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

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

Requesting Organization

Universal Network for Knowledge & Empowerment Agency (UNKEA)

Project CAP Code

SSD-13/H/52572/14572

CAP Project Title

To provide basic Primary Health Care Packages to the vulnerable Returnees, host community and IDPs

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
Upper Nile	100%	Nasir

Total Project Budget requested in the in South Sudan CAP	US$: 529,000
Total funding secured for the CAP project *(to date)*	US$ N/A

Funding requested from CHF for this project proposal	US$: **150,000**

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

Direct Beneficiaries

	Number of direct beneficiaries targeted in CHF Project	Number of direct beneficiaries targeted in the CAP
Women:	4,301	8,243
Girls:	6,842	13,114
Men:	3,714	7,119
Boys:	4,692	8,992
Total	**19,548**	**37,428**

Indirect Beneficiaries

59,700 women/girls/boys/men

Catchment Population (if applicable)

201,002 according to 2008 census

Implementing Partner/s

UNKEA

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

6 Months (April – September)

Contact details Organization's Country Office

Contact details Organization's HQ

Organization's Address	P.O Box: 504 Juba, South Sudan Munuki payam Juba along Gudele road at ICCO compound
Project Focal Person	*Lock Simon Peter* *Health Manager* *Locksimon2000@yahoo.com* *+211 912 613 429*
Country Director	*Mr. Simon Bhan Chuol* *Unkea.sudan@yahoo.com* *Unkea.southsudan@gmail.com* *www.unkea-southsudan.org* *+211 955 295 774* *+211 917 976 984*
Finance Officer	*Mr. David Dak Deng* *Deng_dak@yahoo.co.uk* *+211 955 812 211*

Organization's Address	Nasir County P.O Box: 504 Juba
Desk officer	*See at the left hand side*
Finance Officer	*See at the left hand side*

SECTION II

A. Humanitarian Context Analysis

Post conflict areas such as Nasir in South Sudan, are often faced with similar challenges ranging from inadequate social services, high mobility of the displaced people, incompetent governance systems, and overwhelming budgetary demands on the government's limited resources.

Nasir is a county with dismal socio-economic indicators: a doctor/patient ratio of 1/200 for a population of 210, 000[1] only 2% of all deliveries being attended to by a qualified medical person; 5% and 35% access to proper sanitation and clean water respectively; 8% toilet coverage resulting in mass open defecation leading to recurrent health hazards like cholera and diarrhea outbreaks which claim tens of the lives of men, women, boys and girls and especially to under five boys/girls. Moreover, lack of immunization for girls/boys under five increases the risk of under five mortality rates which though at 4.5% against a national 8.4%[2], is still high if weighted against the global average of 230/100,000[3]. The situation is further compounded by the presence of over 11,000 IDPs, over 1000 returnees and a poor insecure host community.

Effects of mass poverty and traumas resulting from displacement including living in congested, insecure and unhygienic spaces with poor or non-existent sanitation facilities, worsened by the cumulative effects of poor hygiene multiplies the communities' vulnerabilities to disease outbreaks like cholera, measles for girls/boys under five, diarrhea, pneumonia and TB to create almost continuous states of health emergencies.

The results of August 2011 needs and assets conducted by UNKEA in Nasir revealed that effects of low literacy levels, widespread poverty[4] and early marriages increase the maternal mobility and mortalities especially among adolescent girls under 15 resulting from pregnancy related and child birth complications including severe bleeding and infections(mostly after birth), pregnancy induced High blood pressure(pre-eclampsia and eclampsia).These complications contributed to more than 83% of all maternal mortalities. Malaria, AIDS, and unsafe abortion practices constitute the rest. Poor women among vulnerable IDPs/returnees and host communities in the identified Payams are the least likely to receive adequate health care due to low numbers of skilled health workers, long walking distances to medical facilities, Lack of appropriate information especially in regard to emergency response, pregnancies/child birth and myths surrounding HIV/AIDS, inadequate services at government run health facilities including personnel and drug shortages and negative cultural practices which prohibit the digging of pit latrines.

With the withdrawal of ***Save the Children,*** which has been funding the health facilities of Jikmir PHCC, Kierwan PHCU, Mandeng PHCU and Torpuot PHCU, from Nasir in 2012, the 69,699 women/girls/boys and men beneficiaries of health services are now exposed to serious health reversals. With no supplies and staff, 69.699 women, girls, boys and men are without emergency health services and hence dangerously exposed to mass ill health and possible deaths. Health Units in Nasir County, which is generally characterized by occasional inter and intra community tensions and consequent flare ups, not only need to be functional but also have updated capacities in emergency secondary and surgical care.

Source

1 : Population & Housing Census, GOSS, 2008

2:Nasir County Statistics Office

3: Source: http://pulitzercenter.org

4:Relationship between poverty & disease prevalence:(WHO/Maternal Mortality Fact Sheet, May 2012)

B. Grant Request Justification

The majority of IDPs and returnees in Nasir County live in congested settlements, on public or private land, without adequate access to water and sanitation facilities and often are beholden to “gatekeepers” to ensure that assistance is received. Socialization issues also expose them to high risks of contracting HIV/AIDS within these makeshift settlements. IDP/returnee life is mostly characterized by frequent abuse, exploitation, insecurity, child abuse, neglect and sexual violence. In the absence of strong and effective state institutions, IDPs and returnees together with members of host communities will continue to face serious primary health care concerns. Even for those IDPs and returnees being resettled on individual farms post-camp life is characterized by serious social-economic recovery struggles with health indicators being extremely poor, with high rates of HIV/AIDS and malaria, poor nutrition and low Reproductive, New born and Child Health Indicators. Maternal, Statistics for children under five are especially dismal, in sharp contrast to progress being made in the rest of African countries in maternal and child survival.

From the foregoing, urgent availing of primary health care packages including the provision of skills and capacities necessary to recognize and manage common child/under five boys/girls and maternal illness at the home and community as the populations resettle into their long abandoned villages is absolutely critical. This programme will improve access to ante natal services for young mothers, help them to receive postpartum care and support, information to prevent unwanted and too-early pregnancies especially to school age girl adolescents of under 17, access to family planning, immunization for under five, capacity building for key project staff to enhance their capacities in delivering health solutions to community, increased community awareness of HIV/AIDS issues while appreciating the role of women in decision making to enhance the health of the community. Through the equipping of the health units with essential supplies, UNKEA enhances easier access to vulnerable and marginalized groups like women to receive health care services. Women are especially targeted as key beneficiaries to mainstream their voices in the county decision making processes.

Its UNKEA’s experience that a culture of exclusivity where women are only to follow male decisions exists up to date ;thus, UNKEA will purposely ensure women are given special consideration especially in regard to training and other capacity building initiatives.

Universal Network for Knowledge & Empowerment Agency formerly name; Upper Nile Kalaazar Eradication Association will maintain its existing health personnel’s at four health facilities of Nasir County .These are qualified and experienced personnel who bring expertise in this emergency response ensuring speedily and impactful component deliverables. UNKEA is currently running four health facilities of Jikmir PHCC, Kierwan PHCU, Mandeng PHCU, and Torpuot PHCU serving a combined population of 69,699 community members. UNKEA’s long presence in the community gives it the advantage of cultivated community goodwill and trust essential for any effective community intervention and sustainability of intervention outcomes. What is more, UNKEA will find it easy getting volunteers from youthful members of the community ensuring cost effectiveness and sustainability of the initiative.

C. Project Description (For CHF Component only)

i) Contribution to Cluster Objectives

Equipping the health units in Jikmir PHCC, Kierwan PHCU, Mandeng PHCU, Torpuot and PHCU with essential supplies and enhancing the capacity of medical personnel to respond to health emergencies like do enhance the capacity of these health units to urgently and effectively manage health challenges of the IDPs/returnees and host communities while competently making appropriate referrals thereby contributing to key health cluster objective 1 of , Maintaining the existing safety net by providing basic health packages and emergency referral services .Additionally, By implementing objective (b) in Part C(ii) below, UNKEA enhances the surgical capacitates of health personnel which in effect increases the emergency preparedness for both the personnel and the health units thereby contributing to the achievement of cluster priority

(2)Emergency Preparedness.

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)

I. To prevent and reduce excess mortality and morbidity rate by providing basic health packages and emergency referral services
II. Control the spread of communicable diseases
III. Strengthen the capacity for response to emergencies including surgical intervention

iii) Proposed Activities

I. Request and distribution of 5,000 in-kind treated mosquito nets for malaria and Kalaazar prevention to 5,000 beneficiaries in Nasir hospital, Jikmir PHCC, Mading PHCC and three PHCUs of Mandeng, Kierwan, Torpuot
II. Conduct accelerated training and refresher courses to reach 12 community health workers on emergency related illnesses, I clinical officer/4 midwives/6 nurses on emergency obstetrics and minor operation,6 EPI staff on Immunization, and 4 county health department staff on management of emergency diseases in Nasir, Kierwan, Torpuot, Jikmir, Mandeng.
II. Conduct 45 community theatre outreaches on EPI/Immunization, Measles Vaccination, HIV/AIDS, Hygiene, Sanitation, waste disposal and open defecation sensitization awareness campaigns in Kierwan, Torpuot, Jikmir, Mandeng.
V. Conduct 1 capacity building training for 30 community health Committee and CHD in Kierwan, Torpuot, Jikmir, Mandeng.
V. Procurement of medical supplies and transportation such as laboratory equipments, lab regent, coaches, MCH materials to Jikmir PHCC, Mading PHCC and three PHCUs of Mandeng, Kierwan and Torpuot by May 2013

Activity	Nasir						Jikmir						Mading						Mandeng						Kierwan					
	Male			Female			Male			Female			Male			Female			Male			Female			Male			Female		
	<5	<18	>18	<5	<18	>18	<5	<18	>18	<5	<18	>18	<5	<18	>18	<5	<18	>18	<5	<18	>18	<5	<18	>18	<5	<18	>18	<5	<18	>18
Distribution of Mosquito nets	145	150	200	150	200	150	145	155	200	175	175	150	200	150	200	175	150	150	150	150	200	150	130	150	200	150	200	150	200	150
Improving health services	1156	890	890	3,500	1130	1130	890	890	890	1130	1130	1130	890	890	890	1130	1130	1130	890	890	890	1130	1130	1130	890	890	890	1198	1130	1130
Training			7			8	6				5		6					5	6					6	6					6
Immunization	160			240			160			240			160			240			160			240			160		240			
Theatre outreaches			720			1080			720			1080			720			1080			720			1080		720			1080

iv). Cross Cutting Issues

Emergency issues in Africa, especially in post conflict and other grossly underdeveloped societies emanate from and feed onto each other. Successful response to these emergencies is therefore to be tied to respond to many and cross-cutting and mutually reinforcing thematic areas in the community. Accordingly, UNKEA will in addition to responding to specific and urgent health concerns, seek to respond to other social challenges including HIV/AIDS, hygiene and sanitation, especially with a campaign against open defecation and women empowerment as a mechanism of maintaining the existing safety net. Accordingly, UNKEA with community will conduct theatre outreaches on HIV/AIDS, Sanitation and Hygiene, Environmental Conservation and Women in decision making, UNKEA will identify talented artists in various genres such as acting, story telling, poetry and miming after which various themes will be identified from which scripts will be made. The various thematic issues e.g. environmental conservation will be scripted in form of dilemmas to be enacted by the artists and role played by members of public in a public place specially agreed upon by the beneficiaries and the local public administration in conjunction with UNKEA. Public members will debate the dilemmas while identifying the best options for each dilemma

which after public consensus will be painted onto a large mural for community members to continue with the discussions which lead to behavior change.

v) Expected Result/s

This intervention has clearly spelt out outcomes. During the life time of the project thousands of vulnerable returnees, IDPs and host communities will access quality health care to be out of immediate health dangers to their lives. Secondly, the intervention will lead to the strengthening of the Health System to deliver appropriate preventive and curative health care to mother and children especially to children under five. Additionally, through the community outreaches, mass public campaigns and capacity building of key personnel in the line of community health, communities KAP in 12 key areas including : Prevention of malaria within the community through bed-net distribution, indoor residual spraying and clean environment campaign, Promotion of personal behaviors of prevention and treatment of malaria, Promotion of early seeking for care for pregnant women and children, Promotion of early seeking for care for pregnant women and children, Promotion of behavior that prevents HIV and TB infection, Promotion of early seeking for care for HIV and TB positives, Reinforcement of community capacities in HIV positive home based care, Taking children as scheduled to complete a full course of immunizations before their first birthday, Promotion of taking appropriate actions to prevent and manage child injuries, Protection of the environment and Promotion of Increased participation of marginalized segments of the community like women to decision making institutions activities are improved. Finally, partnerships are developed with relevant local NGOs and institutions identified by communities that supports are needed to achieve the goal of the project. In effect, this project will enable the vulnerable IDPs/returnees and host community members to continue accessing primary health care services and integrated reproductive health in existing UNKEA managed health facilities to reduce morbidity and mortality rate in community resulting in improved health status of women and positively impact in enhanced productivity of the individual at household level.

SOI (X)	#	Output Indicators	Target (indicate numbers or percentages)
(X)	1.	31,814 women/girls/boys/men accessing integrated health services	**Male** | **Total** | **Female** | **Total** **<5** | **<18** | **>18** | | **<5** | **<18** | **>18** | 5,726 | 4,500 | 2,500 | **12,726** | 9,088 | 6,200 | 3,800 | **19,088**
	2.	5,000 treated ,long lasting mosquito nets distributed to 5,000 beneficiaries	**Male** | **Total** | **Female** | **Total** **<5** | **<18** | **>18** | | **<5** | **<18** | **>18** | 7,120 | 5,660 | 1,443 | **14,223** | 11,234 | 8,500 | 5,600 | **21,334**
(X)	3.	31 health workers trained/refreshed on emergency health response	**Male** | **Total** | **Female** | **Total** **<5** | **<18** | **>18** | | **<5** | **<18** | **>18** | - | - | 12 | **12** | - | - | 19 | **19**
(X)	4.	2000 under five girls/boys immunized	**Male** | **Total** | **Female** | **Total** **<5** | **<18** | **>18** | | **<5** | **<18** | **>18** | 800 | - | - | **800** | 1,200 | - | - | **1200**
	5.	45 Theatre outreaches conducted	**Male** | **Total** | **Female** | **Total** **<5** | **<18** | **>18** | | **<5** | **<18** | **>18** | - | 1440 | 2160 | **3,600** | - | 2160 | 3240 | **5,400**

vi) Implementation Mechanism

The responsibility on the delivery of project outputs will be rest entirely with UNKEA through the strategic leadership of the executive director under the overall supervision and guidance by the board of directors. UNKEA establishes and

appreciates the creation of several layers of responsibility and communication for purposes of cohesiveness, team work and clarity of duties. In this regard, overall project output delivery will lie with the project officer stationed in Nasir. UNKEA, will, however, initiate and promote dialogue and collaboration between the field staff and regional and national offices for information, sharing. UNKEA will seek and promote the effective collaboration with the ministries of health, Gender Child and Social Welfare and humanitarian affairs and disaster management together with relevant County departments and NGOs especially for population/beneficiary data updates and activity feedback analysis.

UNKEA plans to document and disseminate lessons learned from the proposed program and sees opportunities for taking the program to a higher scale at multiple levels: 1) within the NGO and international agency communities in South Sudan (especially the ones working in the, Emergencies, Health, Nutrition and HIV/AIDs sector 2) to inform the global community UNKEA will publish information on its website and in report format, in addition to sharing key findings with groups such as the CORE Group (particularly the working groups on Social and Behavioral Change, IMCI, Nutrition, and M&E), U.S. Coalition for Child Survival, Global Health Council, Inter Action, American Society for Tropical Medicine and Hygiene, and Action by Churches Together (ACT) International, a global alliance of churches and related agencies working to save lives and support communities in emergencies worldwide. Through these fora, UNKEA will be able to share and document, for international consumption, its lessons learnt from the implementation while incorporating expected stakeholder feedback into future program designs.

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)[1].

UNKEA has developed a comprehensive Monitoring and Evaluation plan for the program with clear strategies for data gathering, collation, analysis, quality assurance, reporting and dissemination. M&E activities will include field visits, stakeholder project review meetings and timely monthly and quarterly reporting to the donor. These will provide opportunity for reflection on strategies, progress, lessons and challenges and exchange of technical support from the key partners. The meetings will also provide a forum for discussing emerging issues. Below is UNKEA's' proposed approach to M&E:

Data collection and Analysis - Project data will be collected and analyzed immediately by the Project Assistants under the supervision of the Project Officer. This will be a continuous process as it will be inbuilt into project implementation process so that it will be concurrent with activity implementation. The officers will also be responsible for compiling the data into a fair draft which will be reviewed by the project coordinator to ensure that data is collected for the relevant indicators, adherence to reporting formats and quality of the document

Quality of data will be assured through the use of standardized data collection tools duly protected for reliability, completeness, and consistency and; approved. The tools will be developed and applied in line with the Project M&E plan They will include tools such as, questionnaires, participant observations checklists, field visit schedules, interviews forms, event evaluation forms, and events attendance forms, Senior project staff will make occasional visits to the field to monitor and verify reported information as well as project compliance with set guidelines and benchmarks. Stakeholder meetings will also be used to validate collected data based on feedbacks. Agencies and other partners will be invited to

[1] 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.

quarterly planning and review sessions of the project, which will form part of project quality assurance. All collected data will be stored electronically and manually to ensure its security as part of control and safety measure.

Reporting - will be both an individual role of the project officers as well as team responsibility. Community mobilizers and project officers will send monthly reports, to the project coordinator and further share the reports in the monthly meetings of the Project Advisory Committee. This organ will approve the reports for forwarding to the donor using the relevant reporting recommended by the latter. Efforts will be made to ensure that the proposed project's work plan and budget are adhered to as well as timely realization of targets. Any necessary changes in strategy and adjustments will be made when and if necessary and will be done in consultation with the donor.

Process Evaluation will be supported by regular reporting of the following targets:

- Number of activities carried out
- Number of under five girls/boys immunized
- Number of women/girls/boys/men among IDPs/returnees/host communities accessing integrated health services
- Audience responses from the activities and training sessions, quality of discussions, participation , comments and presentations
- Daily features and programs monitoring report summarized in a form
- Monthly Project Advisory Committee review meetings
- Project monthly and eview report
- Number of treated long lasting mosquito nets distributed
- Net women/girls/boys/men among IDPs/returnees/host communities using treated long lasting mosquito nets
- Number of women/girls/boys/men among IDPs/returnees/host communities discussing women/environment issues
- Number of men among IDPs/returnees/host communities willing to support women empowerment
- Number of women/girls/boys/men among IDPs/returnees/host communities avoiding HIV/AIDS risk factors.
- End of project evaluation report

Outputs

- Timely Weekly/Monthly field reports
- Timely Daily tree planting/pellet outreach activity report
- Timely Midterm project review reports
- Timely End of the project impact reports

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)
Nil	Nil

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: SSD13/H/52572	**Project title:** To provide basic Primary Health Care Packages to the vulnerable Returnees, host community and IDPs	**Organisation:** UNKEA

	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?*	**Assumptions:**
Overall Objective	• Maintain the existing safety net by providing basic health packages and emergency referral services • Strengthen emergency preparedness including surgical interventions • Respond to health related emergencies including controlling the spread of communicable diseases	• Numbers and percentage of people access safe nets • Numbers and percentage of health staffs trained on surgical emergency related • Numbers and percentage of communicable disease control	• Safe nets distribution reports • Training reports • Morbidity and mortality report	• Supplies will be obtain from Government and UNICEF/WHO • Beneficiaries will use the safe nets **Risks:** Insecurity and movement of the community during dry season

Purpose	**CHF Project Objective:** *What are the specific objectives to be achieved by the end of this CHF funded project?* • To prevent and reduce excess mortality and morbidity rate by providing basic health packages and emergency referral services • Control the spread of communicable diseases • Strengthen the capacity for response to emergencies including surgical intervention	**Indicators of progress:** • *What indicators will be used to measure whether the CHF Project Objectives are achieved. Indicators may be quantitative and qualitative* • Numbers and percentage of community treated in health facilities and emergencies referrals • Percentage and numbers of treated and preventive measure of communicable diseases • Numbers of medical personnel trained on emergency response and surgery	**How indicators will be measured:** *What sources of information already exist to measure this indicator? How will the project get this information?* • Daily in and out patience records • Morbidity and mortality reports • Training reports and participants attendant lists • Records of referral cases • Assessment or evaluation reports	**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?* • Funds/resources will be availed on time for timely procurement • Key Health Staff will be available for training • The weather will be conducive for the conduct of community theatre outreaches **Risks** • The onset of rainy season in March/April may disrupt filed activities like community theatre outreaches • Insecurity
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*. • Capacity of the health system to respond to maternal & under five disease in emergencies strengthened • Community capacity to control communicable diseases and HIV/AIDS care /support/behavior change is enhanced • Reduced morbidity & mortality rate of the population is four health facilities • Immunization of children under five years is improved	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged outcomes?* • Numbers of the health personnel trained on emergency responses • Number and Percentage of key health care units/personnel able to perform basic life-saving emergency care • Number and percentage of people treated • Number and percentage of under five children immunized	**How indicators will be measured:** *What are the sources of information on these indicators?* • Training reports • Health facility report • Monthly morbidity and mortality report • Immunization record • Project evaluation report	**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?* • Enhanced access to health services will increase beneficiary behavior towards uptake of the services • Health staff will be willing/available to have their skills capacity built **Risks** • Traditional practices coupled with traditional patriarchy may hinder uptake of emergency health services at the household level
	Immediate-Results - Outputs (tangible): *List the products, goods and services **(grouped per areas of work)** that will result from the*	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the*	**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*

	implementation of project activities. Ensure that the outputs are worded in a manner that describes their contribution to the outcomes. • 5000 treated mosquito nets distributed to prevent malaria and Kalaazar • 31 key health providers trained on immunization/emergency & trauma management/management of /emergency deliveries/emergency obstetrics/emergency operations/referrals • 45 community theatre outreaches on community sensitization on EPI/Immunization/Measles Vaccination/HIV/AIDS/WASH/Open defecation are conducted • Assorted emergency response medical supplies in form of laboratory equipment, lab regent, coaches, MCH materials are procured and distributed	*envisaged outputs?* *Ensure the indicators identified in Section II (v) of this proposal are adequately inserted in this section.* • Number and percentage of people received mosquito nets • Number of health personnel trained on emergency related illness • Numbers and percentage of outreach conducted • Number and percentage of medical supplies pre-position	• Distribution records or report • Training reports • Monthly outreach report • Delivery report • Final report	*expected outcomes? What factors may get in the way of achieving these objectives?* • Beneficiaries will use mosquito nets for intended purposes/targets • Weather will allow conduct of outreaches • Time schedules in emergency situations will be flexible enough to allow for health staff capacity building **Risks:** • Insecurity • Early rainy season

	Activities: *List in a chronological order the key activities to be carried out. Ensure that the key activities will results in the project outputs.* • 31,814 women/girls/boys/men accessing integrated health services • 31 health workers trained/refreshed on emergency health response • 5,000 treated ,long lasting mosquito nets distributed to 5,000 beneficiaries • 2000 under five girls/boys immunized • 45 Theatre outreaches conducted	**Inputs:** *What inputs are required to implement these activities, e.g. staff time, equipment, travel, publications costs etc?* • Staff time sheet • Transportation • Trainee availability • Theatre artists • Professional Trainers • Request of mosquito nets and transportation costs	• Work Plan • Budget • Project Implementation Plan • Activity Reports • Monthly Donor Report • Financial Reports	**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?* **pre-conditions** • Availability of resources in response to the 2012 CAP appeal **Assumptions** The baseline informing the CAP appeal will remain valid throughout the implementation period **Risks** Increased of the returnees and IDPs in the areas Insecurity

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**		
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
Request and distribute 5,000 in-kind treated mosquito nets for malaria and Kalaazar prevention to 5,000 beneficiaries in Nasir hospital, Jikmir PHCC, Mading PHCC and three PHCUs of Mandeng, Kierwan, Torpuot by June 2013							x	x	x						
Conduct capacity building training for 30 community health Committee and CHD in Kierwan, Torpuot, Jikmir, Mandeng, and Mading Payams by June 2013									x						
Procurement of medical supplies and transportation such as laboratory equipment, lab regent, coaches, MCH materials to Jikmir PHCC and three PHCUs of Mandeng, Kierwan and Torpuot							x	x							
Conduct accelerated training and refresher courses to reach 12 community health workers on emergency related illnesses, I clinical officer/4 midwives/6 nurses on emergency obstetrics and minor operation,6 EPI staff on Immunization, and 4 county health department staff on								x							

PROJECT WORK PLAN

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

Activities	Q1/2013			Q2/2013			Q3/2013			Q4/2013			Q1/2014		
management of emergency diseases in Nasir.															
Conduct 45 community theatre outreaches on EPI/Immunization, Measles Vaccination, HIV/AIDS, Hygiene, Sanitation, waste disposal and open defecation sensitization awareness campaigns				x	x	x	x	x	x						
Routine immunization of boys/girls in all facilities and surrounding villages				x	x	x	x	x	x						
Provision of primary health care services to all communities member in OPD/IPD				x	x	x	x	x	x						

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