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

- 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)

Cluster Geographic Priorities for this CHF Round

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

MENTOR

Project CAP Code

SSD-13/H/55464/8662

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

Emergency Control of Malaria and other Major Vector Borne Diseases (VBD) amongst IDPs, Returnees and Vulnerable Host Communities in Conflict and Flood Affected Areas of Warrap, Unity and Upper Nile 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
Warrap	50	Twic, Gogrial West
Upper Nile	50	Malakal

Total Project Budget requested in the in South Sudan CAP	US$ 1,220,000
Total funding secured for the CAP project ***(to date)***	US$ 500.000

Funding requested from CHF for this project proposal	US$ 200.000

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[1]	Number of direct beneficiaries targeted in the CAP[2]
Women:	77.884	233.668
Girls:	20.116	63.032
Men:	81.884	230.268
Boys:	20.116	63.032
Total:	**200.000**	**590.000**

Indirect Beneficiaries

Health care workers, MoH State teams.

Catchment Population (if applicable)

1.000.000

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

N/A

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

Indicate number of months: 7 (March – September)

[1] Gender and age ratios are calculated using the following percentages : Total population 51% male / 49% female (source: Statistical Year Book of Southern Sudan 2010); population under 5 years of age (girls and boys): 18.8% (source: 'Children in South Sudan', Unicef South Sudan, data from Southern Sudan Household Survey 2010)

[2] Total number of direct beneficiaries targeted in the CAP includes the direct target population for the MENTOR Multi Cluster Proposal, targeting refugees in Yida (Unity State) and camps in Maban County Upper Nile State. Gender and age rations therefore also considers the following percentages for the 190.000 refugees: Total population 47% male / 53% female of these 12% girls under 5 / 12% boys under 5 (source: UNHCR Data on Refugees 11th January 2013, http://data.unhcr.org)

Contact details Organization's Country Office	
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Finance Officer	*Kayleigh Hortop, finco.southsudan@mentor-initiative.net, +211 912 683 846*

Contact details Organization's HQ	
Organization's Address	The Pinnacle, Central Court, Station Way, Crawley, West Sussex RH10 1JH, UK
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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[3]

Following independence on the 9th July 2011, after five years of semi-autonomous status and decades of conflict between the north and the south in what was previously Africa's largest country, the Republic of South Sudan continues today to face immense challenges both externally and internally: While the relations with Sudan to the north continue to be hostile with recurrent armed conflicts, a functional state system is yet to be established to allow the population to access quality health care, education and general infrastructure, and in the conflict affected areas, health services are generally speaking very poor, and sometimes none existent.

Population movements in the northern states of South Sudan continue to be very important due to ongoing fighting between the SPLA and the SAF and dissident internal militia groups as well as inter-tribal conflicts and floods, droughts and consequent food insecurity. While an estimated 300.000 people were displaced internally in the country in 2012, OCHA expects an additional 200.000 people to be displaced in 2013. Following the "Come Home to Choose campaign" launched by the Republic of South Sudan in September 2010, 1.5 million southerners living in north were encouraged and facilitated the return, primarily from Sudan. According to OCHA the number of returnees from Sudan arriving during 2012 was around 132,000. An additional 125.000 people are expected to return from Sudan to South Sudan during 2013.

An important part of these population movements takes place in the two border states of Warrap and Upper Nile where the presence of Vector Borne Diseases (VBD) is posing high risks of epidemics for these vulnerable populations. In this context of large scale people displacement, insecurity, limited or no access to vulnerable populations during floods and/or insecurity incidents as well as a very basic health system struggling to cope with the needs of the communities it serves, malaria is endemic and recorded as being the principal course of mortality and morbidity. And according to MoH data provided by WHO, the number of cases has been more than doubling since 2010 across the target States (in Upper Nile, six times as many cases as in 2010 were recorded in 2012). Other VBDs, such as yellow fever, kala azar and trachoma are present, though to a much lesser scale but with a high risk of outbreaks.

The MENTOR Initiative proposes, with this requested support from (among others) CHF, to provide VBD control activities in Warrap and Upper Nile. It is expected that 30% of the total population in the three States targeted (Upper Nile: 964,353 and Warrap: 972,928) will have access to improved case management services following the MENTOR intervention and within this catchment population, an estimated 200.000 individuals will furthermore profit directly from vector control campaigns. MENTOR activities will be concentrated in the following returnee / displaced people intensive counties: Twic and Gogrial West (Warrap) and Malakal (Upper Nile).

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.

MENTOR started VBD control activities in South Sudan in May 2012 following an evaluation mission in February and extensive requests for support from partner organisations and agencies as well as Ministry of Health (MoH) in conflict areas in the border states towards Sudan. MENTOR, a specialized organization in emergency control of malaria and other VBDs, is currently implementing case management and vector control campaigns in Warrap and Upper Nile States among returnees, displaced people and surrounding host population and will pursue to do so (with expansion into Unity State) during 2013 in order to respond to the continued critical gaps within VBD control in these States.

The epidemiology of malaria (transmitted by anopheles mosquitoes) varies across the targeted states: Warrap has a high malaria transmission all year round (20 to 25% of caseloads at health facility level), which makes the more than 50.000 returnees/displaced people present in Warrap, originating from areas with little malaria transmission, extremely vulnerable to develop severe malaria due to lack of immunity. Upper Nile has the lowest annual transmission of malaria of all northern state. Therefore its conflict torn communities have no natural immunity to the disease and the risk of outbreaks is extremely high.

Other VBDs are highly present in the northern states and are all at risk of escalating when communities are displaced into transmission areas, or when living conditions (water and sanitation) deteriorate, and access to health services is cut by flooding etc. Outbreaks of Kala Azar (transmitted by sandflies) occurred extensively in Upper Nile during 2012 and as treatment facilities are few,

[3] 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.

access to treatment is a challenge. While Trachoma (transmitted by flies) is widespread in South Sudan, much of Warrap State and some parts of Upper Nile State suffer the highest incidence of this disease. Lymphatic Filariasis (transmitted by Aedes and Anopheles mosquitoes) as well as dengue fever, yellow fever and rift valley fever (transmitted by aedes mosquitoes) pose additional epidemic risk to the target population in the present emergency context.

MENTOR is the only organization in South Sudan that has the skills-set to apply a holistic approach to achieve control of the ongoing VBD emergencies: Training of health care workers in management of vector borne (communicable) diseases particularly in emergency settings; critical gap filling of essential VBD diagnostic tests and treatments to meet acute needs during the rainy season; and delivery of targeted vector control campaigns to minimize the risk of outbreaks. Epidemic preparedness is a key word in all MENTOR activities and, as such, CHF funding through this round1 will be extremely timely in order to prepare for the rainy season 2013. Alternative funding is presently being requested for from USAID, whilst partnerships are being built with agencies such as WHO and Unicef for additional, specific support (GIK, small scale PCAs etc.).

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.

Basic safety net: Supply lines of malaria tests and treatments are regularly interrupted. And vital diagnostic tools for other VBDs are chronically lacking in the target areas – leading to mistreatment and very likely missed outbreaks. While it is expected that drugs and diagnostic tests for outbreak contingency stocks will be provided from alternative donors, CHF funding to this proposal would allow for vital gap filling stocks to be provided for the anticipated drug ruptures at health facility level.

Emergency Preparedness: This CHF funding would allow for essential training of health care workers on epidemic preparedness and management of VBD. In addition, through support visits directly in the health facilities serving the catchment population, MENTOR will be providing onsite supervision of data collection in order to facilitate early warning in case of risk of epidemics.

Emergency Response: While the MENTOR medical team will be participating in an emergency response through direct technical / clinical support with case management, outbreak vector control campaigns will equally be organised in case of an epidemic or high risk of the same. While commodities for such campaigns will be supplied from alternative donors, this CHF funding would allow for payments to community based workers whose work is essential to mount an efficient response. Participation in these campaigns will allow for empowerment of the beneficiaries as they would receive important technical training on control mechanisms in case of VBD outbreaks.

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)

With supplementary funding from alternative donors and targeting an estimated 200.000 IDPs, returnees and surrounding host communities affected by floods, displacement and/or conflict in Warrap and Upper Nile States in South Sudan from March to September 2013 (6 months):

1. Mitigate the risk of VBD epidemics during the coming rainy season and prepare for an efficient response in case of an outbreak in target areas in Warrap and Upper Nile States.
2. Reduce the burden and impact of major VBDs during the coming rainy season amongst the target population by improving access to quality diagnosis and treatment of VBDs within health facilities in the target area.

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).

In order to achieve the project objectives, the following activities will be carried out:

- Train health care workers from the targeted health facilities on epidemic preparedness and diagnosis / case management of major VBDs. This includes the provision of treatment guidelines, differential diagnosis diagrams and other tools to obtain increased quality in VBD case management.
- Implementation of regular on-site coaching sessions by the MENTOR technical team to the target health facilities in order to check drug stock levels, ensure application of correct diagnosis and treatment protocols and facilitate early detection of epidemics through improved epidemiological reporting.
- Provide malaria rapid tests and drugs to targeted health facilities in case of stock rupture. A contingency stock of malaria drugs and tests will be provided through alternative funding and supplied in case of epidemics.
- Provide rapid tests for major VBDs (other than malaria) to selected health facilities with capacity to properly treat these illnesses.
- Organise outbreak vector control campaigns to respond in case of risk of epidemics. Such campaigns will be implemented by community based workers from the target areas. While CHF funding will allow for payment of the community based workers, all equipment and consumables (insecticides) required for these campaigns will be provided from alternative funding.

It is intended to carry out all of the above activities in target Counties in Warrap and Upper Nile States – except for the outbreak vector control campaigns which will be dependent on where areas with high risks of epidemics are identified. The expected age and gender ratio for the activities will mirror the percentages presented on the first page.

iv). Cross Cutting Issues

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

The beneficiaries of this programme cover all age groups and sex. In addition, outbreak vector control campaigns will be implemented in targeted host/returnee villages and towns in flood risk areas, with MoH and key State based partner agencies. It is important to note that such campaigns effectively target the community as a whole and is therefore not subject to any form of gender inequality.
The training sessions and following on-site technical coaching will include instructions on proper disposal of medical commodities and sharps boxes will be provided. The insecticides used during outbreak vector control campaigns have been selected on the basis of their suitability to the local vectors, the local operating context and national policy. They are environmentally adapted and best suited to deliver effective VBD protection for targeted communities living in temporary camps, villages and towns.
Generally speaking, the suggested activities will aim to cover all populations within the target areas regardless of ethnic background, HIV/AIDS status, religious belief and political background.

v) Expected Result/s

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

The objectives for this proposal are two-fold and yet completely integrated and interdependent: In order to achieve efficient outbreak preparedness and response for malaria and/or other VBDs in the target areas, it is vital to improve the case management skills of the health care workers as these will play an important role during a potential outbreak. As such, it is expected that, through training sessions, on-site technical coaching at health facility level and supply of drugs and diagnostic tests in case of stock-outs, the capacities of the targeted health staff (at least 30 people) to properly diagnose and treat malaria and other major VBDs will have increased. In addition, it is expected that these same health technicians will have achieved sufficient outbreak preparedness and response skills. This includes implementation and an understanding of the importance of timely reporting on morbidity (and mortality) at their respective health facility.

MENTOR will furthermore implement vector control campaigns in order to mitigate the risk of epidemics amongst the target populations. Such campaigns will be implemented to scale wherever the risk for an outbreak is considered high. It will be members from the communities that will be participating directly in these campaigns and through this activity it is expected that, on top of the improved health conditions for these populations, general knowledge of malaria and other VBDs will be greatly improved among these very vulnerable community members.

The aim of reaching 200.000 direct beneficiaries may seem ambitious for a six months proposal, however, this is to be achieved with supplementary funding from other donors.

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	200.000[4]
X	2.	Proportion of communicable diseases detected and responded to within 48 hours	Weekly monitoring of outbreaks will be undertaken Responding to 80%-85% of the outbreaks within 48 hours
X	3.	Number of health workers trained in communicable diseases / outbreaks	At least 30 health workers
	4.	Number of supported health facilities experiencing stock outs for malaria commodities for longer than one week during the first month of an identified malaria epidemic	0
	5.	Percentage of patients attending programme supported health facilities with suspected clinical malaria are tested with a rapid diagnostic test or microscopy to confirm the diagnosis prior to treatment with ACT	70%
	6.	Percentage of RDT confirmed malaria cases seen at programme supported facilities receive appropriate treatment with ACT	85%

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.

While MENTOR started operations in South Sudan only in May 2012, the organization has today a well-established capacity on the ground to implement the suggested activities. MENTOR is officially registered in South Sudan and is part of the NGO forum. The required human resources (local as well as international staff) with the needed skills-set are present in the country and MENTOR provides consistent technical support to the National Malaria Control Programme (NMCP) both at State and National level, participates actively in cluster meetings (health, multi sector, logistics) and is part of other coordinating mechanisms related to VBDs (for instance the forum on Neglected Tropical Diseases). As such, MENTOR is today an important stakeholder for VBD control amongst both national and international stakeholders.

- A support base is functional in Juba and field bases (with adequate logistical means such as cold chain and vehicles) are already set up in Warrap and Upper Nile (Malakal).
- Activities will be initiated in the areas where MENTOR already has an operational set up and then programme implementation

[4] Malaria affects all age groups in these low transmission, epidemic prone target areas. We therefore choose to indicate the total target numbers). During the house-to-house data collection when undertaking the prevention campaigns, a specific census will be obtained on whether the covered population is host, returnee or IDPs and possibly the specific number of men/women covered if evaluated suitable for the extensive data collection.

will proceed to the other target areas as soon as these have the required support structures in place.
- Drugs and rapid diagnostic tests will be ordered immediately upon approval of this proposal to avoid delays in supplying these to the targeted health facilities during the upcoming rainy season. As MENTOR has been importing these vital commodities over the past year, our organization is by now well known by the local authorities involved with importation and tax exemption.
- Training sessions of health care workers from the targeted health centers will be organised as a priority as this is the foundation of obtaining efficient emergency preparedness and response as well as improving VBD management in the basic health system.
- Regular visits to health facilities will be organised to organize for on-site technical coaching – following the above mentioned training sessions – which, in addition to clinical aspects of VBD control, will include reporting, data collection and stock management.
- Based on epidemiological data, outbreak vector control campaigns will be organised wherever there is a high risk of an epidemic.
- Coordination and collaboration with other stakeholders (national as well as international) are keywords to the success of this programme (as it is the case for activities currently implemented). Clear and detailed Memorandums of Understanding (MoUs) will be set up with the MoH/NMCP and, as appropriate, with other stakeholders to ensure a transparent and efficient support right from the beginning.

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)[5].

All activities will be monitored through the use of standard monitoring templates for vector borne disease control activities at health facility level and at community level.
Key areas of monitoring and evaluation will include:

a. Quality of health service diagnostic capacity and case management capacity
b. Malaria commodity supply chain and stock outs
c. IRS coverage and acceptability
d. Larvicide and fly control campaign coverage and impact.

MENTOR has a well developed, tried and tested package of malaria health service monitoring templates that will be adapted for the given locations in South Sudan, as part of monthly health facility technical coaching / supervision trips by heath partners and programme staff. Furthermore, an existing survey tool for measuring coverage and usage of prevention tools is now in use in this setting.

In addition, internal bi-weekly situation reports from the field mission to HQ allows for regular and rather detailed updates and exchanges on progress as well as challenges and furthermore ensures that technical support to the field is provided as and when required. Formal monthly reports on programme progress towards objectives are also set up and shared with local stakeholders and donors. These include information on activities and results.

Finally, it is important to mention that MENTOR possesses a true field based organizational culture and, as such, both international and local staff are spending an important part of their time in the field next to the beneficiaries – which allows for regular and direct follow up on activities and recording of results.

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)
OFDA 2012	500,000

Total of USD 895.275 is required in addition to the requested funds requested from CHF, to complete the full extent of the programme (kindly refer to the Budget). USD 500,000 has already been secured from other sources and additional sources are being identified to secure the remaining for 2013.

[5] 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/55464	**Project title: Emergency Response to Control Malaria and other Major Vector Borne Diseases (VBD) amongst IDPs, Returnees and Vulnerable Host Communities in Conflict and Flood Affected Areas of Warrap and Upper Nile States**	**Organisation: The MENTOR Initiative**

LOGICAL FRAMEWORK				
CHF ref./CAP Code: SSD-13/H/55464	**Project title: Emergency Response to Control Malaria and other Major Vector Borne Diseases (VBD) amongst IDPs, Returnees and Vulnerable Host Communities in Conflict and Flood Affected Areas of Warrap and Upper Nile States**		**Organisation: The MENTOR Initiative**	
Overall Objective	**Cluster Priority Activities for this CHF Allocation:** *What are the Cluster Priority activities for this CHF funding round this project is contributing to:* • Basic Safety Net • Emergency Preparedness • Emergency Response	**Indicators of progress:** *What are the key indicators related to the achievement of the CAP project objective?* • 70% of patients attending (programme supported) health facilities with suspected clinical malaria are tested with a rapid diagnostic test to confirm the diagnosis prior to treatment with ACT. • 70% of all RDT confirmed malaria cases seen at programme supported facilities receive appropriate treatment with ACT for uncomplicated cases (or IV Quinine / IM artemether) for severe cases. • 75% of clinically (or RDT) confirmed dengue cases receive basic symptomatic treatment. • Haemorraghic cases (confirmed not as dengue) are sampled and sent for testing by a partner laboratory with test facilities for Rift Valley and other viral VBDs. • Minimum 80% of the targeted beneficiaries are protected from malaria using IRS (plus reduced risk from other mosquito borne diseases). • Up to 345.672 people protected from fly born disease and nuisance insects in camp /settlement settings through control of insect breeding sites and fly control. • At least 35 functioning health facilities (including mobile and static) serving the most vulnerable targeted communities will receive support (technical, material or both) • At least one health provider from at least 35 health facilities (including mobile and static) in targeted emergency areas will receive on the job technical coaching. • The following will be distributed: ACT: 60,000 treatments, Artemether: 3.000 treatments, RDT (malaria): 100.000 tests, RDT (dengue fever): 4000 tests Indicator 7: Number of people trained in the use and safe disposal of medical	**How indicators will be measured:** *What are the sources of information on these indicators?* • Patient records from health facilities • Supervisory forms used during technical coaching visits to health facilities • MENTOR stock records • Material used for training of health care worker.	

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Purpose	**CHF Project Objective:** *What are the specific objectives to be achieved by the end of this CHF funded project?* • Mitigate the risk of VBD epidemics during the coming rainy season and prepare for an efficient response in case of an outbreak in target areas in Warrap and Upper Nile States. • Reduce the burden and impact of major VBDs during the coming rainy season amongst the target population by improving access to quality diagnosis and treatment of VBDs within health facilities in the target area.	**Indicators of progress:** *What indicators will be used to measure whether the CHF Project Objectives are achieved. Indicators may be quantitative and qualitative* • Emergency Preparedness Response set up through contingency stocks of drugs and RDTs as well as training of community members in the implementation of IRS campaigns • Overall average monthly incidence rate of malaria as recorded within the targeted health facilities is below 20% for Warrap and below 15% for Upper Nile at the end of the programme period.	**How indicators will be measured:** *What sources of information already exist to measure this indicator? How will the project get this information?* • MENTOR stock records • MENTOR training records • Statistics collected at health facility level.	**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?* • The main operational partners of MENTOR in South Sudan, i.e. MoH, National Malaria Control Programme, UN agencies, IOM and international NGOs will continue to co-ordinate well together. • The security situation in Warrap and Upper Nile will allow adequate access to the targeted communities. • Flooding during the rainy season may render certain areas of intervention difficult to access. The programme will use air, boat and road transport flexibly to meet these challenges, and will where ever possible maximize the options for sending cargo on partner NGO, IOM and UN existing transport flights, boats and trucking routes.
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*. • Increase in case management skills within the targeted health facilities. • Improved knowledge at community level in regards to prevention against VBDs	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged outcomes?* • 70% of patients attending programme supported health facilities with suspected clinical malaria are tested with a rapid diagnostic test or microscopy to confirm the diagnosis prior to treatment with ACT • Within selected health facilities, which possess the necessary capacity for dengue fever clinical diagnosis, all cases which test negative for malaria by RDT and which have dengue fever symptoms, are tested with dengue RDTs to confirm cause of illness • 80% of the targeted population receive Information-Education-	**How indicators will be measured:** *What are the sources of information on these indicators?* • Health facility records • Information recorded during technical coaching visits. • Internal records from prevention activities	**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 IDP, returnee and host communities continue to supportive of interventions. • Health care workers will collaborate, and be willing to use tools and technical support provided.

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		Communication concerning prevention against VBDs through the community members trained in the usage of standard prevention tools		
	Immediate-Results - Outputs (tangible): *List the products, goods and services **(grouped per areas of work)** that will result from the implementation of project activities. Ensure that the outputs are worded in a manner that describes their contribution to the outcomes.* Improved case management at health facility level: Standard training sessions, complemented by on-site technical coaching of at least 30 health care workers; Supply of drugs and diagnostic tests in case of stock-outs • Outbreak preparedness: Improved timely reporting on morbidity (and mortality) from the targeted health facilities. Training of community members in the correct use of vector control tools. • Vector Control: Three different kinds of prevention tools will be used during vector control campaigns: Indoor Residual Spraying (IRS), Larviciding and Fly Control in the aim to provide prevention against a large specter of VBDs.	**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.* • Total direct beneficiaries: 200.000 people • 80-85% of detected outbreaks are responded to within 48hrs • At least 30 health workers are trained in communicable diseases / outbreaks • 0 supported health facilities experiencing stock outs for malaria commodities for longer than one week during the first month of an identified malaria epidemic • 70% patients attending programme supported health facilities with suspected clinical malaria are tested with a rapid diagnostic test or microscopy to confirm the diagnosis prior to treatment with ACT • Percentage of RDT confirmed malaria cases seen at programme supported facilities receive appropriate treatment with ACT	**How indicators will be measured:** *What are the sources of information on these indicators?* • Records from health facilities. • MENTOR stock records • Internal MENTOR records from prevention campaigns	**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?* • International suppliers of VBD control materials will be able to provide commodities in a timely manner. • Authorisation to import program commodities free of tax will be granted by the South Sudan government. • Other donors will provide co-funding to the activities.

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	Activities: *List in a chronological order the key activities to be carried out. Ensure that the key activities will results in the project outputs.* • Train health care workers from the targeted health facilities on epidemic preparedness and diagnosis / case management of major VBDs. This includes the provision of treatment guidelines, differential diagnosis diagrams and other tools to obtain increased quality in VBD case management. • Provide malaria rapid tests and drugs to targeted health facilities in case of stock rupture. A contingency stock of malaria drugs and tests will be provided through alternative funding and supplied in case of epidemics. • Provide rapid tests for major VBDs (other than malaria) to selected health facilities with capacity to properly treat these illnesses. • Implementation of regular on-site coaching sessions by the MENTOR technical team to the target health facilities in order to check drug stock levels, ensure application of correct diagnosis and treatment protocols and facilitate early detection of epidemics through improved epidemiological reporting. • Organise outbreak vector control campaigns to respond in case of risk of epidemics. Such campaigns will be implemented by community based workers from the target areas. While CHF funding will allow for payment of the community based workers, all equipment and consumables (insecticides) required for these campaigns will be provided from alternative funding.	**Inputs:** *What inputs are required to implement these activities, e.g. staff time, equipment, travel, publications costs etc.?* • ACTs and RDTs (Malaria, Chikungunya and Schistosomiasis) • Three technical coordinators, three medical managers and 12 core supervisors (25% funded by CHF) • Support staff (20-33% funded by CHF) • 3200 dayworker-days members from the target communities) • International travel for technical coordinators and internal travel (by UNHAS flight and vehicle)		**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?* • Qualified human resources (international and national) are available. • Price levels in country (including fuel prices and salary level within humanitarian activity) remain relatively stable.

PROJECT WORK PLAN

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

Activities	Q1/2013			Q2/2013			Q3/2013			Q4/2013			Q1/2014		
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
Training of health care workers			X	X											
Provide ACT and RDTs in case of stock gap			X												
On-site coaching visits				X	X	X	X	X	X						
Outbreak vector control campaigns				X	X	X	X	X	X						
Activity 5															
Activity 6															
Activity 7															
Activity 8															
Activity 9															
Activity 10															

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