9	Midwifery practice model		1	1	2
10	Maternity model (child)		1	1	2
11	Puerperal uterine model		1	1	2
12	Pregnant Scale	5	6	5	16
13	Baby Scale	5	6	5	16
14	Working Table	5	6	5	16
15	Chair	20	24	20	64
16	Cabinet with key	2	2	2	6
VME In-service training					
1	Starter Kit (VMW)	60	60	60	180
Family Health Unit					
1	Thermometer	5	5	5	15
2	Fetalscope	5	5	5	15
3	Sphygmomanometer	5	5	5	15
4	Stethoscope (single)	5	5	5	15
5	Tape measure	5	5	5	15
6	Delivery Table	5	5	5	15
7	Pregnant Scale	5	5	5	15
8	Baby Scale	5	5	5	15

Appendix-3. PDM of Component 1 (Health)

Project for Human Resources Development for Darfur Phase II

Project Design Matrix (Health Component) (26th May 2014)

Project Period: January 2015 - December 2018

Target Group 1) People living in North Darfur state, South Darfur State, and West Darfur state
Target Group 2) Staff of Ministries of Health (SMoHs) of North Darfur state, South Darfur State, and West Darfur state

Ver.0

Narrative Summary	Indicators	Verification Measures	Important Assumption
Super Goal Strengthening peace and stability of three Darfur states through improvement of quality of life of people in three Darfur States			
Overall Goal Public well-being is enhanced in three Darfur States (*Well-being is defined as conditions where public happiness, public trust and public services are fulfilled for the people.)	**(Common indicators among three sectors)** o-1 Public happiness is increased o-2 Public trust on the government is promoted o-3 Satisfaction on public services is increased **(Component-specific indicators)** ho-1 Number of ANC provided by VMWs is increased in three Darfur states ho-2 Number of births attended by skilled-birth attendant (including VMWs) is increased in three Darfur states ho-3 Number of community referral is increased in three Darfur States ho-4 Healthy behavior (XXXXXXX etc.) is promoted in three Darfur states	Questionnaire survey/ focus group discussion Questionnaire survey/ focus group discussion Questionnaire survey/ focus group discussion Records/statistics of SMoHs Records/statistics of SMoHs Baseline survey/endline survey. Records/statistics of SMOHs Records/statistics of SMoHs	
Project Purpose 1) Community-based maternal and child health services considering public needs are inclusively provided in pilot project area 2) Institutional capacity of the State Ministry of Health (SMoHs) in the provision of community-based maternal and child health services is strengthened	**(Common indicators among three sectors)** p-1. Selection process of the pilot areas become inclusive (include the most conflict-affected people and community, etc. into target groups with consideration for coexistence) p-2. Recognition of implementing agencies on public needs is improved (Contacts with community is increased, attitude of implementing agencies to community people become responsive from neglective, etc.) p-3. Capacity (to make the services efficient, transparent and peace promotion) of service providers perceived by stakeholders is improved **(Component-specific indicators)** hp-1 Public satisfaction on selected health services is increased in pilot areas hp-2 Number of ANC provided by VMWs is increased in pilot areas hp-3 Number of births attended by skilled-birth attendant (including VMWs) is increased in pilot areas hp-4 Number of community referral is increased in pilot areas hp-5 Healthy behavior (XXXXXXX etc.) is promoted in pilot areas hp-6 Pilot Projects are repeatedly implemented as planned	360 degree survey with questionnaire Most Significant Change method 360 degree survey with questionnaire Most Significant Change method 360 degree survey with questionnaire Most Significant Change method Baseline survey/endline survey Records/statistics of SMoHs Records/statistics of SMoHs Baseline survey/endline survey. Records/statistics of SMOHs Survey Pilot Project Plan	
Output 1 Planning and coordination skills necessary to conduct pilot projects(community mobilization/Supportive supervision of VMW) in consideration of public needs and inclusiveness are improved	hop-1.1 Pilot Projects plan is prepared in consideration of public needs and inclusiveness hop-1.2 Overall annual plan of pilot projects is prepared every year and is reviewed more than X times a year	Project records	Policies of the Federal Ministry of Health and/or SMoHs regarding primary health care and maternal health care remain unchanged. Organization structure of State Government is not drastically changed.
Output 2 Skills and knowledge of SMoHs on the management of the pilot projects with awareness for public needs and inclusiveness are improved	hop-2.1 More than oo RH coordinators/HVs/AHVs/MA/SMOH(Health Promotion) receive technical training hop-2.2 More than oo VMW/CHW/CHP receive training hop-2.3 Number of VMWs who receive regular supervision is increased (at least oo times a year) hop-2.4 Satisfaction of VMWs who receive supervision is increased hop-2.5 Community Health Committee organize meetings more than oo times a year hop-2.6 Community mobilization activities are implemented more than oo times a year hop-2.7 More than oo persons participate in the activity hop-2.8 Skills, knowledge and awareness of SMoHs staff are improved	Training records of SMoHs Supportive supervision record of SMoHs Training records of SMoHs Questionnaire survey/ Training evaluation report of SMoHs Health promotion activity records of SMoHs Health promotion activity records of SMoHs Health promotion activity records of SMoHs Interview with SMoH staff	
Output 3 Operational procedure of pilot projects in SMOHs (supportive supervision and community mobilization) is improved for public needs and inclusiveness	hop-3.1 Good practice and lessons learned of pilot projects are compiled as a case manual in each state. hop-3.2 State Community mobilization strategy is developed in each state hop-3.3 Supportive supervision improvement plan is developed in each state	Developed case manual Developed state community mobilization strategy Developed supportive supervision improvement plan	
Activities (Output 1) 1.1 Establish Pilot Project Management Team at SMOH 1.2 Select pilot areas in consultation with stakeholders including State Water Cooperation 1.3 Conduct baseline study and situational analysis of community health (especially on MCH) activities and VMW supportive supervision 1.4 Prepare and review Community Mobilization Action Plan for MCH with Community Health Committee and supportive supervision implementation plan in discussion with stakeholders including FMOH (Output 2) 2.1 Based on activity 1.3, identify the training needs. 2.2 Check the available training programs and existing guidelines and manuals and develop a training plan. 2.3 Conduct training courses for capacity development of SMOH personnel (TOT training for RH coordinator/HV/AHV on Supportive Supervision, ToT for SMOH on Health Promotion, training for Capacity development of health staff in Health Centers). <Community mobilization> 2.4 Provide Community mobilization training (Training for CHW/VMW, Training for community health committees' core members). 2.5 Improve the functions of Community Health Committees in pilot areas in order to implement community mobilization activities(health education on MCH, community referral, etc) 2.6 Implement activities with Community Health Committee based on the Community Mobilization Action Plan <Supportive supervision> 2.7 Conduct necessary trainings (In-service training for VMW etc). 2.8 Conduct supervision for VMWs by supervisors <Management of pilot project> 2.9 Prepare activity reports of community mobilization and supportive supervision, and organize regular meeting. 2.10 Procure necessary equipment for management and PHC centers 2.11 Evaluate pilot projects (Activities related to Output 3) 3.1 Develop a case manual of good practice of community mobilization and share it with other stakeholders 3.2 Review current supportive supervision system and develop the improvement plan 3.3 Develop state Community mobilization strategy	**Input** 【JICA side】 1. Experts 2. Necessary equipment 3. Trainings in Japan and third countries 4. Operational cost	【Sudanese side】 1. Assignment of counterpart ① Health Sector Project Director ② Health Sector Project Manager ③ Health Sector Pilot Project Management Team members 2. Securing space, facility and equipment for project ① SMoHs facility ② Other equipment and materials necessary for trainings 3. Operational expenses to implement pilot activities (partly) 4. SMOH staff salary and allowance	Security situation does not worsening significantly

Appendix-4. Shortlist of pilot communities

【North Darfur】

NO	Name of community	Locality	Population number	Community health committee (yes or No)	Number of working VMW	Number of CHP	Any other donor agency or NGOs working in the same area if yes what they are doing?	Any risks to be considered (e.g. internal conflict, security)
1	Elfashiraboshok IDP	Elfashir	70,000	Yes	50	60	No	No
2	Golo	Elfashir-Rural	5,000	Yes	5	30	No	No
3	Shagrat	Elfashir-Rural	3,000	Yes	3	30	No	No
4	Azgrfah	Elfashir-Rural	3,000	Yes	2	20	No	No
5	Lwabed	Elfashir-Rural	2,100	Yes	1	20	No	No
6	Eltwesha	Eltwesha	50,000	Yes	1	30	No	No
7	Jabber	Eltwesha	20,000	Yes	5	30	No	No
8	Umjoribidah	Eltwesha	3,000	Yes	2	20	No	No
9	Kabkabia	Kabkabia	5,000	Yes	1	25	No	No
10	Wadah	Kalamido	3,000	Yes	5	30	No	No
11	Elkrdah	Omkdada	4,750	Yes	1	25	No	No
12	Donkey shtah	Elfashir-Rural	1,850	Yes	1	15	No	No
13	Abojera	Malat	2,350	Yes	1	25	No	No
14	Umhejlej	Alkoma	8,750	Yes	1	35	No	No
15	Khibish	Alkoma	2,855	Yes	1	20	No	No
16	Kodel	Malat	2,000	Yes	1	20	No	No
17	Wama	Malat	1,000	Yes	1	15	No	No
18	Kos kori	Malat	2,000	Yes	1	20	No	No
19	Kafot	Kutom	8,000	Yes	7	35	No	No
20	Tawelaroanda IDP	Tawela	20,000	Yes	3	40	No	No
21	Tawelaargo IDP	Tawela	25,000	Yes	3	45	No	No
22	Taweladali IDP	Tawela	2,000	Yes	2	35	No	No
23	Korma	Elfashir-Rural	10,000	Yes	3	35	No	No
24	Torah	Elfashir-Rural	3,500	Yes	2	25	No	No
25	Aineldes	Malat	3,000	Yes	2	25	No	No

*Communities highlighted in yellow are the priority areas identified by the SMOH. Communities in blue are the commonly selected communities both by Health and Water Sector.

【South Darfur】

NO	Name of community	Name of locality	Population number	Community health committee (yes or No)	Number of working VMW	Number of VMW who received inservice training	Number of CHW	Any other donor agency or NGOs working in the same area if yes what they are doing?	Any risks to be considered (e.g. internal conflict, security)
1	Mjook	Neyala	2,678	Yes	4	2	4	No	No
2	Abo ajora	Elslam	14,883	Yes	6	4	2	No	No
3	Klmah elgrya	Beleil	3,000	Yes	4	2	8	No	No
4	Jurf	Meshering	5,513	Yes	4	2	1	No	No
5	Baba	Beleil	3,960	Yes	4	2	2	No	No
6	Greidah	Greidah	33,603	Yes	19	17	4	Yes	No
7	Skli	Neyala	10,559	Yes	7	7	2	Yes	No
8	Mosay	Neyala	4,230	Yes	4	3	1	No	No
9	Beleil	Beleil	17,337	Yes	13	9	8	No	No
10	Elsafya	Elslam	11,552	Yes	5	4	2	Yes	No
11	Mohajreya	Elslam	4,750	Yes	3	2	1	No	No
12	Monwashi	Meshering	13,709	Yes	5	4	2	Yes	No
13	Merir	Nateigah	3,054	Yes	3	2	1	No	No
14	Um jnah	Eid elforsan	6,079	Yes	5	2	2	No	No
15	Drgalah	Eid elforsan	4,711	Yes	5	2	2	No	No
16	Um zalifa	Eid elforsan	5,529	Yes	5	2	2	No	No
17	Elmalm	Elwihdah	39,501	Yes	7	5	3	No	No
18	Um lbasah	Kubm	57,997	Yes	7	6	2	No	No
19	Kubm	Kubm	65,235	Yes	9	9	2	No	No
20	Tulus	Tulus	60,802	Yes	5	2	2	Yes	No
21	Kteila	Kteila	58,903	Yes	7	4	9	No	No
22	Elrihed elreaya	Rehid elbrdi	10,800	Yes	11	8	2	No	No
23	Um ksara	Meshering	2,014	Yes	2	1	1	No	No
24	Buram elraya	Buram	91,072	Yes	9	7	8	No	No
25	Wd hjam	Elradom	17,162	Yes	4	3	2	No	No

* Communities in blue are the commonly selected communities both by Health and Water Sector. In South Darfur, there is no such committee called Community Health Committee. The response “Yes” indicates the establishment of Service Committee, which instead organizes activities that meet community needs in the areas of health, education, and sanitation.

【West Darfur】

NO	Name of community	Name of locality	Population number	Community health committee (yes or No)	Number of working VMW	Number of CHW	Any other donor agency or NGOs working in the same area if yes what they are doing?	Any risks to be considered (e.g. internal conflict, security)
1	Eljnena	Eljenena	247,477	No	108	16	Isamic relief ,human relief – supporting IDPs clinics in ryiad and krendg 2	No
2	Bawri	Serba	39,709	No	5	2	No	No
3	Serba	Serba		No	24	2	No	No
4	Koma	Serba	1,131	No	14	2	No	No
5	Kendby	Serba	9,311	No	12	2	No	No
6	Abo seroj	Serba	5,018	No	9	2	No	No
7	Selea	Jbl moon	42,522	No	9	2	No	No
8	Hjeleja	Jbl moon	580	No	3	2	Concern –clinic support	No
9	Mjora	Jbl moon	580	No	2	2	Concern –clinic support	No
10	Abo remil	Jbl moon	633	No	4	2	Concern –clinic support	No
11	Gozamino	Kerinik	1,595	No	4	2	Concern –clinic support	No
12	Umtjok	Kerinik	9,514	No	12	6	International relief	No
13	Gendrni	kerinik	1,334	No	5	1	No	No
14	Hajer tama	kerinik	6,439	No	4	1	No	No
15	Rmlayh	kerinik	6,381	No	3	1	No	No

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