South Sudan
2013 CHF Standard Allocation Project Proposal

for CHF funding against Consolidated Appeal 2013

For further CHF information please visit http://unocha.org/south-sudan/financing/common-humanitarian-fund
or contact the CHF Technical Secretariat chfsouthsudan@un.org

This project proposal shall be submitted by cluster partners in two stages to the Cluster Coordinators and Co-coordinators for each project against which CHF funds are sought. In the first stage, before cluster defenses, applying partners fill sections I and II. The project proposal should explain and justify the activities for which CHF funding is requested and is intended to supplement information already available in the CAP Project Sheets. The proposals will be used by the cluster Peer Review Team in prioritizing and selecting projects for CHF funding during CHF Standard Allocation round. Partners should also fill and submit to cluster coordinator/ co-coordinator the CHF Project Summary (Annex 1). In the second stage projects recommended for funding by the CHF Advisory Board must complete Section III of this application and revised/update sections I and II if needed.

SECTION I:

CAP Cluster	**Health**

CHF Cluster Priorities for 2013 First Round Standard Allocation
This section should be filled by the cluster Coordinators/Co-coordinators before sending to cluster partners. It should provide a brief articulation of Cluster priority activities and geographic priorities that the cluster will recommend for funding from the CHF in line with the cluster objectives highlighted in the CAP 2013.

Cluster Priority Activities for this CHF Round	**Cluster Geographic Priorities for this CHF Round**
• Maintain the existing safety net by providing basic health packages and emergency referral services • Strengthen emergency preparedness including surgical interventions • Respond to health related emergencies including controlling the spread of communicable diseases ***(see chf 2013 R1 health cluster priorities description document for more details on specific supported activities)***	All states. Grossly underserved counties in the equatorial states (Western, Eastern and Central Equatorial)

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

Requesting Organization
CCM/CUAMM
Project CAP Code
SSD-13/H/55330/6931
CAP Project Title *(please write exact name as in the CAP)*
Ensuring health safety nets and EP&R to health needs of host, IDPs and returnees' communities in Greater Yirol (Lakes State) and Greater Tonj (Warrap State).

Project Location(s) (list State, and County (or counties) where CHF activities will be implemented. If the project is covering more than one State please indicate percentage per State)

State	**%**	**County**
LAKES	40%	Greater Yirol (Awerial, Yirol East, Yirol West)
WARRAP	60%	Greater Tonj (Tonj East, Tonj North, Tonj South)

Total Project Budget requested in the in South Sudan CAP	US$ 888,300
Total funding secured for the CAP project ***(to date)***	US$ 579,263

Funding requested from CHF for this project proposal	US$ 218,655

Are some activities in this project proposal co-funded?
Yes X No ☐ *(if yes, list the item and indicate the amount under column i of the budget sheet)*

Direct Beneficiaries *(Ensure the table below indicates both the total number of beneficiaries targeted in the CAP project and number of targeted beneficiaries scaled appropriately to CHF request)*

	Number of direct beneficiaries targeted in CHF Project	**Number of direct beneficiaries targeted in the CAP**

Indirect Beneficiaries

Target population is composed of communities living scattered, in remote/underserves areas and cattle camps, IDP/returnees' camps, with very poor or discontinuous access to basic services (73% reached by CCM, 27% by CUAMM). U5 (27% of the beneficiaries) and women in reproductive age (50% of the beneficiaries, out of which at least 6% pregnant) are the most exposed to epidemic outbreaks and health complications due to low quality health care, poor health/nutrition education and hygienic conditions, men-driven RH decisions and delayed emergency response. Other MARPs categories include HIV+/TB patients and victims of inter-clan clashes. Health prevention/raising awareness target mostly caretakers (including men) and opinion leaders (VHCs, HHPs,

Women:	36,960	153,500
Girls:	21,752	41,700
Men:	28,636	67,175
Boys:	21,752	41,700
Total:	109,100	304,075

community/religious leaders, local institutions) to promote safe health, hygiene and sanitation behaviors (at least 15% of the beneficiaries). Indirect beneficiaries count 485,000 people (70% of the population in the catchment area).

Catchment Population (if applicable)

Approximately 697,000 people, including IDPs and returnees.

Implementing Partner/s (Indicate partner/s who will be sub-contracted if applicable and corresponding sub-grant amounts)

Doctors with Africa – CUAMM

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

Indicate number of months: 6 months
Start date (mm/dd/yy): 04/01/13
End date: (mm/dd/yy): 09/30/13

Contact details Organization's Country Office	
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SECTION II

A. Humanitarian Context Analysis

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

Greater Yirol (Lakes State) and Greater Tonj (Warrap State) counties count together 626,304 natives (50% women, 50% men), 32,970 returnees (1,813 more organized returnees have been transferred by IOM to Yirol East county and 98 spontaneous returned have moved in Warrap State in the sole December 2012) and around 32,680 IDPs.

Yirol East and Awerial are marked by WFP as 'in food crisis', while the remaining counties (Yirol West and Greater Tonj) are 'stressed' (191,200 people expected in need for food aid in 2013). The area is highly exposed to seasonal floods, drivers of dramatic malaria and water-born diseases incidence, appalling hygiene conditions and movement constraints, preventing isolated households from accessing health services (Jun-Oct). On the contrary, the long dry season affecting availability of water sources and shrinking grazing grounds results into sub-tribal clashes, which raise the demand for emergency and frontline health services. Inter/intra ethnic fights and cattle raids have dramatically raised in 2012: 67 incidents with 125 deaths (106 only in Tonj East) have been reported. Tonj East is even currently seriously challenged by prolonged clashes due to cattle raids, causing more than 20 deaths and estimated 3,500 displaced only in January week 1 and 2 (OCHA/CCM). Also in Yirol East cattle raids in January 2013 caused already 3 deaths, 70 injured and mass-displacement (CCM). Insecurity and IDPs flow further hinder access to basic services for MARPs (U1, U5, P&LW, people living in remote areas) and congest the few functional health facilities. On top of this, in 2012 measles outbreaks erupted in Awerial and principles of outbreaks were reported in Tonj East and North. Poverty prevalence rate stands at 48.9% and lack of infrastructure, huge unemployment and poor safety nets further affect living standards.

General health data are dire:

- maternal mortality: 2,340/100,000 (GoSS 2011)
- neonatal mortality: 49/1,000 (GoSS 2011)
- U5 mortality: 114/1,000 (GoSS 2011)
- Average DPT3 coverage: 92% (the lowest: 31& in Tonj East, 61% in Yirol East and 63% in Yirol West) (GoSS 2012).

In both host and IDP/returnees' communities, P&LW and U5 are the most exposed to health emergencies due to inadequate PHC service coverage, scarce hygiene practices, cultural barriers and dependence on men for survival (poor prevention, late emergency referral). Almost 50% of the whole population (flood affected communities) can barely access facility-based services during the rainy season and massive scale-up of outreaches is required to ensure prepositioning of health supplies and minimum emergency response. As consequence of recurrent cattle-raids and clashes, IDPs flow congestions functional health facilities.

Both Greater Yirol and Greater Tonj health systems suffer from huge gap in qualified human resources, equipment, drugs and emergency referral means. RoSS Austerity Plan has shrunk MoH resources: in 2012 MoH staffing (HF and CHDs) remained unchanged from the previous year and quarterly drug supplies were provided with huge delays or in not adequate quantities. On top of it, populations' seasonal movements and extremely poor road network do hinder access and utilization of facility-based health services, which should be complemented by increased outreaches meant at tackling emergencies and/or reach remote communities for health preventive services (EPI, ANC/PNC, surveillance).

CCM/CUAMM 2012 annual data show relative good coverage in health safety net and emergency preparedness/response:

- U5 OPD: 92,205 (50% boys, 50% girls),
- Adult OPD: 219,328 (40% men, 60% female),
- Assisted deliveries (including CEmONC): 3,981
- ANC clients: 20,555
- Emergency surgical operations: 205.

Anyhow, CCM/CUAMM struggle to maintain the minimum level of quality service delivery, due to gaps in financial resources meant at ensuring EP&R, health surveillance, outbreaks control and emergency treatment/referral.

B. Grant Request Justification

Briefly describe (in no more than 500 words) the reasons for requesting CHF funding at this time. Explain how CHF funding will help address critical humanitarian gaps in your cluster. Explain the value added by your organization (e.g. geographical presence). Indicate if any other steps have been taken to secure alternative funding.

In Greater Yirol, CCM and CUAMM are the only SMoH partners, supporting integrated health & nutrition service delivery in 11 facilities (40% of all the existing facilities):

- Awerial: 1 PHCC (Bunagok) and 2 PHCUs (Awerial Centre and Mingkaman),
- Yirol East: 1 rural hospital (Adior) and 2 PHCUs (Pagarau and Thonabuktot),
- Yirol West: 1 county hospital (Yirol) and 4 PHCUs, (Pabur, Pandit, Anuol, Aruau)

Most of the remaining facilities in Greater Yirol are poorly or not functional due to lack of human resources, capacities, supplies and logistic support (all the catchment population refers exclusively to CCM/CUAMM supported facilities for health service delivery).

In Greater Tonj, CCM currently supports 18 facilities (50% of the existing facilities):

- Tonj East: Nabagok PHCC and 5 PHCUs (Ananatak, Kacuat, Kuelchuk, Paliang and Wunlit),
- Tonj North: Akop PHCC and 3 PHCUs (Aliek, Langkap, Rualbet),
- Tonj South: Thiet PHCC and 7 PHCUs (Mabior Yar, Malual Muok, Manhiel Thony, Jak, Aguko, Pankdit and Wan Alel).

In Tonj South CCM is the only SMoH partner in PHC service delivery, while in Tonj East and Tonj North additional facilities are supported by other IPs (WVI in Tonj East and Theso in Tonj North). Anyhow, still about 30% of the whole facilities in Greater Tonj

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

are not functional, which explains the high burden of the operational ones.

To meet the Minimum Standards in Health Services (SPHERE, 2004) standards) and set-up effectively EP&R system in the whole project catchment area, the following needs have been assessed: (i) expansion of safety nets, (ii) scaling up of outreaches, (iii) capacity building of PHCC/PHCUs to reduce the burden at hospital level, (iv) strengthening of the emergency referral mechanism and surgical capacities, (v) building institutional capacities in surveillance, data collection and M&E of performances.

Both CCM/CUAMM got funds (Crown Agents) to ensure continuation of PHC service delivery in the project catchment area until the start of the HPF (August 2013). Anyhow, the availed resources cover exclusively the ordinary health service provision and cannot be allocated to EP&R activities to face additional incumbent and recurring needs due to the consequences of floods (spread of malaria and water-born diseases), outbreaks (i.e. measles), assistance to victims of clashes (injured/wounded/traumatized and IDPs). This project proposal is exclusively meant at complementing available resources and ensuring that:

- drugs are timely prepositioned to flood-affected communities and IDPs,
- supported facilities are adequately provided with drugs, lab and medical supplies.
- health facilities with wider catchment area and/or emergency response capacities are staffed with the minimal essential cadres,
- local trained (not skilled) staff is on-the-job mentored to ensure effectiveness of diagnosis and treatment,
- the emergency referral system is improved and surgical capacities at hospital level are boosted,
- outreach services to under-served areas is expanded, focusing mostly on U5 and women in reproductive age.

Added values of the proposal are:

- Increased capacities in epidemiological surveillance, outbreaks investigations and response,
- Prevention and control of diseases outbreaks (i.e. malaria and measles),
- Integration with Nutrition program at facility level, according to MoH guidelines,
- Performing frontline primary health care, including improved emergency prevention services
- Strengthened hospital capacities to perform emergency surgical operations and widen patients' catchment area,
- Improved health referral system for local communities, IDPs and returnees,
- Enhanced health supervision and monitoring system, working closely with concerned CHDs.

Coordination between CCM/CUAMM and other stakeholders on the ground shall prevent overlapping and facilitate the search for synergies to provide an integrated response to health emergencies.

C. Project Description (For CHF Component only)

i) Contribution to Cluster Objectives

Briefly describe how CHF funding will be used to contribute to the achievement of the cluster priority activities identified for this allocation.

The overall objective of the project is to maintain Greater Yirol and Greater Tonj population's access to health safety nets, mostly focusing on underserved communities, marginalized groups, IDPs and returnees.

The project purpose is perfectly integrated within the Health Cluster strategy and is in line with the 3 Cluster priorities:

1. Maintain existing safety nets by providing basic health packages and emergency referral services,
2. Strengthen emergency preparedness including surgical interventions,
3. Respond to health related emergencies including controlling of communicable diseases.

Both static and outreach frontline health services are offered to the catchment population – focusing on women, girls/boys, people living under the poverty line, in flooded-remote areas, cattle camps, IDP/returnees' camps. Health emergency response (including 24/7 surgical capacities) is provided in Yirol Hospital serving Greater Yirol, while in Greater Tonj the referral system to county hospitals is enhanced.

ii) Project Objective

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

Specific objective of the project is to ensure continuity of essential health service delivery (safety nets) and adequate emergency preparedness and response capacities - including surgical intervention and EmONC - in all Greater Yirol and Greater Tonj through:

- The increase of 10% in the utilization rate of PHC at facility level in 6 months, including at least 15% increment in women's access (monthly baseline: 3,800 boys, 3,800 girls, 9,100 men, 9,100 women),
- the increase of 25% in the access to emergency health service in 6 months (monthly baselines: 17 emergency surgical operations);
- the increase of 25% in the number of referred patients in 6 months (monthly baseline: 40 referred patients);

For the objective and the identified expected results (see below) specific measurable indicators have been selected, most of which are indicated as Health Cluster priorities and/or are MoH requirements for health reporting since relevant to achieve the HSDP 2011 – 2015 targets, as well as health related MDGs.

The project timeframe (6 months) is adequate to meet the project objectives, since: (i) both implementing partners (CCM and CUAMM) are already operating and have functioning field bases in each target county; (ii) collaboration with institutional partners (Lakes MoH, Warrap State MoH and concerned CHDs in both states) has been established and is fruitful, (iii) health data confirm that the rainy season (June-October) in the project catchment area always turns into serious health emergency (malaria and water-born diseases outbreaks) which requires both preparation and response answer capacities.

iii) Proposed Activities

List the main activities to be implemented with CHF funding. As much as possible link activities to the exact location of the operation and the

corresponding number of direct beneficiaries (broken down by age and gender to the extent possible).

Output n. 1. Frontline health service provision to underserved host, IDPs and returnees' communities in Greater Yirol and Greater Tonj counties supporting 2 hospitals, 4 PHCCs and 23 PHCUs is ensured

1.1 Procurement/prepositioning and administration/informed distribution of essential/emergency drugs, non medical supplies to the facilities (i.e., IEHK/DDK kits to face infectious diseases outbreaks)
1.2 Ensuring continuous OPD services in all facilities and IPD service in hospitals/PHCC, including trauma management and serious cases' stabilization
1.3 Maintaining MISP in RH services (ANC/PNC, STIs, FP) and childhood disease integrated management in all supported facilities, especially to most vulnerable women and children (IDPs, returnees, victims of conflicts and violence)
1.4 Scaling-up EPI service provision in all supported facilities
1.5 Enforcement of mobile clinics (outreach services) to serve remote/IDPs/returnees populations in the 6 counties, offering comprehensive MCH services to most vulnerable (unaccompanied children, U5, P&LW, victims of conflicts)
1.6 Training and TA for local health staff of up to 29 facilities on: (i) epidemic preparedness/EWARN, (ii) management of communicable diseases, (iii) surveillance.

TARGET
- U5 consultation: 35,500 (50% men, 50% women)
- Adult consultations: 47,870 (50% men, 50% women)
- ANC clients receiving IPT2: at least 3,250
- Skilled attended deliveries: at least 705
- DPT3 (static and outreach): at least 3,600
- Trained facilities staff: 70 (at least 30% female)

Output n. 2 Effective response to emergencies, including health referral and surgical treatment, is ensured

2.1 Maintenance/strengthening of Yirol Hospital OT, Emergency Department, Surgical Wards to respond to emergencies
2.2 Maintenance/strengthening of blood bank at Yirol Hospital to support the OT ensuring the prompt management of hemorrhagic emergencies
2.3 Maintenance/equipment of PHCCs IPDs, maternity rooms and laboratories to enhance diagnosis/treatment/referral capacities
2.4 Upgrading Yirol West ambulance service and in Greater Tonj
2.5 On-the-job training of Yirol Hospital staff on surgical intervention, management and follow up of obstetric emergencies and neonatal complications
2.6 Training of PHCC/PHCU staff on emergency response and referral (first aid, triage, trauma management patients' stabilization);
2.7 Epidemiological surveillance and organization of health emergency response (i.e. mass vaccination campaigns)

TARGET
- Surgical emergency interventions: at least 100
- Emergency referrals: at least 250
- Emergency treatments (wounds/injured, burns, EmONC, blood transfusions): at least 3,360
- Measles vaccinations: at least 2,650
- Staff trained on emergency response and referral: 81 (at least 30% female)

Output n. 3 Health, Hygiene and Sanitation practices of host, IDPs and returnees' communities are enhanced and preventive health approach is promoted

3.1 Organization of daily health, hygiene & sanitation education sessions (prevention of communicable diseases/STIs/malaria, EPI, health seeking behavior, hygiene, mainstreaming HIV/AIDS related-issues) in all supported facilities, targeting caretakers (men and women);
3.2 Organization of workshops on health, hygiene and sanitation principles (including mainstreaming of HIV) targeting opinion leaders and peer-to-peer educators (i.e. VHCs, HHPs, religious/community leaders, teachers);

TARGET
- Community members reached by health education messages: 11,500 (at least 30% men)
- HHPS, VHCs and other leaders sensitized on safe health and hygiene practices: 150

Output n. 4 Enhancing IDSR, EP&R capacities and PHC system management in Greater Yirol and Greater Tonj is improved

4.1 Training/TA for CHDs on epidemiological surveillance, MoH DHIS/IDSR, e-warn systems;
4.2 Scale up of joint CHD/implementing partners' supporting supervision of health performances in each target county;
4.3 Participation to the Health Cluster coordination mechanism (state and national)
4.4 Facilitation of inter-cluster coordination at state and national level (WaSH, Nutrition and Food Security clusters).

TARGET
- CHD members capacity built: 14

iv). Cross Cutting Issues

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

DISASTER RISK REDUCTION is mainstreamed in all project components through the provision of basic health services for resident, IDPs and returnees' communities both at facility and outreach level, by implementing the following activities: (i) improving the emergency preparedness and control mechanisms, which will strengthen the current capacity of the PHCCs/PHCUs and CHDs to early detect and respond to any public health emergencies; (ii) maintaining the IPD within the PHCC; (iii) supporting the routine mass immunization for all children U5; iv) strengthening the referral system to the next level of care

ENVIRONMENT: (i) incinerators and placenta pits for hazardous waste management are in use and periodically maintained in all CCM-CUAMM supported facilities, (sharps, needles, syringes, blades and bottles) are incinerated while rests of waste are burned to

ash in the disposal pit (ii) the outreach teams shall be trained on how to manage the waste material produced during the outreaches visits, (iii) periodic maintenance will be regularly done on the ambulance and project vehicles as well as on HFs' generators, in order to limit the waste of fuel and related-emissions, (iv) most of the facilities hosting a cold chain system have a solar fridge and a solar panel system is set in all CCM Office/residence compound.

HIV: CCM/CUAMM will ensure that the universal procedures to prevent HIV and AIDS are respected and implemented, as well as that the staff is informed on HIV/AIDS prevention. Posters and leaflets will be distributed in the PHCC/PHCU. On top of it, implementing partners shall ensure: (i) mainstreaming of FP (including contraceptives distribution) in comprehensive RH services, (ii) promoting VCT and PMTCT services availed in Yirol Hospital (priority target: prisoners, soldiers, youths, P&LWs, TB/HIV positive persons), (iii) facilitating the counseling and referral of HIV positive patients to facilities where ARV treatment is available, (iv) including HIV/AIDS awareness messages in health education sessions at facility and community level, (v) guaranteeing universal precautions and safe blood supply during direct transfusions (surgery), (vi) managing the consequences of sexual violence, including provision of PEP and linking with protection cluster for client follow-up.

GENDER: (i) equal opportunity of accessing the health services offered by the involved HFs will be ensured to both male and female patients; (ii) mobile clinic service in the most remote areas and critical contexts (as returnees and IDPs camps) will facilitate women in accessing health care, as they are usually more penalized by HFs distance because of their home care duties and of some traditional rules regulating their movements; (iii) reproductive health enhancement as one of the project's targets. Moreover, women will play a great role in the successful implementation of the project activities through: (i) active participation of the female health staff in the health activities, including outreach and health education sessions, (ii) involvement of women's CBOs in the catchment area to valorize women's skills and capacities (mediation, knowledge of the context, pear-to-pear communication, etc.), promote gender balance in RH and FP decision-making and to make health promotion and sensitization more effective.

CAPACITY DEVELOPMENT: theoretical and on the job trainings, workshops and coordination meetings involving both health personnel and institutional partners (State and County level) have been included as main project activities to concretely enforce the early warning and health emergency risk reduction and ensure adequate sustainability to the project. The identified implementation modalities (see below) envisage and pursue full and active involvement of the institutional stakeholder in the project follow up and consistent monitoring, as well as in the regular info and data sharing with other stakeholders to better coordinate emergency response and manage integrated resources. As far as health personnel is concerned, when availability of qualified health staff is limited, also the task shifting approach (endorsed by WHO), backed by continuous supportive supervision is pursued.

v) Expected Result/s

Briefly describe (in no more than 300 words) the results you expect to achieve at the end of the CHF grant period.

The project is aimed at achieving 4 main results, which are strictly linked to the overall and specific objectives of the project and which the above mentioned activities stem from:

1. Frontline health service provision to underserved host, IDPs and returnees' communities in Greater Yirol and Greater Tonj counties, supporting up to 2 hospitals, 4 PHCCs and 23 PHCUs in ensured
   - all supported facilities are properly equipped, staffed and provided with essential drugs for emergency EP&R,
   - all the supported facilities have functional OPD/IPD, MISP for RH and EPI services, with scaling-up capacities in case of emergency,
   - IDPs, returnees and isolated communities are reached by mobile clinics,
   - Local staff is trained on (i) epidemic preparedness/EWARN, (ii) management of communicable diseases, (iii) surveillance.

2. Effective response to emergencies, including health referral and surgical treatment, is ensured:
   - Yirol Hospital emergency and surgical capacities are boosted (including blood transfusions),
   - Emergency referrals system in the whole project catchment area is enhanced,
   - Yirol Hospital staff is trained on surgical intervention, management and follow up of obstetric emergencies and neonatal complications.
   - PHCC/PHCU staff is trained on emergency response and referral (first aid, triage, trauma management patients' stabilization);
   - Timely response to possible outbreaks id provided (namely via mop ups, mass campaigns, based on needs),

3. Health, Hygiene and Sanitation practices of host, IDPs and returnees' communities are enhanced and preventive health approach is promoted
   - Community members (men and women, including IDPs and returnees) are sensitized on safe health and hygiene practices,
   - Key opinion leaders (HHPs, VHCs, traditional/religious leaders) are awareness-raised on safe health and hygiene practices and involved as peer-to-peer educators.

4. IDSR, EP&R capacities and PHC system management in Greater Yirol and Greater Tonj are improved
   - Concerned CHDs capacities in surveillance, DHIS/IDSR reporting and e-warn systems are strengthened,
   - Participation to the Health and inter-Cluster coordination mechanisms at State and National level is ensured.

List below the output indicators you will use to measure the progress and achievement of your project results. At least three of the indicators should be taken from the cluster defined Standard Output Indicators (SOI) (annexed). Put a cross (x) in the first column to identify the cluster defined SOI. Indicate as well the total number of direct beneficiaries disaggregated by gender and age.

SOI (X)	#	Output Indicators (Ensure the output indicators are consistent with the output indicators that will be used in the results framework section III of this project proposal).	Target (indicate numbers or percentages) (Targets should be disaggregated by age and sex as per the standard output indicators list and add-up to the number of direct beneficiaries identified page 1)
	1.	number of >5 consultations (male and female)	Greater Yirol: 25,870 (at least 50% women) Greater Tonj: 22,000 (at least 50% women)
	2.	number of <5 consultations (boys and girls)	Greater Yirol: 19,100 (50% boys, 50% girls)

			Greater Tonj: 16,500 (50% boys, 50% girls)
	3.	Number of measles vaccinations given to under 5 in emergency or returnee situation	Greater Yirol: 1,100 Greater Tonj: 1,550
	4.	Number of births attended by skilled birth attendants	Greater Yirol: 645 Greater Tonj: 60
	5.	Number of antenatal clients receiving IPT2 second dose	Greater Yirol: 2,250 Greater Tonj: 1,000
	6.	Number of health workers trained in MISP / communicable diseases / outbreaks / IMCI / CMR	Greater Yirol: 35 Greater Tonj: 35

vi) Implementation Mechanism

Describe planned mechanisms for implementation of the project. Explain if it is implemented through implementing partners such as NGOs, government actors, or other outside contractors.

Project implementing partners are the INGOs CCM (Comitato Collaborazione Medica) and CUAMM – Doctors with Africa, respectively Lakes SMoH partners for health care service provision in Awerial/Yirol East and Yirol West counties (11 facilities supported: 3 in Awerial, 3 in Yirol East, 5 in Yirol West). CCM also is Warrap SMoH partner in Greater Tonj (18 facilities supported: 6 in Tonj East, 4 in Tonj North, 8 in Tonj South). CCM/CUAMM share similar vision/mission, core sectors of intervention and have operational MoU signed with concerned SMoH for supporting the provision of integrated primary/secondary health care and nutrition services in the respective catchment areas. Strengthening local health system through collaboration with stakeholders and researching for synergies, preventing duplications or establishment of parallel health/nutrition structures, are CCM/CUAMM pillars in programme planning and implementation. Both CCM/CUAMM are registered INGOs in SS and acknowledged also by the national MoH. At local level, smooth collaboration with CHD and other local institutions (Counties Manager, RRC Office, Commissioner, etc.) is already in place.

CCM/CUAMM partnership ensures effective coordination in maintaining frontline basic health safety nets in primary health service provision as well as timely answer to health emergency and/or emergency referral for life saving interventions. Existing coordination to enhance the referral system, build CHD capacities and raise community awareness on preventive health and outbreaks control shall be strengthened and targeted actions shall be planned to answer the needs, which shall have been identified. Expansion of outreaches, enforcement of effective referral system and focus on awareness raising for preventive health practices are meant at widening population access to and utilization of health safety nets services, as well as to expand the surveillance capacities.

The project design is based on sound collaboration among CCM/CUAMM, health institutions at state and county level, other stakeholders (OCHA, WHO, UNICEF, UNFPA, other INGOs CBOs). In order to ensure proper coordination, adherence to the activity plan and capacity of prompt project adjustments (when required), 2 project coordination bodies will be purposely established and meet on regular basis to ensure achievement of expected results:

- MANAGEMENT COMMITTEE (one per county): Composed of CHDs Manager and CCM/CUAMM Project Managers, the MC will meet on monthly basis in each county and will be responsible for: (i) defining/consolidating/readjusting the work plan, (ii) sharing information and data on the activities carried out and in pipeline, (iii) debating possible project implementation challenges and identifying the related way forward, (iv) providing technical assistance in the project supervision, (v) consolidating quarterly project reports, (vi) representing the Project board in front of local stakeholders and when project-related decisions are taken.
- STEERING COMMITTEE (one per State): Composed of Lakes/Warrap State MoH DG (or his/her delegate), CCM/CUAMM Country Representatives in South Sudan (or his/her delegate), the SC will meet on quarterly basis and will be responsible for: (i) supervising the general project implementation and provide related feedback/advice to the Management Committee, (ii) facilitating integration of the project with other health activities in the catchment areas, (iii) linking with other stakeholders at federal and state level (Nutrition & Health Clusters, WaSH clusters, UNFPA, WHO, UNICEF, other INGOs, etc.) to facilitate the project implementation and promotion.

vii) Monitoring and Reporting Plan

Describe how you will monitor and report on the progress and achievements of the project. Notably:

1. Explain how will you measure whether a) Activities have been conducted, b) Results have been achieved, c) Cross-cutting issues have been addressed, and d) Project objectives have been met
2. Indicate what monitoring tools and technics will be used
3. Describe how you will analyze and report on the project achievements
4. Ensure key monitoring and reporting activities are included in the project workplan (Section III)[2].

CCM/CUAMM shall ensure continuous monitoring of project activities by:

- EFFECTIVE REPORTING SYSTEM: (i) compilation of daily/weekly/monthly health facility registers, (ii) compilation of outreach reports, (iii) compilation of monthly and quarterly reports for concerned CHDs and State MoH (DHIS reporting tools), (iv) compilation of quarterly progress report for the SC and the donors, (v) monthly and quarterly reports to HQ project department. With regard to data collection and analysis, utilization of DHIS shall ensure integration of project data within the MoH reporting system.
- QUALIFIED TECHNICAL ASSISTANCE: both implementing partners have envisaged employment of technical human resources skilled in Health and emergency related programme management and supervision, responsible for assisting local health staff at both facility and outreach level. They will be based in each main project location and will ensure daily supervision of the quality of the services provided and consistency of data collected.
- M&E OFFICER: CCM staff includes M&E officer based in SS Head Office (Juba), who will be responsible of periodic visits in the project areas, to check about indicators, targets and performances. The same role will be played by CUAMM Country

[2] CHF minimum narrative reporting requirements will include the submission of a final narrative report and where applicable a narrative mid-term report. Narrative reports will include a progress on the project achievements using the outputs indicators listed in this project proposal.

Manager;

- EXTERNAL MONITORING: implementing partners will share periodical information and data on the project implementation with Health Cluster focal persons both at Lakes State and federal level, to compare views and get additional inputs and comments.
- STEERING COMMITTEE & MANAGEMENT COMMITTEE: among the SC ToR, supportive supervision and technical assistance to the MC throughout the project implementation is included. The MC shall utilize the project logical framework and work plan as primary tools to assess project performances, achieved versus expected results/targets and respect of the timeframe;
- EFFECTIVE FINANCIAL MONITORING SYSTEM: (i) CCM accounting systems is based on the double-entry system, which records transactions into journals and ledgers. Daily transactions, including purchases, cash receipts, accounts receivable and accounts payable are recorded using a specific accounting software which is reconcile on a weekly/monthly basis under the supervision of HQ administrative department; II) Budget follow-up are elaborated and approved by HQ project department together with the request for funds (ii) procurement plan is elaborated at the begin of the project and review on a quarterly basis with the support and supervision of HQ procurement officer; III) compilation of financial report is elaborated by CCM/CUAMM country administration with the support of a Project accountant and subsequently approved by HQ administrative department.

E. Total funding secured for the CAP project
Please add details of secured funds from other sources for the project in the CAP.

Source/donor and date (month, year)	**Amount** (USD)
CUAMM (Yirol West - Lakes). Donors: Italian Ministry of Foreign Affairs, UNICEF, EU	191,803 USD
CCM (Awerial and Yirol East – Lakes). Donors: Crown Agents	167,460 USD
CCM (Greater Tonj – Warrap). Donors: UNICEF, Crown Agents	220,000 USD

F. Budget Guideline

Each CHF project proposal must include a budget which details the costs to be funded by CHF. The budget should reflect activities described in the project narrative, and include sufficient detail to provide a transparent overview of how CHF funds will be spent. Budget lines should be itemized including quantity and unit prices of items to be procured whenever possible.
Use the annexed excel sheet to fill the budget ensuring it strictly adheres to CHF budget guidelines hereafter. These guidelines provide guidance on budget category description (section i), type of budgetary information required (section ii) and guidance on Direct and Indirect costs (section iii)

Note i) Description of Budget Categories

1. RELIEF ITEMS and TRANSPORTATION	NOTES
• Direct operational input including the procurement of consumable supplies for project implementation (e.g. drugs, food, NFIs, seeds, tools, etc.); and related costs of transportation and handling.	• Breakdown by line item and indicate unit/ quantity/ cost per unit • Provide itemized description for those without quantity/cost per unit • If relief items are received from pipeline or other sources please list the items and indicate the amount under column i "Other funding to this project including in kind". • Cost for supplies should be presented separately from cost of transport in the budget sheet.
2. PERSONNEL	
• Organization staff costs and entitlements involved in the implementation of the project (programme and support staff)	• Provide detailed description of Responsibility/title, post location, quantity and the percentage of full time equivalent (FTE) dedicated to the CHF project • Indicate the percentage dedicated to the CHF project. • Do not include consultancies with firms or agreements with implementing partners (which go under Category 5 Contracts)
3. STAFF TRAVEL	
• Costs incurred for the travel of staff members	• Provide detailed description of staff members (title, post location) • Provide breakdown of all costs (frequency, amount and number of staff)
4. TRAINING WORKSHOPS/SEMINARS/CAMPAIGNS	
• Only training directly related to implementation of the project to be included (counterparts and staff members)	• Describe type of training, number of participants, location, duration, unit cost • Provide breakdown of costs incurred during each of the training
5. CONTRACTS	
• Specialized services provided to the project by an outside contractor including groups, firms, companies, and NGOs (e.g. printing press, consultancy firms, construction companies)	• Depending on type of contract and services provided- the budget line should be itemized • Give itemized breakdown of pass-through funding for each Implementing Partner
7. VEHICLE OPERATING AND MAINTENANCE COSTS	
• This budget line includes the purchase/rental of vehicles directly serving the implementation of the project	• Rental of vehicles and maintenance could be a paid on a monthly basis (Lump Sum) or $/kilometer • Provide breakdown by item/activity, location, quantity, unit cost
8. OFFICE EQUIPMENT AND COMMUNICATION	
• Procurement of non-consumables (telecom equipment, IT equipment, office supplies, etc.) • Office rent and fuel for the generators, utilities (telephone, water, electricity etc)can be included in this budget line	• Provide breakdown by item/activity, location, quantity, unit cost • Other office supplies that cannot be itemized can be indicated as lump sum (LS)
9. OTHER ADMINISTRATIVE COSTS	
• Other costs related to the project not covered by the above such as bank transfer charges, courier charges,. etc	• Provide itemized description of costs if not possible to breakdown by unit/quantity/cost per unit
OVERHEAD/PROGRAMME SUPPORT COSTS (PSC)	
• To cover PSC at HQ/regional and country level.	• PSC not to exceed 7% **of subtotal** project costs
AUDIT Costs	
• NGOs are required to budget at least 1% of total project cost for audit, UNDP/TS will contract external audit	
11. GRAND TOTAL COSTS	
• The total of project costs	• The Sum of subtotal project costs, PSC and Audit.

Note ii) type of budgetary information required

(a) Items Description: Provide a brief description of items required to implement the project.
(b) Location: The place where the cost is incurred. This column is key to determine the Direct and Indirect nature of the budget line in column c.
(c) Cost Type (I or D): Indicate if a budget line is D (direct) or I (indirect). See Notes iii) below for guidance on how to determine the cost type.
(d) Unit of measurement: indicate the unit used to measure the budget line. e.g months, tonnage, pieces etc
(e) Percentage/full-time-equivalent (FTE): indicate the percentage or FTE that CHF will cover.
(f) Quantity: the amount in relation to the unit of measurement, such as number of people, number of months etc
(g) Unit Cost: the cost of one item.

(h) Total CHF Cost: the sheet automatically calculates once column e, f and g are filled in
(i) Other funding to this project including in kind: indicate if there is any other funding or resources (cash or in-kind) received toward activities of this project. e.g supplies received from the pipelines.

Note iii) Guidance on Direct and Indirect Costs

1. RELIEF ITEMS and TRANSPORTATION

- If relevant to the project all cost fall under **direct** cost
- Cost for supplies should be presented separately from cost of transport in the budget sheet

2. PERSONNEL

Direct costs:

- All Staff costs, including entitlements, of personnel **directly** involved in the implementation of the project and based at project location. *(Remember to provide in the budget a detailed description of staff members title & post location.)*

Indirect costs:

- All Staff costs and entitlements of personnel not directly involved in the implementation of the project (Juba/other state capital headquarters staff). (*For Juba/ other state capital HQs staff, charged to the project please provide in the budget a detailed description of staff members title, location and percentage of time devoted to the project and equivalent dollar amount. For example for an M&E officer at Juba level, devoting 10% of his/her time for six months, the row will be filled as follows:*

Item Description	Location	Cost type (Direct or Indirect)	Unit of measurement	Percentage/ FTE	Quantity	Unit Cost	**Total**
One M&E officer	Juba	I	months	10%	6	1,200	**720**

Please note, the budget sheet will automatically calculate the total cost.

3. STAFF TRAVEL

Direct costs:

- Travel cost of staff **directly** involved in the implementation of the project (staff based at project area) are direct. Please specify in the budget line where from and where to is travel intended.

Indirect costs:

- Travel cost for support staff not directly involved in the implementation of the project (e.g. headquarters staff travelling on mission to the project location).

4. TRAININGS, WORKSHOPS, SEMINARS, CAMPAIGNS

Direct costs:

- All costs of training, workshop, seminars and campaigns if they are directly related to the outcome of the project (e.g. mobilization campaign to promote hygiene and sanitation; training of nurses on safe delivery). *(Remember to describe in the budget the type of training, the number of participants, location and duration of the training).*

5. CONTRACTS

- All costs under contracts fall under **direct.** Please remember to provide a description of the services provided.

6. VEHICLE OPERATING & MAINTENANCE COSTS

Direct costs: if related to vehicles used at the project implementation area

Indirect costs: if related to vehicles outside project areas (e.g. vehicle cost in Juba for a project being implemented in Bor)

7. OFFICE EQUIPMENT & COMMUNICATIONS

Direct costs:

- If items/service is used at the project implementation area

Indirect costs:

- If items/service is used outside of the project implementation area (e.g. Cost of services in Juba Country Office for a project being implemented in Bor).

8. OTHER COSTS (bank charges, …)

Direct costs:

- If items/service is used at the project implementation area costs

Indirect costs:

- If items/service is used outside of the project implementation.
- Visibility is considered Indirect cost.

9. Programme Support costs (Indirect cost)

10. AUDIT COSTS for NGO implemented projects (Indirect Cost)

SECTION III:

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

The logical framework is a tool to present how the implementation of CHF funded activities and their results (outputs and outcomes) will contribute to achieving higher level humanitarian results (project and cluster objectives) and how these results will be measured.
Fill in the logical framework below for this project proposal ensuring the information provided is in accordance with the strategies and activities described in the narrative section of this proposal, in particular section C.

LOGICAL FRAMEWORK		
CHF ref./CAP Code: SSD-13/H/55330/6931	**Project title:** Ensuring health safety nets and EP&R to health needs of host, IDPs and returnees' communities in Greater Yirol (Lakes State) and Greater Tonj (Warrap State)	**Organisation:** CCM – Comitato Collaborazione Medica (in conjunction with Doctors with Africa CUAMM)

	Cluster Priority Activities for this CHF Allocation: *What are the Cluster Priority activities for this CHF funding round this project is contributing to:*	**Indicators of progress:** *What are the key indicators related to the achievement of the CAP project objective?*	**How indicators will be measured:** *What are the sources of information on these indicators?*	
Overall Objective	• Maintain the existing safety net by providing basic health packages and emergency referral services • Strengthen emergency preparedness including surgical interventions • Respond to health related emergencies including controlling the spread of communicable diseases	- Basic health packages and emergency referral services maintained and fully functional in 100% of the supported facilities (2 hospitals, 4 PHCCs and 23 PHCUs); - Incidence rates for selected communicable diseases relevant to the local context (malaria, measles, ARI, diarrhea, etc) are decreased - Health emergency successful treatment rates do improve	- Quarterly Narrative project reports for donors and WSMoH, - Quarterly Technical Performance reports for donors and SMoHs, - Monthly DHIS/HMIS data - Weekly IDSR data	

Purpose	**CHF Project Objective:** *What are the specific objectives to be achieved by the end of this CHF funded project?* To ensure continuity of essential health service delivery (safety nets) and adequate emergency preparedness and response capacities - including surgical intervention and EmONC - in all Greater Yirol and Greater Tonj.	**Indicators of progress:** • *What indicators will be used to measure whether the CHF Project Objectives are achieved. Indicators may be quantitative and qualitative* - Utilization rate of PHC at facility level increased of 10% by the end of the project, (at least 15% increment in women's access (monthly baseline: 3,800 boys, 3,800 girls, 9,100 men, 9,100 women), - The access to emergency health service increased of 25% by the end of the project (monthly baselines: 17 emergency surgical operations); - The number of referred patients increased of 25% by the end of the project (monthly baseline: 40 referred patients);	**How indicators will be measured:** *What sources of information already exist to measure this indicator? How will the project get this information?* - Final project report; - Consolidated official health data from concerned SMoHs and CHDs; - Other data sources (OCHA, IOM, etc.)	**Assumptions & risks:** *What factors not under the control of the project are necessary to achieve these objectives? What factors may get in the way of achieving these objectives?* • Internal and cross-borders political stability; • Stable economic conditions, • Institutional willingness to effectively target emergencies; • No movement restrictions for implementing partners
Results	**Results - Outcomes (intangible):** *State the changes that will be observed as a result of this CHF Project. E.g. changes in access, skills, knowledge, practice/behaviors of the direct beneficiaries*. 1. Frontline health service provision to underserved host, IDPs and returnees' communities in Greater Yirol and Greater Tonj counties, supporting up to 2 hospitals, 4 PHCCs and 23 PHCUs in ensured 2. Effective response to emergencies, including health referral and surgical treatment, is ensured, 3. Health, Hygiene and Sanitation practices of host, IDPs and returnees' communities are enhanced and preventive health approach is promoted 4. IDSR, EP&R capacities and PHC system management in Greater Yirol and Greater Tonj are improved	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged outcomes?* Monitoring of progress towards meeting the total expected beneficiaries: • Women: 36,960 • Men: 28,636 • Girls: 21,752 • Boys: 21,752 Out of the total 109,100 beneficiaries: - 90,995 (83,4%) will have access to frontline health services (Outcome 1) - 6,441 (5,9%) will have access to emergency health services, including surgical emergencies (Outcome 2) - 11,650 (10,6%) will be sensitized on Health, Hygiene and Sanitation (Outcome 3) - 14 (0,02%) are CHD members capacity built on EP&R (Outcome 4)	**How indicators will be measured:** *What are the sources of information on these indicators?* • DHIS reporting system; • EPI reports • Training reports and attendance sheets	**Assumptions & risks:** *What factors not under the control of the project are necessary to achieve the expected outcomes? What factors may get in the way of achieving these objectives?* - Collaboration of concerned State and local institutions (SMoHs, concerned CHDs, HIV/AIDS Commission, etc.); - Conducive environment for INGOs in the project counties; - Collaboration from other stakeholders (UN agencies, other IPs and in Nutrition/WaSH, returnees' sectors),

	Immediate-Results - Outputs (tangible): *List the products, goods and services **(grouped per areas of work)** that will result from the implementation of project activities. Ensure that the outputs are worded in a manner that describes their contribution to the outcomes.*	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged outputs?* *Ensure the indicators identified in Section II (v) of this proposal are adequately inserted in this section.*	**How indicators will be measured:** *What are the sources of information on these indicators?*	**Assumptions & risks:** *What factors not under the control of the project are necessary to achieve the expected outcomes? What factors may get in the way of achieving these objectives?*
	For Outcome n. 1: - all supported facilities are properly equipped, staffed and provided with essential drugs for emergency EP&R, - all the supported facilities have functional OPD/IPD, MISP for RH and EPI services, with scaling-up capacities in case of emergency, - IDPs, returnees and isolated communities are reached by mobile clinics, - Local staff is trained on (i) epidemic preparedness/EWARN, (ii) management of communicable diseases, (iii) surveillance.	For Outcome n. 1: - U5 consultation: 35,500 (19,000 in GY and 16,500 in GT) (50% men, 50% women) - Adult consultations: 47,870 (25,870 in GY and 22,000 in GT) (50% men, 50% women) - ANC clients receiving IPT2: at least 3,250 (2,250 in GY + 1,000 in GT) - Skilled attended deliveries: at least 705 (645 in GY + 60 in GT) - DPT3 (static and outreach): at least 3,600 - Trained facilities staff: 70 (at least 30% female)	For Outcome n. 1: - Health facilities patients' registers (daily, weekly, monthly), - Health facilities drug consumption registers (daily, weekly, monthly), - Health facilities monthly and quarterly reports (DHIS, EPI, MCH, Malaria sentinel report), - Outreach registers, - Training attendance sheets.	For Outcome n. 1: - Concerned SMoHs honour the provisions of the MoU signed with CCM and CUAMM for collaboration in Primary and Secondary Health Service provision in selected counties of Warap and Lakes State, - Project funds are timely availed - Local communities, IDPs and returnees do acknowledge and are willing to access/utilize hospital services
	For Outcome n. 2: - Yirol Hospital emergency and surgical capacities are boosted (including blood transfusions), - Emergency referrals system in the whole project catchment area is enhanced, - Yirol Hospital staff is trained on surgical intervention, management and follow up of obstetric emergencies and neonatal complications. - PHCC/PHCU staff is trained on emergency response and referral (first aid, triage, trauma management patients' stabilization); - Timely response to possible outbreaks id provided (namely via mop ups, mass campaigns, based on needs)	For Outcome n. 2: - Surgical emergency interventions: at least 100 - Emergency referrals: at least 250 - Emergency treatments (wounds/injured, burns, EmONC, blood transfusions): at least 3,360 - Measles vaccinations: at least 2,650 (1,100 in GY and 1,550 in GT) - Staff trained on emergency response and referral: 82 (at least 30% female)	For Outcome n. 2: - Yirol Hospital Emergency Department registers (daily, weekly, monthly), - PHC facility referral data, - EPI registers (both static and outreach) - Training attendance sheets, programmes and pictures	For Outcome n. 2: - Project funds are timely availed - Local communities, IDPs and returnees do acknowledge and are willing to access/utilize hospital services - Concerned CHDs, RRC and other local institutions are supportive in coordinating IPs activities in providing humanitarian aid to host population, IDPs and returnees to prevent overlapping, - Local authorities are supportive in mobilizing community members on EP&R
	For Outcome n. 3: - Community members (men and women, including IDPs and returnees) are sensitized on safe health and hygiene practices,	For Outcome n. 3: - Community members reached by health education messages: 11,500 (at least 30% men) - HHPS, VHCs and other leaders	For Outcome n. 3: - Health Education registers, - Workshop Reports and Pictures and attendance sheets.	For Outcome n. 3: - Concerned CHDs, RRC and other local institutions are supportive in coordinating IPs activities in providing humanitarian aid to host population, IDPs and returnees to

	- Key opinion leaders (HHPs, VHCs, traditional/religious leaders) are awareness-raised on safe health and hygiene practices and involved as peer-to-peer educators. <u>For Outcome n. 4:</u> - Concerned CHDs capacities in surveillance, DHIS/IDSR reporting and e-warn systems are strengthened, - Participation to the Health and inter-Cluster coordination mechanisms at State and National level is ensured	sensitized on safe health and hygiene practices: 150 <u>For Outcome n. 4:</u> - CHD members capacity built: 4 - N. of Health Clusters attended at State and National level: at least 75%	<u>For Outcome n. 4:</u> - Training attendance sheet, report and pictures - Health Clusters minutes / attendance sheets	prevent overlapping, - Local authorities are supportive in mobilizing community members on EP&R <u>For Outcome n. 4:</u> - Concerned SMoHs prioritize the maintenance of effective CHDs in their agenda, by recruiting/monitoring adequate staff
	Activities: *List in a chronological order the key activities to be carried out. Ensure that the key activities will results in the project outputs.*	**Inputs:** *What inputs are required to implement these activities, e.g. staff time, equipment, travel, publications costs etc.?*		**Assumptions, risks and pre-conditions:** *What pre-conditions are required before the project starts? What conditions outside the project's direct control have to be present for the implementation of the planned activities?*
Activities for Result n. 1				
	<u>Activity 1.1</u> Procurement/prepositioning and administration/informed distribution of essential/emergency drugs, non medical supplies to the facilities (i.e., IEHK/DDK kits to face infectious diseases outbreaks)	<u>Inputs:</u> - Human resources: Procurement Officer - Logistic/procurement capacities - Collaboration with concerned institutions (federal and state MoH, CHD, Commissioner, etc.) - Coordination among partners on the ground		<u>Assumptions, risks:</u> - Availability of procurement protocols/guidelines; - Suppliers' and transporters' respect of contract timing
	<u>Activity 1.2</u> Ensuring continuous OPD services in all facilities and IPD service in hospitals/PHCC, including trauma management and serious cases' stabilization	<u>Inputs:</u> - Human resources: PHC Supervisors - Collaboration with SMoHa to sustain local qualified health staff, - Collaboration with concerned CHD and other stakeholders on the ground - Cultural mediation		<u>Assumptions, risks:</u> - No staff turnover; - Availability of pharmaceuticals and other medical supplies,
	<u>Activity 1.3</u> Maintaining MISP in RH services (ANC/PNC, STIs, FP) and childhood disease integrated management in all supported facilities, especially to most vulnerable women and children (IDPs, returnees, victims of conflicts and violence)	<u>Inputs:</u> - Human resources: MCH Supervisors, - Collaboration with SMoH to sustain local qualified health staff, - Collaboration with concerned CHDa and other stakeholders on the ground		<u>Assumptions, risks:</u> - No staff turnover; - Availability of pharmaceuticals and other medical supplies,

		- Cultural mediation		
	Activity 1.4 Scaling-up EPI service provision in all supported facilities	Inputs: - Human resources: PHC/EPI supervisors - Logistic and movement capacities - Collaboration with concerned institutions (federal and state MoH, CHD, Commissioner, etc.) - Coordination among partners on the ground		Assumptions, risks: - Movement capacities, - Availability of functional vehicles - Availability of functional cold chains
	Activity 1.5 Enforcement of mobile clinics (outreach services) to serve remote/IDPs/returnees populations in the 6 counties, offering comprehensive MCH services to most vulnerable (unaccompanied children, U5, P&LW, victims of conflicts)	Inputs: - Human resources: PHC/EPI supervisors - Logistic and movement capacities - Collaboration with concerned institutions (federal and state MoH, CHD, Commissioner, etc.) - Coordination among partners on the ground		Assumptions, risks: - Movement capacities, - Availability of functional vehicles - Supportive communities
	Activity 1.6 Training and TA for local health staff of up to 29 facilities on: (i) epidemic preparedness/EWARN, (ii) management of communicable diseases, (iii) surveillance.	Inputs: - Human resources: PHC Supervisors and trainers, - Link with MoH at federal level to ensure continuous update on training strategies, manuals, priorities, etc. - Procurement capacities (training materials)		Assumptions, risks: - Availability of standard protocols/guidelines; - Collaborative attitude from CHD; - No staff turnover.
Activities for Result n. 2				
	Activity 2.1 2.1 Maintenance/strengthening of Yirol Hospital OT, Emergency Department, Surgical Wards to respond to emergencies	Inputs: - Human resources: PM, Procurement Officer - Procurement, contracting and transportation capacities,		Assumptions, risks: No stuff turnover -Availability of the needed drugs and consumables -Availability of constructors and building materials -Availability of the needed equipment
	Activity 2.2 Maintenance/strengthening of blood bank at Yirol Hospital to support the OT ensuring the prompt management of hemorrhagic emergencies	Inputs: - Human resources: PM, Procurement Officer - Procurement, contracting and transportation capacities, - Effective power system - Community involvement		Assumptions, risks: -Collaborative aptitude from potential blood donors -Cold chain regular running -Lab regular functioning

	Activity 2.3 Maintenance/equipment of PHCCs IPDs, maternity rooms and laboratories to enhance diagnosis/treatment/referral capacities	Inputs: - Human resources: PM, Procurement Officer - Procurement, contracting and transportation capacities, - Community involvement		Assumptions, risks: - Availability of contractors and construction materials; - Availability of stores
	Activity 2.4 Upgrading Yirol West ambulance service and in Greater Tonj	Inputs: - Human resources: PHC supervisor, - Referral capacities		Assumptions, risks: -Movement capacities and road accessibility -Availability of adequate vehicles
	Activity 2.5 On-the-job training of Yirol Hospital staff on surgical intervention, management and follow up of obstetric emergencies and neonatal complications	Inputs: - Human resources: trainers - Link with MoH at federal level to ensure continuous update on training strategies, manuals, priorities, etc. - Procurement capacities (training materials)		Assumptions, risks: -Staff positive aptitude -No high staff turnover -Availability of enough qualified mentoring staff
	Activity 2.6 Training of PHCC/PHCU staff on emergency response and referral (first aid, triage, trauma management patients' stabilization);	Inputs: - Human resources: PHC Supervisors and trainers, - Link with MoH at federal level to ensure continuous update on training strategies, manuals, priorities, etc. - Procurement capacities (training materials)		Assumptions, risks: - Availability of standard protocols/guidelines; - Collaborative attitude from CHD; - No staff turnover.
	Activity 2.7 Epidemiological surveillance and organization of health emergency response (i.e. mass vaccination campaigns)	Inputs: - Human resources: PHC/EPI supervisors - Logistic and movement capacities - Collaboration with concerned institutions (federal and state MoH, CHD, Commissioner, etc.) - Coordination among partners on the ground		Assumptions, risks: - Collaborative attitude from CHD; - Basic IT capacities;
Activities for result n. 3				
	Activity 3.1 3.1 Organization of daily health, hygiene & sanitation education sessions (prevention of communicable diseases/STIs/malaria, EPI, health seeking behavior, hygiene, mainstreaming HIV/AIDS related-issues) in all supported facilities, targeting caretakers (men and women);	Inputs: - Human resources: PHC Supervisors, - Link with MoH at federal level to ensure continuous update on training strategies, manuals, priorities, etc. - Cultural mediation, - Community involvement		Assumptions, risks: - Availability of standard protocols/guidelines; - No staff turnover.

	Activity 3.2 Organization of workshops on health, hygiene and sanitation principles (including mainstreaming of HIV) targeting opinion leaders and peer-to-peer educators (i.e. VHCs, HHPs, religious/community leaders, teachers);	Inputs: - Human resources: PHC Supervisors and trainers, - Link with MoH at federal level to ensure continuous update on training strategies, manuals, priorities, etc. - Procurement capacities (training materials), - Cultural mediation, - Community involvement		Assumptions, risks: - Collaborative attitude from CHD; - Basic IT capacities;
Activities for result n. 4				
	Activity 4.1 Training/TA for CHDs on epidemiological surveillance, MoH DHIS/IDSR, e-warn systems;	Inputs: - Close and continuous collaboration with CHD; - DHIS utilization capacities		Assumptions, risks: - Availability of standard protocols/guidelines; - Collaborative attitude from CHD; - No staff turnover.
	Activity 4.2 Scale up of joint CHD/implementing partners' supporting supervision of health performances in each target county;	Inputs: - Networking and communication capacities; - Close and continuous collaboration with CHD; - DHIS utilization capacities		Assumptions, risks: - Collaborative attitude from CHD; - Basic IT capacities; - Road accessibility / freedom of movement
	Activity 4.3 Participation to the Health Cluster coordination mechanism (state and national)	Inputs: - Networking and communication capacities; - Close and continuous collaboration with concerned CHDs and SMOHs; - Movement capacities		Assumptions, risks: - Road accessibility / freedom of movement - Availability of functioning vehicle
	Activity 4.4 Facilitation of inter-cluster coordination at state and national level (WaSH, Nutrition and Food Security clusters).	Inputs: - Networking and communication capacities; - Close and continuous collaboration with CHD; - Movement capacities		Assumptions, risks: - Road accessibility / freedom of movement - Availability of functioning vehicle

PROJECT WORK PLAN

This section must include a workplan with clear indication of the specific timeline for each main activity and sub-activity (if applicable).
The workplan must be outlined with reference to the quarters of the calendar year.

Activities	Q1/2013			Q2/2013			Q3/2013			Q4/2013			Q1/2014		
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
Result n. 1															
Activity 1.1 Procurement/prepositioning and administration/informed distribution of essential/emergency drugs, non medical supplies to the facilities (i.e., IEHK/DDK kits to face infectious diseases outbreaks)				X	X	X	X	X	X						
Activity 1.2 Ensuring continuous OPD services in all facilities and IPD service in hospitals/PHCC, including trauma management and serious cases' stabilization				X	X	X	X	X	X						
Activity 1.3 Maintaining MISP in RH services (ANC/PNC, STIs, FP) and childhood disease integrated management in all supported facilities, especially to most vulnerable women and children (IDPs, returnees, victims of conflicts and violence)				X	X	X	X	X	X						
Activity 1.4 Scaling-up EPI service provision in all supported facilities				X	X	X	X	X	X						
Activity 1.5 Enforcement of mobile clinics (outreach services) to serve remote/IDPs/returnees populations in the 6 counties, offering comprehensive MCH services to most vulnerable (unaccompanied children, U5, P&LW, victims of conflicts)				X	X	X	X	X	X						
Activity 1.6 Training and TA for local health staff of up to 29 facilities on: (i) epidemic preparedness/EWARN, (ii) management of communicable diseases, (iii) surveillance.					X	X	X	X	X						
Result n. 2															
Activity 2.1 2.1 Maintenance/strengthening of Yirol Hospital OT, Emergency Department, Surgical Wards to respond to emergencies				X	X	X	X	X	X						
Activity 2.2 Maintenance/strengthening of blood bank at Yirol Hospital to support the OT ensuring the prompt management of hemorrhagic emergencies				X	X	X	X	X	X						
Activity 2.3 Maintenance/equipment of PHCCs IPDs, maternity rooms and laboratories to enhance diagnosis/treatment/referral capacities				X	X	X									
Activity 2.4 Upgrading Yirol West ambulance service and in Greater Tonj				X	X	X	X	X	X						
Activity 2.5 On-the-job training of Yirol Hospital staff on surgical intervention, management and follow up of obstetric emergencies and neonatal complications				X	X	X	X	X	X						
Activity 2.6 Training of PHCC/PHCU staff on emergency response and referral (first aid, triage, trauma management patients' stabilization);						X			X						
Activity 2.7 Epidemiological surveillance and organization of health emergency response (i.e. mass vaccination campaigns)				X	X	X	X	X	X						
Result n. 3															

PROJECT WORK PLAN

This section must include a workplan with clear indication of the specific timeline for each main activity and sub-activity (if applicable).
The workplan must be outlined with reference to the quarters of the calendar year.

Activities	Q1/2013			Q2/2013			Q3/2013			Q4/2013			Q1/2014		
Activity 3.1 3.1 Organization of daily health, hygiene & sanitation education sessions (prevention of communicable diseases/STIs/malaria, EPI, health seeking behavior, hygiene, mainstreaming HIV/AIDS related-issues) in all supported facilities, targeting caretakers (men and women);				X	X	X	X	X	X						
Activity 3.2 Organization of workshops on health, hygiene and sanitation principles (including mainstreaming of HIV) targeting opinion leaders and peer-to-peer educators (i.e. VHCs, HHPs, religious/community leaders, teachers);					X			X							
Result n. 4															
Activity 4.1 4.1 Training/TA for CHDs on epidemiological surveillance, MoH DHIS/IDSR, e-warn systems;					X	X									
Activity 4.2 Scale up of joint CHD/implementing partners' supporting supervision of health performances in each target county;				X	X	X	X	X	X						
Activity 4.3 Participation to the Health Cluster coordination mechanism (state and national)				X	X	X	X	X	X						
Activity 4.4 Facilitation of inter-cluster coordination at state and national level (WaSH, Nutrition and Food Security clusters).				X	X	X	X	X	X						

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