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

1. Maintain the existing safety net by providing basic health packages and emergency referral services
2. Strengthen emergency preparedness including surgical interventions
3. 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)

Cluster Geographic Priorities for this CHF Round

All states.

(In the equatorial states (Western, Eastern and Central Equatorial), only grossly underserved counties).

Project details

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

Requesting Organization

International Rescue Committee

Project CAP Code

SSD-13/H/55421/5179

CAP Project Title *(please write exact name as in the CAP)*

Basic and Emergency Primary Health Care Services in Northern Bahr el Ghazal and Unity States

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
Northern Bahr el Ghazal	85%	Aweil East, Aweil South, Aweil Center, Aweil North, Aweil West
Unity	15%	Panyijiar

Total Project Budget requested in the in South Sudan CAP	US$ 5,206,533
Total funding secured for the CAP project ***(to date)***	US$ 2,980,544

Funding requested from CHF for this project proposal	US$ 450,000

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)*

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**
Women:	66,740	86,959
Girls:	35,308	48,559
Men:	40,074	55,373
Boys:	35,308	48,559
Total:	**177,230**	**239,450**

Indirect Beneficiaries

This project will indirectly benefit 229,274 people. This figure is based on the total population (2008 census) for the payams targeted by this proposal, allowing for 3% annual population growth.

Catchment Population (if applicable)

In accordance with MoH guidelines, the catchment population for a PHCU is 15,000 and 50,000 for a PHCC. This project targets 35 facilities (30 PHCUs and 5 PHCCs). In order to avoid double counting between PHCU and PHCC catchment populations, we have used the PHCU catchment population estimate for all 35 facilities, i.e. 35 x 15,000 = 525,000 people

Implementing Partner/s (Indicate partner/s who will be sub-contracted if applicable and corresponding sub-grant amounts)
Not applicable

CHF Project Duration (12 months max., earliest starting date will be Allocation approval date)
Indicate number of months: 7 months (March – September)

Contact details Organization's Country Office	
Organization's Address	Hai Cinema, Juba, South Sudan
Project Focal Person	Phillida Strachan Email: Phillida.Strachan@Rescue.org Tel: +211 (0) 954199395
Country Director	Susan Purdin Email: Susan.Purdin@Rescue.org Tel: +211 (0) 959000667
Finance Officer	Gabriel Munga Email: Gabriel.Munga@Rescue.org Tel: +211 (0) 959000668

Contact details Organization's HQ	
Organization's Address	122 E 42nd Street, New York, NY 10168-1289
Desk officer	Pamela Hershey Email: Pamela.Hershey@Rescue.org Tel: +1 212 551 3073
Finance Officer	Getenet Kumssa Email: Getenet.Kumssa@Rescue.org Tel: +1 212 551 3073

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]

This project targets the border States of Northern-Bahr-El-Ghazal (NBeG) and Unity. Both states have experienced extremely high levels of population growth in the last 12 months. In 2012 alone, NBeG received 12,936 returnees, and Unity State 11,973 (OCHA, Jan 2013). Internal population movements are also increasing, with inter-communal fighting, cross-border conflict and flooding displacing over 56,000 people in NBeG and Unity in 2012 (OCHA, Nov 2012). In January, aerial bombardments along the border displaced 8,000 people in NBeG (WHO Humanitarian Situation Report, Jan 2013). The IRC participated in a joint assessment verifying 651 households displaced at Warlang and Maker Anei in Aweil East (IRC, Jan 2013). Similarly life-threatening situations have been experienced in Unity State. A cattle raid in the extremely remote county of Panyijiar, the third in the year, left 27 casualties and 638 households displaced (OCHA, 18-20 December). Many families were already displaced by extensive flooding in the area. Resupplying of markets was a serious challenge due to inaccessibility during the floods, leaving communities without food and with a spoiled harvest which will have serious effects in the months to come. The inability to access life-saving surgical interventions, including comprehensive obstetric care (the nearest hospital located in Leer) also has devastating impact on families.

The Ministries of Health (MoH) in NBeG and Unity lack the resources and skills to respond to such rapid and frequent displacements. Returnees and IDPs are particularly vulnerable, often living in temporary settlements far from existing facilities and usually without financial means to pay for services, exposing them to serious health risks. A further significant influx of returnees is expected in 2013, with UN planning figures of 200,000 across the country.

NBeG and Unity also face a significant risk of disease outbreaks. Many returnees have not been immunized against communicable diseases, a contributing factor to the measles outbreak in NBeG in 2012. With many areas inaccessible during the rainy season, immunization coverage remains a challenge, leaving children exposed to recurrent outbreaks. According to IRC's 2013 KPC survey only 61.7%of children under 5 in NBeG had received measles vaccination, while in Panyijiar County just half of the targeted children under 1 had received DPT 3.

In 2012, IRC-supported facilities (21 in NBeG, 9 in Panyijiar) treated 277,302 cases, of which 33% were diagnosed with malaria. A surge in malaria cases was noted during the rainy season - from 53,098 (2011) to 65,285 (2012). This may have been related to the unusually high flooding, and increased conflict-related displacements, leading to poor sanitary conditions. Unexpectedly high caseloads added strain on the MoH's supply chain. Prepositioning of buffer stocks is vital in preparedness for potential health emergencies.

Maternal mortality rates remain critical, especially in NBeG, which has the highest rate in the county; 2,182 deaths per 100,000 people (SSHHS, 2010). IRC has worked intensively to improve maternal health care services in the target areas. ANC1 attendance in NBeG increased by 47% from 9,749 first visits in 2011 to 14,423 in 2012. The number of facility deliveries almost tripled from 574 (2011) to 1,715 deliveries (2012). Although much has been achieved, there remain significant gaps in coverage that require urgent attention, with only 32.4% of deliveries attended by skilled birth attendants (IRC KPC survey 2013).

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.

IRC's CAP 2013 budget is USD 5,206,533, of which USD 2,980,544 has already been met (Health Pooled Fund Phase1, SV Foundation, CHF Round 2 2012), leaving a gap of USD 2,225,989. IRC supports 35 facilities across NBeG and Unity, 15 of which were previously funded by BSF bridge-fund, 15 by OFDA and 5 by CHF Round2. All 35 facilities have now transitioned into HPF Phase1, which is focused on providing minimal services through a bridge-fund until Phase2 is established mid-year. For the 15 facilities previously supported by BSF, this means they will have been operating with significantly reduced budgets for 12 months by the end of HPF Phase1. Across the 35 clinics, IRC is struggling to maintain the existing safety net and is providing services at a reduced level compared to previous programs. The momentum of increased uptake of services among vulnerable communities, especially for maternal and child health, will be lost without urgent support.

IRC's proposed CHF activities will support the maintenance of the existing safety net in Panyijiar County, Unity State and Aweil East, South, Center, West and North Counties, NBeG State. CHF funding will be used to provide surge capacity to maintain coverage in maternal and child health care, easing the severe potential humanitarian consequences of the reduction in services and support. IRC will ensure adequate measures of infection control are taken at the facility level to reduce cross-infection and contamination. Emergency referrals will be strengthened by providing a motor boat to Panyijiar County, for river transport of patients requiring life-saving surgical interventions during the rainy season. These activities directly support Priority1 of the Health Cluster for 2013; maintaining the existing safety net by providing basic health packages and emergency referral services.

CHF funding will also be used to support a population of 450,000 vulnerable people in emergency preparedness and response, in line with the Health Cluster priorities of strengthening emergency preparedness and responding to health related emergencies including controlling the spread of communicable diseases. Learning from previous exposure to

[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.

public health emergencies IRC has identified the need to strengthen emergency preparedness and response of the CHDs as well as at facility level (including buffer stocks of essential drugs and training on case management of outbreak and communicable diseases), and enhance coordination and capacity-building of the MoH. CHF funding will ensure a complementary and standardized approach to life-saving emergency service provision.
IRC will prioritize safety net activities early in the grant to cover the humanitarian gap, and continue to provide EP&R throughout the project. IRC will ensure there is no overlap with our current CHF R2 2012 project, as this will end before the start of CHF R1 2013. IRC is also seeking complementary funding from ECHO, and later in the year from HPF Phase2. CHF funding will ensure there is no gap in life-saving service provision in the interim. IRC has been operational in Unity and NBeG since 1995, with ongoing health programming in both States. In addition to supporting 35 static facilities, IRC also operates mobile health clinics that give us the capacity for rapid and flexible emergency response, as well as surge capacity for gaps in coverage by health facilities.

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.

Priority 1: Maintain the existing safety net by providing basic health packages and emergency referral services
IRC will contribute to this objective through providing surge capacity to 35 facilities across NBeG and Unity States to meet the basic and life-saving health needs of the most vulnerable. IRC will distribute long-lasting impregnated mosquito nets to the most vulnerable members of the community, prioritizing pregnant women and children under 5. Hygiene promotion and awareness-raising on relevant topics affecting the communities will be conducted from the facilities and during outreach services. During National Immunization Days, logistical support will be provided to the CHDs, and vaccinators will be appointed to join the exercise in order to ensure greater coverage within the counties. Safe motherhood activities will be supported at the targeted facilities, through refresher trainings for staff and provision of supplementary RH supplies at the facilities.
Priority 2: Strengthen emergency preparedness including surgical interventions
CHF funding will be used to strengthen emergency preparedness, at the community, county and state levels, through capacity building of health staff, County Health Department (CHD) and State MoH members in Emergency Preparedness and Response (EP&R). Communities, through existing Village Health Committees, facility staff and other key stakeholders, will receive training on public health risks and ways to mitigate the effects of outbreaks and displacements or isolation due to flooding, making them more resilient to shocks. The CHD and State MoH will be supported in contingency planning, refresher training on EP&R, IDSR and initial needs assessments. Based on the local context, medical supplies will be prepositioned prior to the onset of the rainy season.
Priority 3: Respond to health related emergencies including controlling the spread of communicable diseases
Specific attention will also be paid to infection control and adherence to Universal Precautions (UP) at the health facility level, by ensuring a safe and clean environment and by providing sufficient supplies, personal protective equipment and refresher training on UP. When health related emergencies do occur, a timely response is critical to mitigate the effects of the emergency. The IRC will participate in initial rapid needs assessments and investigations together with the CHD and other partners. Based on the result the IRC will provide technical support to the CHDs to develop action plans, and assist in the implementation of these plans. Depending on the type of emergency, this may involve mass vaccination campaigns, establishing ORT corners and commencing mobile clinics in areas with an acute increase in population. Identified risks in the targeted Counties are: outbreaks (AWD, measles, meningitis, and surges in malaria cases), displacements caused by insecurity (border areas, Aweil North, Aweil East, Panyijiar) and flooding (Aweil East, Aweil South, Aweil West, Panyijiar). The IRC will also ensure the implementation of MISP for reproductive health during an acute emergency.

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)

Objective 1. Access to quality maternal and child health care services among returnee, conflict-affected and host communities is maintained through to September 2013

Objective 2. County Health Departments (Aweil East, Aweil South and Panyijiar) are strengthened to prepare and respond to public health emergencies by the end of September 2013

Objective 3. Public health emergencies related to displacements caused by flooding or insecurity and disease outbreaks (AWD, measles, meningitis, malaria) are responded to in a timely manner through to September 2013

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).

Objective 1: Access to quality maternal and child health care services among returnee, host and conflict-affected communities is maintained through to September 2013

- Provision of maternal and child health care services at the 35 supported primary health care facilities in Aweil

East, West, South, Center, North and Panyijiar Counties

- On-job training of 30 CHW or MCHWs (60% male, 40% female) at the PHCUs on ANC, PNC and referral for delivery
- Provision of equipment and supplies for maternal health care, based on needs (8,244 women of childbearing age)
- IMCI refresher training for 35 health care workers (75% men, 25% women)
- Health education and hygiene promotion sessions at the community level reaching 10,000 people (35% men, 65% women)
- Refresher training on universal precautions and infection control at the health facilities for 15 health workers (75% men, 25% women)
- Distribution of LLINs to pregnant women at ANC and children < 5 at EPI (and other vulnerable people such as the disabled)
- Strengthen referral system in Panyijiar County (Unity State) during the rainy season, a motorboat will be procured for emergency obstetric cases and other acute emergencies.

Objective 2: County Health Departments (Aweil East, Aweil South and Panyijiar) are strengthened to prevent and respond to public health emergencies by the end of September 2013,

- County level training on Emergency Preparedness and Response – Aweil East, Aweil South, Panyijiar counties, (10 members in each County, 90% men, 10% women)
- Prepositioning of buffer stocks at 35 facilities and essential drugs and supplies at 15 facilities that regularly become inaccessible during the rainy season
- Training of VHCs, health staff and other key community members in high-risk areas on EP&R

Objective 3: Public health emergencies related to displacements caused by flooding or insecurities and disease outbreaks (AWD, measles, meningitis, malaria) are responded to in a timely manner through to September 2013

- Participate in joint needs assessments and suspected outbreak investigations
- Support CHDs in coordination and implementation of emergency response
- Respond to health emergencies, through mobile clinics, outreach services, mass vaccination campaigns, oral rehydration treatment corners and awareness-raising, according to the need.
- Refresher trainings for health workers on case management of diseases with epidemic potential – 35 health workers (75% men, 25% women)

iv). Cross Cutting Issues

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

The impact of this project on the **environment** will be limited by use of proper disposal mechanisms for medical and non-medical waste, through incineration and fenced disposal pits. Project activities such as cleaning campaigns of facility compounds and other public areas, and hygiene promotion, contribute to improved sanitary environments. IRC will also ensure that facilities are adequately staffed by cleaners that provide a safe and clean environment for the provision of basic and life-saving health care.

Although recorded HIV prevalence is currently still low in the target States (<1%), so is HIV awareness (40-64%; OCHA 2009), and with on-going population movements this can lead to a potential crisis if not consistently addressed. By providing personal protective equipment and supplies, and ensuring adherence to Universal Precautions by health workers, exposure to **HIV/AIDS** in the workplace will be reduced. HIV/AIDS awareness-raising activities will be conducted at community level and in the health facilities. Condoms will be available at each facility. Post-exposure prophylaxis is available at IRC-supported PHCCs and IRC field offices. With technical support from IRC's Women's Protection and Empowerment unit, the IRC ensures health staff at PHCCs are able to manage, treat and refer survivors of sexual violence. IRC has taken a lead in the training and roll-out of MISP and Clinical Care of Sexual Assault Survivors throughout several states, including Northern Bahr el Ghazal and Unity.

IRC will ensure that all data collected from IRC-supported facilities and from community-based activities will be disaggregated by sex, in order to identify any **gender** disparities that may indicate vulnerability, particularly of women and girls. IRC will also ensure the implementation of MISP during an acute emergency, and provision of the basic reproductive health care package to maintain the existing safety net.

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.

At the end of the grant, it is expected that:

1. At least 1,500 women delivered at the IRC supported health facilities
2. All 35 IRC-supported health facilities in NBeG and Unity have infection control plans in place, updated and adhered to by facility staff
3. Three CHDs have EP&R plans in place and implemented, with timely response to health related emergencies
4. All suspected outbreaks are responded to within 48 hours of notification, limiting the number of cases

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, disaggregated by age and sex	66,740 women, 35,308 girls, 40,074 men and 35,308 boys (curative consultations, measles vaccinations during campaigns, facility deliveries & health workers trained)
x	2.	No. of measles vaccinations given to under 5 in emergency or returnee situation	7,000 girls, 7,000 boys
x	3.	Number of facility deliveries	1,500 (16% of expected births among the population)
	4.	No. r of county updated EP&R plans available	3
x	5.	Proportion of outbreaks detected, responded to within 48 hours	100%
x	6.	No. of health workers trained in MISP / communicable diseases / outbreaks / IMCI	170 health workers (70% men, 30% women) trained in one or more of the topics.

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.

The IRC will directly implement the proposed activities at the targeted project sites in coordination with the SMoH in NBeG and Unity States, and with the CHDs in Aweil East, Aweil South, Aweil North, Aweil West, Aweil Center, and Panyijiar Counties. For emergency preparedness and response the IRC will collaborate closely with the CHDs of Aweil East, Aweil South and Panyijiar Counties and other relevant stakeholders present in the target areas.

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].

Monitoring of project implementation will be conducted through monthly team meetings to update the staff on progress made, using the workplan and indicator tracking tools for the project. During quarterly meetings further analysis will be conducted by the team on progress of the project towards reaching the objectives and ensuring cross cutting issues are being addressed.

The IRC will use the MoH data tools, and supplement them with the IRC's own tools where no tools exist, to record health events in our primary health care program. The data collected will be fed into the MoH surveillance system to support epidemic surveillance, health planning and program management. IDSR data will be compiled weekly and submitted to the relevant CHDs and the SMoH. Data on morbidity, maternal and child health and immunization will be compiled monthly and entered into DHIS with a copy submitted to the SMoH. The analysis of the data on a monthly basis will inform program decision making as it pertains to progress made in the implementation process. Analysis on a quarterly basis will inform decision-making on program strategies in terms of best practice and review of lessons learned in the course of implementation.

Routine monitoring visits, conducted monthly by program staff and quarterly jointly with the CHDs, will be undertaken at the health facilities to ensure that services are in line with national treatment protocols, that quality standards are upheld and that skills and concepts covered during in service trainings are being correctly applied. The IRC will use its supervision checklist for the monthly visits and the MoH quarterly supervision checklist for the quarterly supervision visits. Through joint supervision the IRC will strengthen the CHDs' monitoring and evaluation skills.

IRC is an active participant in the Health Cluster at both State and national level and will share assessment findings with Cluster members, as well as updates on the operating context for health interventions in the target area and impact of the proposed project. IRC is the host agency for the NGO Health Forum Coordinator and Health Forum Assistant, playing a key role in basic and emergency health care coordination across agencies in South Sudan. IRC is also a member of the Health Forum Advisory Team, providing a leadership role in NGO health coordination.

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)
HPF Bridge funding Unity State: 1 January – 30 June 2013	**549,132**
HPF Bridge funding NBeG State: 1 January – 31 August 2013	**2,006,083**
Stichting Vluchteling Foundation: 1 November 2012 – 31 July 2013	**282,829**
CHF Round 2 2012: 1 November 2012 – 28 February 2013	**142,500**

[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.

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/55421	**Project title:** Basic and Emergency Primary Health Care Services in Northern Bahr el Ghazal and Unity States	**Organisation:** IRC

	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	1. Maintain the existing safety net by providing basic health packages and emergency referral services 2. Strengthen emergency preparedness including surgical interventions 3. Respond to health related emergencies including controlling the spread of communicable diseases	• Utilization rate (maintained at 0.4 consultations per person per year) • Percentage of public health emergencies investigated within 48 hours. • Number of consultations at mobile clinics/outreach (target 5,000 in 6 months	• MOH registration book • Weekly IDSR reports, rapid assessment reports • Patient registration books at mobile clinics or outreach posts	

	CHF Project Objective:	Indicators of progress:	How indicators will be measured:	Assumptions & risks:
Purpose	*What are the specific objectives to be achieved by the end of this CHF funded project?* • Access to quality maternal and child health care services among returnee, conflict-affected and host communities is maintained through to August 2013 • County Health Departments (Aweil East, Aweil South and Panyijiar) are strengthened to prepare and respond to public health emergencies by the end of August 2013 • Public health emergencies related to displacements caused by flooding or insecurity and disease outbreaks (AWD, measles, meningitis, malaria) are responded to in a timely manner through to August 2013	• *What indicators will be used to measure whether the CHF Project Objectives are achieved. Indicators may be quantitative and qualitative* • Percentage of DPT 3 among all children < 1 (target 4,108 in 6 months, baseline 4,108). • Percentage of ANC1 visits among expected pregnancies (target 82% in 6 months, baseline 82%) • Number of CHDs with updated EPR plans available • Case fatality rates of communicable diseases which have caused outbreaks are within WHO standards	*What sources of information already exist to measure this indicator? How will the project get this information?* • Patient registers, population census 2008 data • Training reports, CHD workplans, • Line-listing reports, IDSR weekly reports, patient registers	*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?* • The project area remains accessible during the project period (security, roads passable) • There are no significant unexpected political or economic shocks • Inflation remains stable
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. At least 1500 deliveries conducted at the supported facilities 2. Universal precautions are adhered to by trained staff at all supported health facilities	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged outcomes?* 1. Number of deliveries conducted by skilled birth attendant (target 900 facility deliveries in 6 months, baseline 850) 2. Percent of supported facilities with maximum score for infection control during supervision (target 80% of facilities during 6 months, baseline tbd)	**How indicators will be measured:** *What are the sources of information on these indicators?* • Delivery registers • Supervision checklists	**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?* • The project area remains accessible during the project period (security, roads passable) • The MOH protocol for EPI remains in place • Continuous vaccines and drugs supply from MOH • Staff levels are maintained • CHDs are present and functional

	3. CHDs proactively identify and organize a response to outbreaks 4. Outbreaks are contained timely and geographically, limiting excess morbidity and mortality	3. Number of CHDs with updated EPR plans available (target 3 CHDs, baseline 0) 4. Percent of suspected outbreaks responded to within 48 hours of notification (target 90%)	• EPR plans • Rapid assessment reports • IDSR reports • Emergency response reports	• IRC maintains support to Panyijiar County facilities through HPF after June. • The applied population data and its composition are realistic
	Immediate-Results - Outputs (tangible): *List the products, goods and services **(<u>grouped per areas of work</u>)** 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?*
	1. All 35 IRC supported health facilities provide primary health care services in line with the BPHS 2. All supported PHCCs are able to provide all the components of B-EmONC services in managing common complications in pregnancy and delivery. 3. All 35 IRC-supported health facilities in NBeG and Unity have infection control plans in place, updated and adhered to by facility staff 4. Three CHDs have EP&R plans in place and implemented, with timely response to health	• Total direct beneficiaries, disaggregated by age and sex (target 176,930, baseline 162,930 excl emergency response) • Percentage of PHCCs with trained midwifes, availability of drugs and equipment[3] to perform all 7 B-EmONC signal functions, in place (target 100%) • Number of health workers trained in universal precaution and infection prevention (target 80 health workers) • Percentage of supported facilities with infection control plans in place (target 90%) • Number of CHDs with updated EPR plans available (target 3)	• Patient registration books • Supervision reports • Stock reports facility • HR records and training reports • Training reports • Supervision reports • CHD EPR plans	• The project area remains accessible during the project period (security, roads passable) • Staff levels are maintained • CHDs are present and functional • Community midwives (18months training) are considered as skilled birth attendants • Expect at least one emergency situation during project implementation (measles outbreak, AWD, or mass displacements by floods or insecurity) • IRC maintains support to Panyjiar County facilities through HPF after June • The applied population data and its composition are realistic

[3] Essential B-EmONC supplies: iv-antibiotics, diazepam, magnesium sulphate, oxytocin/misoprostol, MVA equipment, vacuum extractor and neonatal ambubag

	related emergencies 5. All suspected outbreaks are responded to within 48 hours of notification	• Proportion of communicable diseases detected and responded to within 48 hours (target 90%) • Number of measles vaccinations given to under 5 in emergency or returnee situation (target tbd)	• Assessment reports • EPI reports, outbreak response reports	
	Activities: *List in a chronological order the key activities to be carried out. Ensure that the key activities will results in the project outputs.* 1. Provision of maternal and child health care services at the 35 supported primary health care facilities in Aweil East, West, South, Center, North and Panyijiar Counties 2. On-job training of 30 CHW or MCHWs (60% male, 40% female) at the PHCUs on ANC, PNC and referral for delivery 3. Provision of equipment and supplies for maternal health care, based on needs (8,244 women of childbearing age) 4. IMCI refresher training for 35 health care workers (75% men, 25% women) 5. Health education and hygiene promotion sessions at the community level reaching 10,000 people (35% men, 65% women) 6. Refresher training on universal precautions and infection control at the health facilities for 15 health workers (75% men, 25% women) 7. Distribution of LLINs to pregnant women and children <	**Inputs:** *What inputs are required to implement these activities, e.g. staff time, equipment, travel, publications costs etc.?* • Staff, equipment, drugs and medical supplies, stationeries • Supervisor, training tools, travel • RH materials and equipment • Facilitators, venue, refreshments, accommodation, transport, perdiems, stationeries and training tools • Staff, transport, IEC materials • Facilitators, venue, refreshments, accommodation, transport, perdiems, stationeries and training tools		**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?* • Project area remains accessible to the organization (politically, security, geophysically) • Staff levels are maintained • Economy remains relatively stable without significant inflation • CHDs are present and functional • Community midwives (18months training) are considered as skilled birth attendants • Expect at least one emergency situation during project implementation (measles outbreak, AWD, or mass displacements by floods or insecurity) • IRC maintains support to Panyjiar County facilities through HPF after June

	5 at EPI (and other vulnerable people such as the disabled) 8. Procure motorboat for Panyijiar County for emergency referrals during rainy season 9. County level training on Emergency Preparedness and Response – Aweil East, Aweil South, Panyijiar counties, (10 members in each County, 90% men, 10% women) 10. Prepositioning of buffer stocks at 35 facilities and essential drugs and supplies at 15 facilities that regularly become inaccessible during the rainy season 11. Training of VHCs, health staff and other key community members in high-risk areas on EP&R 12. Participate in joint needs assessments and suspected outbreak investigations 13. Support CHDs in coordination and implementation of emergency response 14. Respond to health emergencies, through mobile clinics, outreach services, mass vaccination campaigns, oral rehydration treatment corners and awareness-raising, according to the need. 15. Refresher trainings for health workers on case management of diseases with epidemic potential – 35 health workers (75% men, 25% women)	• LLINs, transport for distributions, stationeries for recording. • Motorboat, fuel, maintenance, jetty rental, guard, driver • Facilitators, venue, refreshments, accommodation, transport, perdiems, stationeries and training tools • Medical supplies, drugs, storage box.cupboard. • Facilitators, venue, refreshments, accommodation, transport, perdiems, stationeries and training tools • Staff, transport, stationeries, assessment tools if applicable • Transport, stationeries, assessment tools • Transport, staff-per diems, drugs and supplies, stationeries, furniture, IEC materials • Facilitators, venue, refreshments, accommodation, transport, perdiems, stationeries and training tools		

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**		
			Mar	Apr	May	Jun	Jul	Aug	Sep						
Activity 1 Provision of maternal and child health care services at the 35 supported primary health care facilities															
Activity 2 On-job training of 30 CHW or MCHWs on ANC, PNC and referral for delivery															
Activity 3 Provision of equipment and supplies for maternal health care, based on needs															
Activity 4 IMCI refresher training for 35 health care workers															
Activity 5 Health education and hygiene promotion sessions at the community															
Activity 6 Refresher training on universal precautions and infection control at the health facilities for 15 health workers															
Activity 7 Distribution of LLINs to pregnant women and children < 5 at EPI															
Activity 8 Procure motorboat for Panyijiar County for emergency referrals during rainy season															
Activity 9 County level training on Emergency Preparedness and Response															
Activity 10 Prepositioning of buffer stocks at 35 facilities and essential drugs and supplies at 15 facilities that regularly become inaccessible during the rainy season															
Activity 11 Training of VHCs, health staff and other key community members in high-risk areas on EP&R															
Activity 12 Participate in joint needs assessments and suspected outbreak investigations															
Activity 13 Support CHDs in coordination and implementation of emergency response															
Activity 14 Respond to health emergencies according to the need.															
Activity 15 Refresher trainings for health workers on case management of diseases with epidemic potential – 35 health workers															

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