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

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
GOAL
Project CAP Code
SSD-13/H/55405/7790
CAP Project Title *(please write exact name as in the CAP)*
Provision of Integrated Primary Health Care services for vulnerable populations and strengthened health emergency response capacity in Twic County, Warrap State; Agok, Abyei Administrative Area and Ulang, Baliet and Maban Counties, Upper Nile 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	**%**[1]	**County**
Upper Nile State	23%	Baliet
Upper Nile State	23%	Ulang
Warrap	35%	Twic
Warrap	19%	Abyei

Total Project Budget requested in the in South Sudan CAP	US$ 9,620,539
Total funding secured for the CAP project *(to date)*	US$ 2,194,973

Funding requested from CHF for this project proposal	US$400,000
Are some activities in this project proposal co-funded? Yes ☒ No ☐ *(if yes, list the item and indicate the amount under column i of the budget sheet)*	

[1] % based on number of clinics per county of overall total.

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 (5% of the total project)	**Number of direct beneficiaries targeted in the CAP**
Women:	**5646**	**112,918**
Girls:	1523	31,241
Men:	5876	117,527
Boys:	1463	30,016
Total:	14585	291,702

Indirect Beneficiaries
Catchment populations = 445,039
Catchment Population (if applicable)
Catchment populations = 445,039

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

CHF Project Duration (12 months max., earliest starting date will be Allocation approval date6)
Indicate number of months: 6 (April- September)

Contact details Organization's Country Office	
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Finance Officer	*Eoin Lennon elennon@ss.goal.ie 00211 959 462 511*

Contact details Organization's HQ	
Organization's Address	12-13 Cumberland St Dun Laoghaire, Dublin, Ireland
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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[2]

Health indicators in Twic County, Agok and the Sobat Corridor reflect a concerning situation. Significant displacement was triggered by conflict in the Abyei area in 2011, with an estimated 105,000 people[3] displaced to Agok and neighbouring Twic. 40,000 of these are expected to return by the end of June[4] despite total destruction of basic services. Local populations in Twic County were also affected by seasonal flooding and temporary displacements in 2012,[5] further hampering communities food security and livelihoods. Continued population movements in 2013 will challenge over-stretched, ill equipped and under-staffed basic services and further strain host communities. Women are often most significantly affected by displacement with over 60% of all households returning to Abyei reported to be led by women[6]. Communities across Ulang and Baliet counties face a complex situation of low health indicators, weak government capacity and proximity to the volatile Jonglei border. The threat of disease outbreaks remains high given recent incidents of kala-azar in Baliet and Ulang and measles and cholera in Twic.

External support is essential to ensure provision of basic lifesaving health services and maintenance of emergency response capacity for unpredictable health needs in these under-served populations, with a focus on women and under-5s. GOAL's 2012 MICS[7] [8]found GAM rates of 32.0% and SAM at 7.5% in Twic, 32.4% GAM and 11.6% SAM in Ulang County, 30.0% GAM and 9.1% SAM in Baliet County and 20.6% GAM and 2.5% SAM in Agok (WHO Ref.); all GAM rates exceed the emergency threshold of 15%. Malnutrition underlies a large proportion of the high levels of child morbidity and mortality in Twic, Agok, Baliet and Ulang where Under 5 mortality rates were estimated at 1.22, 1.02, 0.75 and 0.94 (deaths per 10,000 per day) respectively. 36.9% (Agok), 50.3% (Twic), 58.7% (Baliet) and 64.9% (Ulang) of children under 5 were reported as suffering an illness in the two weeks prior to the survey, with malaria, ARIs and diarrhoea the most prevalent. EPI coverage in all sites remains low, which combined with frequent population movements, results in the high risk of disease outbreaks. Emergency EPI response and outbreak surveillance for diseases remains a major priority for GOAL

Reproductive health indicators remain low, with FGD's highlighting barriers for women in accessing planning and antenatal care given the greater decision-making power of their male partners. 2012 MICS reported ANC2 attendance in Sobat at 51.2%, Twic at 75.7% and Agok at just 34.0%, with clinic deliveries estimated at 45.1% in Agok but only 17.1% in Twic and 10.2% in Sobat. Community awareness of STIs including HIV is low. The minimal initial service package (MISP) remains critical for all pregnant women and women of childbearing age and GOAL will work to ensure the provision of all ANC services stipulated in the BPHS.

Given ongoing instability in South Sudan, GOAL is committed to maintaining a flexible emergency response capacity to respond to needs in existing and new operational areas. Capacity of the MoH, particularly at the county level remains limited.

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 collaboration with the Ministry of Health (MoH), GOAL will support a network of 31 health facilities (11 in Twic, six in Agok, seven in Baliet and seven in Ulang) in the delivery of the Basic Package of Health Services for South Sudan providing a safety net for 445,039 vulnerable people. GOAL has significant experience in South Sudan, having implemented PHC programmes since 1998, and is the lead partner for health in supported counties. Alternative funding for 2013 has been secured from ECHO, OFDA, Irish Aid and World Bank. CHF funding would partially fill a funding gap of $7,425,566. In Baliet and Ulang GOAL is the only NGO working with MOH in provision of health care services.

GOAL will maintain the existing safety net of services by supporting comprehensive PHC services to ensure provision of life-saving curative and preventive care, including EPI, ANC, PNC and safe delivery, in addition to facilitating referrals to secondary facilities. Through a comprehensive community health programme, GOAL aims to improve

[2] 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.
[3] Abyei Dry Season Assistance Plan, 11th December 2012 – UNOCHA.
[4] Abyei Dry Season Assistance Plan, 11th December 2012 – UNOCHA.
[5] Seasonal flooding in October 2012 affected 13,352 people across Warrap State, including Twic.. as reported in the OCHA Humanitarian Bulletin 22-28 October 2012
[6] Abyei Tracking Report – July – August 2012, IOM
[7] GOAL's Multi-Indicator Cluster Surveys; Twic (April 2012), Agok (January 2012) and Sobat (September 2012)

access to family planning services and increase awareness of STIs, including HIV, within a 'Designing for Behaviour Change' Approach. In 2013, GOAL will maintain its network of community volunteer cadres, including EPI volunteers, School Health Clubs and Care Group facilitators.

GOAL anticipates shortages in drug supplies in 2013, based on experiences in 2012 of irregular, late and inadequate supplies. As GOAL services transition into health pooled funding mechanisms, which have limited funding for drugs, GOAL requests funds to procure and transport three months supplies for all sites, to prevent stock ruptures. Given the operational access issues in Twic and Agok, it is essential that drug supplies and equipment are prepositioned prior to the rainy season.

GOAL will continue to respond to communicable disease outbreaks and strengthen emergency preparedness. GOAL works closely with the county health department in assessing, planning and implementing activities, including emergency response and preparedness actions. Outbreak surveillance will remain priority for GOAL to ensure a response launch within the first 48 – 72 hours. EWARN reports are submitted weekly across all sites. GOAL will maintain cholera and meningitis kits in each field site coordinating closely with MoH and WHO should an outbreak of cholera, meningitis or measles occur.

GOAL will maintain emergency response capacity in all sites, providing mobile clinic services and EPI teams for displaced populations and emergency referrals in times of crisis. Currently, GOAL provides a thrice weekly mobile clinic service to populations in Abyei town. These services may be transferred in 2013 to a static facility (Abyei Town PHCC) following rehabilitation. Emergency EPI response will include vaccination against measles, cholera and polio[9], and other antigens (DPT and BCG) within outbreak campaigns.

GOAL aims to improve capacity of facility and MoH staff, on case management of communicable and other common diseases and malnutrition through on-the-job and refresher trainings. Emergency focused trainings will include EWARN, MISP and Public Health in Complex Emergencies (PHCE). Specialised training focused on Clinical Management of Rape will be facilitated in coordination with UNFPA and GBV sub-cluster.

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 CHF funds will be used to ensure that adequate PHC services are available to ensure that host communities and displaced or returning populations are given lifesaving services. Emergency preparedness and response interventions will reduce the incidence of disease outbreaks and contribute to a reduction in deaths due to preventable common illnesses. GOAL aims to ensure that static and mobile health facilities continue to operate despite any influx or crisis, with additional support to ensure that the current standard of health status is maintained. By working to strengthen capacity at county and state MoH level, GOAL will ensure health services maintain sustainable improvements and service delivery.

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)

To improve access to, and utilisation of, health services for 473,398 highly vulnerable men, women girls and boys in Twic, Agok and the Sobat Corridor, with a particular focus on the needs of vulnerable groups (IDPs, returnees, children and pregnant and lactating women)

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).

• Operate curative care services accessible to men women and children 5 days a week in 31 clinics (11 PHCCs and 20 PHCU's) in line with the Basic Package of Health Services, with laboratory services in all PHCCs and emergency referral services in place;	• Warrap State (Twic County and Agok) • Upper Nile State (Ulang and Baliet Counties)	**Total beneficiaries:** 14,585 Men: 5876 Women: 5646 Girls: 1523 Boys: 1463

[9] Measles vaccinations in an emergency setting would be administered to all children between 6 and 59 months, and polio for all children < 5 years of age. Other antigens (BCG and DPT) would be administered as per immunisation schedule.

• Oversee the procurement, supply and distribution of drugs, medical supplies and equipment.	• Warrap State (Twic County and Agok) • Upper Nile State (Ulang and Baliet Counties)	**Total beneficiaries:** 14,585 Men: 5876 Women: 5646 Girls: 1523 Boys: 1463
• Provide Routine ANC services, including TT, IPT, LLITN, iron/folic acid, de-worming in all health facilities, and basic EmOC services in PHCCs with EmOC referral systems in place for PHCUs; PNC and family planning services	• Warrap State (Twic County and Agok) • Upper Nile State (Ulang and Baliet Counties)	Pregnant women: 819
• EPI services run through facilities and community outreach programmes	• Warrap State (Twic County and Agok) • Upper Nile State (Ulang and Baliet Counties)	Number of under ones vaccinated to receive three doses of DPT3: Twic: 80% Agok: 60% Ulang: 50% Baliet: 50%
• Provide clean delivery kits to women at final stage of labour ; conduct regular outreach and support community TBAs in mobilizing women to attend the clinic during pregnancy, for delivery and for PNC	• Warrap State (Twic County and Agok) • Upper Nile State (Ulang and Baliet Counties)	Pregnant women: 819
• Establish EWARN/emergency plans in conjunction with the MoH and provide training in order to strengthen emergency response capacity of health staff; ensure the pre-positioning of EWARN supplies (such as cholera and meningitis kits) to all supported health facilities;	• Warrap State (Twic County and Agok) • Upper Nile State (Ulang and Baliet Counties)	Total Catchment: 445,039
• Conduct formal, refresher and on-the-job training for male and female health staff, community health staff and on topics which aim to address key causes of poor health in communities (IECHC, emergency preparedness and response, EPI). Training will include MoH staff wherever possible.	• Warrap State (Twic County and Agok) • Upper Nile State (Ulang and Baliet Counties)	Total beneficiaries: 25 clinic staff and community volunteers including home health promoters and community TBAs.
• Support facility staff in the detection, recording and response to infectious disease outbreaks through ensuring the submission of weekly Integrated Surveillance and Detection Reports (ISDR).	• Warrap State (Twic County and Agok) • Upper Nile State (Ulang and Baliet Counties)	Total Catchment: 445,039
• Conduct health promotion with locally appropriate IEC materials in clinics and in the community addressing priority diseases including recognition and referral for diarrhea, malaria and ARIs, key health behaviors are also promoted including, the use of LLITNs particularly for pregnant women and children <5, hand washing, breastfeeding and health seeking behavior. All community health messages have a particular focus on mothers of children <5.	• Warrap State (Twic County and Agok) • Upper Nile State (Ulang and Baliet Counties)	Total catchment: 445,039

• Implement Care Group[10] in the communities where GOAL would be operating, targeting villages outside the clinic catchment areas.	Warrap State (Twic County and Agok)	225 female care group members (total attendance of 15 groups consisting of 15 members).
• Community Led Total Sanitation	Upper Nile State (Ulang County) Warrap (Twic)	2,000 people (980 male, 1020 female) (4 villages approximately)

iv). Cross Cutting Issues

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

Gender

Key developments in GOAL's gender strategy include a comprehensive gender audit in 2010 and the drafting of the GOAL South Sudan Country Gender Plan in 2011 following a visit from the Global Gender Advisor. Key actions to follow include further training to Gender Focal Points (GFP's) at each field site to support all staff to integrate gender sensitivity into their work. Adapted Gender checklists were circulated to all field teams in late 2012 to provide specific guidance to each site and programme. GOAL will continue to seek to move beyond the conception of gender as ensuring men and women benefit equally, to ensuring that GOAL's activities are not maintaining existing gender inequalities, but are facilitating and encouraging women and men to redefine their gendered roles and inequalities, for the benefit of the whole communities. The gender plan puts in place specific guidelines to improve recruitment, retention and promotion of women. HR Officers of each site will be prioritised for training to enable them to support line managers to put these guidelines into practice.

GOAL aims to improve well-being of women, girls, boys and men, through ensuring that women and men are consulted during programme planning and implementation. Promoting gender equitable access and utilisation of, health services remains a key aim for GOAL South Sudan. An example of where GOAL is addressing gender directly through its health programming is with the aim of having 30% of key decision making roles given to women, for example in the management of Community Health Committees (CHCs), and equal numbers of boys and girls in School Health Clubs.

GOAL's supported health services are largely utilised by women and children. However, GOAL aims to improve well-being of women, girls, boys and men, through consultation with all groups during planning, for example through women- and men-only FGDs. GOAL has been able to adapt programmes following feedback to increase equitable access. Female-only FGD's indicated that a barrier to accessing family planning and antenatal care was the greater decision-making power of their male partners. Consequently, men were actively included in ANC education sessions. GOAL recognises that gender inequality is a key factor in vulnerability to HIV, with mainstreaming of HIV activities incorporating gender-sensitivity training.

GOAL recognises that despite low community reports of Sexual and Gender-Based Violence in its operational areas, it is possibly masked by low community awareness. In 2013, actions will be taken: the first in coordinating with local protection actors such as Intersos and Save the Children to refer any patients with signs of sexual violence for continued management and follow-up. The
second will be conducting refresher training for health facility staff on clinical management of sexual violence by UNFPA or another specialised provider.

HIV

The response to the HIV pandemic in South Sudan is still at an early stage with very low levels of understanding and low access to treatment and counseling services. HIV prevention is generally limited to information provision and condom distribution. GOAL's strategy has generally mirrored this and has focused on awareness raising and the free availability of condoms for staff in GOAL compounds and the demonstration of their correct use in GOAL-supported facilities. In 2010, GOAL received a technical support visit from the HIV Advisor who was able to look at the current programme and advise on improvement. There is scope for GOAL to work to engage with the MoH on integrating HIV services into PHC, where possible and appropriate. In 2012, in collaboration with the CHD and State MoH, GOAL has been able to establish its first functional, Voluntary Counselling and Testing (VCT) service in Upper Nile State at Baliet PHCC, with referrals made to Malakal Teaching hospital into Prevention of Mother to Child Transmission (PMTCT) of HIV/AIDS and ARV therapy programmes, if required. Pregnant women and their spouses are encouraged to opt for HIV testing with post-test counseling and referral provided for those with positive results. Although, low community awareness on HIV transmission and strong cultural attitudes persist against testing: this is a positive step forward in the

[10] The Care Group model is a peer education approach where GOAL will establish groups of fifteen women who will receive regular training on key health topics which they then disseminate within their peer groups to facilitate learning and behavior change with remote and hard to reach communities.

detection and treatment management of HIV and AIDS and can serve as a model for services to be rolled out across other GOAL sites.

Environment

Organisationally, GOAL takes in to account environmental issues when planning programmes, and tries to ensure that activities do not cause avoidable adverse environmental impact. This includes appropriate disposal (incineration and burial of the ashes remaining) of clinic supplies, including drugs and used medical items complemented with training of staff on universal precautions and a preference for newer models which are more efficient. Initial environmental reviews are undertaken of all the hardware related WASH activities, a process which analyses the potential negative impacts of the project and sets mitigation measures and adequate monitoring systems to guard against them. GOAL also looks to utilize sustainable energy. A number of GOAL supported clinics hold solar-powered fridges to support cold chains storage. As well as being more practical in areas without electricity, these are more environmentally friendly than the use of fuel-powered generators.

Accountability to beneficiaries

At all stages of the programme design and intervention GOAL works to engage communities and ensure that accountability standards can be met. Regular community and PHC staff meetings are held and contribute to GOAL's strategic planning approach, with the Community Health Committees taking a pivotal role. A network of Community Health and Nutrition Promoters, Home Health Promoters and Peer Group volunteers ensure that there are open communication lines in place to hear feedback from beneficiaries and to discuss how to adapt programmes to best suit real needs.

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.

Improved access to sustainable Primary Health Care Services in target locations

In 2013, GOAL will prioritise maintaining a safety net for the provision of free basic health services in clinics and communities including emergency referral services. Preventative care services will be available in all facilities for a minimum of five days a week (apart from Abyei mobile clinic which offers services three times a week) and will include EPI, Reproductive Health, ANC, Growth Monitoring and health and nutrition messaging, in addition to routine curative consultations in all GOAL-supported clinics. GOAL's community health programme continues to move towards community owned behavior change models, including Community Led Total Sanitation, School Health Clubs, Care Group Models and Nutrition Impact and Positive Practice (NIPP) circles.

Strengthen emergency preparedness

GOAL will focus on strengthening the capacity of GOAL and MoH staff to deliver effective health outcomes, particularly in emergency contexts. GOAL will place a particular emphasis on the provision of staff training including on the job refresher and formal training. Facility staff will be supported in the detection, recording and response to infectious disease outbreaks through ensuring the submission of weekly Integrated Disease and Surveillance Response (IDSR). EWARN supplies such as cholera and meningitis kits will also be pre-positioned in all GOAL-supported facilities.

Respond to health related emergencies including controlling the spread of communicable diseases.

GOAL will support facilities in the establishment of EWARN/emergency plans in conjunction with the MoH and the provision of training to strengthen emergency response capacity of health staff. In 2012, eight members of staff attended a Public Health in Emergencies training, which will be rolled out across all field sites in 2013. GOAL will focus on increasing vaccination coverage including supporting MoH immunization campaigns and building local capacity to support communicable disease control, in line with health cluster priorities. Emergency EPI response and outbreak surveillance for diseases remains a major priority for GOAL, with capacity to ensure that any outbreak is responded to within the first 48–72 hours.

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)
x	1.	Total direct beneficiaries	Total direct beneficiaries; 14,585 Women: 5646 Girls: 1523 Men: 5876 Boys 1463

x	2.	Number of under 5 consultations (male and female)	No of children (consultations): 2,986 Total: 2986 Agok: 567 (278 boys,289 girls) Twic: 1045 (512boys, 533 girls) Sobat 1374 (673boys; 701 girls)
x	3.	Number of children <5 vaccinated against measles in emergency or returnee situation	90% children <5 within identified returnee/refugee/IDP communities are vaccinated against measles.
x	4.	Number of births attended by skilled birth attendants	No of births: 819 Twic: 156 Agok: 287 Sobat: 376
x	5.	Communicable disease outbreaks detected and responded to within 72 hours	% of communicable diseases outbreaks detected and responded to within 72 hours. # of disease outbreaks detected # of disease outbreaks responded to within 72 hours
x	6.	Number of antenatal clients receiving IPT2 second dose	No. of antenatal clients: 819 Agok: 156 Twic:287 Sobat: 376
x	7.	• Number of health workers trained in MISP / communicable diseases / outbreaks / IMCI / CMR (Male and Female)	No of workers trained (Male and Female) All sites: 25 (11 male,14 female) Twic:9 Agok:5 Sobat: 11

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.

Implementation

GOAL plans to jointly implement this programme throughout 2013 with the MoH at GoSS, State and County levels. GOAL will continue to provide support to County MoH structures, which includes the secondment of a clinical officer (CO) to the CHD in Twic, with plans for this to be replicated in Ulang in 2013. In 2012, the seconded CO in Twic led a whole county-facility assessment which identified key strategic areas for support from GOAL. In Baliet and Ulang, given the change in funding mechanisms, under World Bank funding, GOAL will be working within a Performance Based Contract model where the CHD takes on the majority of responsibility for the management of health services, GOAL also supports the election and training of Community Health Committees, attached to each facility, who are responsible for ensuring communities are able to hold CHD accountable for health services, representing the needs of the community in health decision making and input on management of the health facilities when necessary and appropriate. GOAL aims to ensure that not only are females represented in the CHCs but that they assume management positions within the committees.

Primary Health Care

Throughout 2013, all GOAL-supported facilities will continue to follow GOSS-MoH diagnosis, treatment and prescription protocols, and will be supplied with drugs according to MoH approved essential drug lists using a consumption based drug management system. GOAL will complement the supply of drugs with equipment and essential supplies and conduct physical pharmacy stock checks every month. GOAL will provide routine, static vaccination at all PHCCs and PHCUs, and outreach EPI services at least once a month to villages more than two hours walk from health facilities, when access allows. Functional cold chains will be maintained in all health facilities. The cold chain systems will be checked routinely and updated as necessary. Additionally, regular training will be provided to EPI teams on fridge maintenance and monitoring.

GOAL will continue to provide the following routine Antenatal Care (ANC) services: early detection of complications leading to appropriate referral; malaria prophylaxis (IPT); anemia prophylaxis (FeFol); administration of tetanus toxoid; administration of de-worming treatment; distribution of LLITNs at first ANC visit and health education during pregnancy.

Basic Emergency Obstetric and Neonatal Care (EmONC) training and distribution of equipment will continue in 2013 to ensure that all clinics are able to provide services and will promote appropriate EmONC referral protocols at all locations. GOAL will maintain and strengthen its current capacity to report health information and respond to communicable disease outbreaks by maintaining and improving a functioning Health Information System (HIS) in each health facility to strengthen surveillance and detect any potential outbreaks. All HIS data will be shared with MoH representatives who will be facilitated by GOAL to disseminate this information to higher MoH/WHO/UNICEF structures and all local stakeholders.

Community Health

With technical, administrative and resource based support from GOAL, community health promoters, home health promoters and Care Group volunteers will undertake priority health promotion within their respective facility catchments throughout the course of the proposed intervention. During 2013, health promotion sessions will be conducted in clinics. The community health promotion will be through the use of care group model, NIPP circles, Community Led Total Sanitation (CLTS) for effective behavior change promotion. The volunteers in these projects will also be used for community mobilization for EPI services and defaulter tracing.

Strengthening capacity

On the job training will be provided on an ongoing basis addressing topics such as C-IMCI/IECHC, syndromic management of STIs, dressing, treatment of common diseases and malnutrition, rational use of medicines, IV and IM injection, and rational use of laboratory services. It is intended that in each location 90% of key clinical staff will be trained in the treatment of common diseases and malnutrition, according to MoH Prevention and Treatment Guidelines. In addition, on the job training and supervision on HIS documentation for improved data reporting will be carried out.

GOAL will focus on co-ordination and information sharing among all stakeholders ensuring better linkages between the County Health Office and the VHCs.

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)[11].

GOAL utilises a comprehensive M&E system to ensure the appropriate delivery of effective and sustainable services. Key tools will include: anthropometric, morbidity and mortality surveys and clinic HIMS data. Anthropometric, morbidity and mortality surveys will be completed for these GOAL's operational areas during 2013, which will be shared with the Health Cluster, the MoH and all other interested parties. These will assist in monitoring trends at a county level and help us to monitor the overall progress of GOAL and other actors in the area. Clinic HMIS data incorporates the use of MOH DHIS and exit surveys. Other means of verification, as outlined in the Logframe will be carried out with local community, partner NGOs and the MoH. In addition, the Primary Health Care Coordinator and other members of the Senior Management Team will make regular visits to the project sites to meet with project staff and assess overall implementation. An M&E team provides specialized technical guidance and coordination in the collection and analysis of the wide bank of information gathered.

GOAL conducts ongoing supervision of staff to confirm activities are being conducted and to GOAL standards. Tools such as quarterly diagnosis/treatment assessments are the main tool for monitoring improved capacity of health care service delivery across programme sites; this will be continued in 2013. GOAL feeds all information to government partners and is an active participant of the Monitoring and Evaluation technical working group of the MoH/GOSS. GOAL submits weekly surveillance/IDSR to GOSS and SMOH and monthly DHIS reports to SMoH. Continued work on gender and HIV checklist will offer a clear way of assessing whether issues are being addressed, data collected is disaggregated by gender

A monthly field report is sent to Juba with analysis and explanations for results and trends and GOAL provides regular reports as per donor request. Weekly field reports are submitted to Juba which identifies any issues which may impact operations. The Multi Indicator Cluster Survey is conducted annually and provides for comparative review and monitoring. In addition, GOAL technical advisors will provide program evaluations, assistance, recommendations and advice on all sectors of programming. The results of these evaluations can be made available to CHF. GOAL will also provide reports as requested by state and central-level clusters and the Health NGO Forum, in the support of agency coordination efforts.

[11] 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.

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)
ECHO (1st March 2012-28th February 2013)	$64,370.00
OFDA (1st August 2012 – 1st July 2013)	$370,000.00
CHF (1st April 2012 -31st March 2013)	$100,000.00

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,	• Provide itemized description of costs if not possible to breakdown by unit/quantity/cost per unit

etc	
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/55405.....	**Project title:** Provision of Integrated Primary Health Care services for vulnerable populations and strengthened health emergency response capacity in Twic County, Warrap State; Agok, Abyei Administrative Area and Ulang and Baliet Counties, Upper Nile State.....	**Organisation: .....GOAL.....**

	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	• CMR<1/10,000/day • U5MR<2/10,000/day	• GOAL Multi Indicator Cluster Survey (MICS)/Antropometric survey • HMIS	• Security situation does not impede humanitarian access • Climatic disasters (unusually severe flooding for example) do not occur • Funding for operations is obtained

Purpose	**CHF Project Objective:** *What are the specific objectives to be achieved by the end of this CHF funded project?* • To improve access to, and utilisation of, health services for 473,398 highly vulnerable men, women girls and boys in Twic, Agok and the Sobat Corridor, with a particular focus on the needs of vulnerable groups (IDPs, returnees, children and pregnant and lactating women)	**Indicators of progress:** • Utilisation rate amongst the population is 0.5-1.0 new visits/per person/per year across all GOAL supported PHC services (HIS and MICS) • >70% of population within coverage of health services in targeted counties	**How indicators will be measured:** *What sources of information already exist to measure this indicator? How will the project get this information?* • Annual GOAL Multi Indicator Cluster Survey (MICS) • Clinic HIS Data	**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?* • Security situation does not impede humanitarian access • Climatic disasters (unusually severe flooding for example) do not occur • Funding for operations is obtained
Results	**Results - Outputs (tangible) and Outcomes (intangible)** *Improved access to sustainable Primary Health Care Services in target locations*	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged outcomes?* Total direct beneficiaries; 14585 Men: 5876 Women: **5646** Girls: 1523 Boys: 1463 No of consultations for <5s Target: 2986 Agok: 567 (278 boys,289 girls) Twic: 1045 (512boys, 533 girls) Sobat 1374 (673boys; 701 girls) Number of births attended by a skilled attendant. Target: 819 Agok: 156 Twic:287 Sobat: 376 • Number of children 6 - 59 months vaccinated against measles in emergency or returnee situation	**How indicators will be measured:** *What are the sources of information on these indicators?* • Clinic HMIS data	**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?* • Access to clinics is not impeded • Procurement chain operates effectively • Staffing requirements met

		Target: 90% children <5		
	Strengthen emergency preparedness	•Number of health workers trained in MISP / communicable diseases / outbreaks / IMCI / CMR (Male and Female) All sites: 25 (11male,14 female)	• Training records	• Relationship with MoH remains strong • MoH capacity does not diminish
	Respond to health related emergencies including controlling the spread of communicable diseases.	% of communicable diseases outbreaks detected and responded to within 72 hours. # of disease outbreaks detected # of disease outbreaks responded to within 72 hours	• Weekly ISDR reports	• Mass population movements GOAL and other agencies capacity
	Activities: *List in a chronological order the key activities to be carried out. Ensure that the key activities will results in the project outputs.* ***Improved access to sustainable Primary Health Care Services in target locations*** • Operate curative care services accessible to men women and children 5 days a week in 31 clinics with night and weekend cover for the PHCCs • Oversee the procurement, supply and distribution of drugs, medical supplies and equipment. • Provide Routine ANC services, including TT, IPT, LLITN, iron/folic acid, de-worming in all health	**Inputs:** *What inputs are required to implement these activities, e.g. staff time, equipment, travel, publications costs etc.?* • Staff time (Direct supervision staff, Field and Juba based support staff) • Medical Equipment • Drugs • GOAL facilities / Office / compounds • Training materials (stationery, etc) • IEC materials • Visibility materials • Vehicles • Flights • Computer and office equipment		**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?* • State and local government authorities remain engaged and committed to the intervention • Staff turnover / recruitment remains stable • Ability to secure funding • Community can access community health services • Uninterrupted procurement chain maintained; no ruptures of stock in GOAL supported health services

	facilities, and basic EmOC services in PHCCs with EmOC referral systems in place for PHCUs; PNC and family planning services • EPI services run through facilities and community outreach programmes • Provide clean delivery kits to women at final stage of pregnancy; conduct regular outreach and support community TBAs in mobilizing women • Conduct formal, refresher and on-the-job training for male and female health staff, community health staff and community volunteers. • Conduct health promotion with locally appropriate IEC materials • Implement Care Group Approach . • Community Led Total Sanitation ***Strengthen emergency preparedness*** • Establish EWARN/emergency plans in conjunction with the MoH and provide training in order to strengthen emergency response capacity of health staff; ensure the pre-positioning of EWARN supplies (such as cholera and meningitis kits) to all supported health facilities; ***Respond to health related emergencies including***			• HIV activities are accepted by community leaders • Community are motivated to participate in activities/campaigns • Lack of knowledge is the limiting factor and constraint to improving infant feeding practices

	controlling the spread of communicable diseases. • Support facility staff in the detection, recording and response to infectious disease outbreaks through ensuring the submission of weekly Integrated Surveillance and Detection Reports (ISDR***).***			

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.

Result 1: ***Improved access to sustainable Primary Health Care Services in target locations***	**Q1/2013**			**Q2/2013**			**Q3/2013**			**Q4/2013**			**Q1/2014**		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec			
Activity 1 Operate curative care services accessible to men women and children 5 days a week in 31 clinics				x	x	x	x	x	x						
Activity 2 Oversee the procurement, supply and distribution of drugs, medical supplies and equipment.				x	x	x	x	x	x						
Activity 3 Provide Routine ANC services, including TT, IPT, LLITN, iron/folic acid, de-worming in all health facilities,; PNC and family planning services				x	x	x	x	x	x						
Activity 4 EPI services run through facilities and community outreach programmes				x	x	x	x	x	x						
Activity 5 Provide clean delivery kits to women at labour; conduct regular outreach and support community TBAs in mobilizing women to attend ANC and deliveries in the health facilities				x	x	x	x	x	x						
Activity 6: Conduct formal, refresher and on-the-job training for male and female health staff, community health staff and community volunteers.				x	x	x	x	x	x						
Activity 10 Conduct health promotion with locally appropriate IEC materials in clinics and in the community.				x	x	x	x	x	x						

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.															
	Q1/2013			**Q2/2013**			**Q3/2013**			**Q4/2013**			**Q1/2014**		
Activity 11 Implement Care Group[12] in the communities where GOAL would be operating, targeting villages outside the clinic catchment areas.				X	X	X	X	X	X						
Activity 12 Community Led Total Sanitation				X	X	X	X	X	X						
Result 2: Strengthen emergency preparedness															
Activity 1: Establish EWARN/emergency plans in conjunction with the MoH and provide training in order to strengthen emergency response capacity of health staff; ensure the pre-positioning of EWARN supplies (such as cholera and meningitis kits) to all supported health facilities;				x	x	x	x	x	x						
***Result 3*: Respond to health related emergencies including controlling the spread of communicable diseases.**															
Activity 1: Support facility staff in the detection, recording and response to infectious disease outbreaks through ensuring the submission of weekly Integrated Surveillance and Detection Reports (ISDR).				x	x	x	x	x	x						x

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

[12] The Care Group model is a peer education approach where GOAL will establish groups of fifteen women who will receive regular training on key health topics which they then disseminate within their peer groups to facilitate learning and behavior change with remote and hard to reach communities.