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 Second 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

i) Provision of drugs/drug kits, medical supplies, reproductive health kits, vaccines and related supplies to facilities in high risk areas
ii) Strengthen or reestablish PHCC s and PHCUs in the affected areas including provision of basic equipment and related supplies to ensure essential basic curative services
iii) Maintain or strengthen medical referral services for emergency cases
iv) Support vaccination campaigns to the vulnerable communities while maintaining the expanded program for immunization
v) Strengthen communicable disease control, prevention, and emergency response capacity including provision of outbreak investigation materials and training of key staff
vi) Maintain surge capacity for emergencies and surgical interventions
vii) Conduct training on emergency preparedness and response at all levels
viii) Provide logistical support to prepositioning of core pipeline supplies to high risk states

Cluster Geographic Priorities for this CHF Round

1. Jonglei (Pibor, Pochalla, Ayod, Akobo, Fangak, Canal, Twic East)
2. Warrap (Twic, Gogrial East, Tonj North, Tonj East, Tonj South)
3. NBeG (Aweil North, Aweil East, Central, Aweil South)
4. WBeG (Raja)
5. Lakes (Awerial, Rumbek North, Cueibet, Yirol East)
6. Unity (Abiemnhom, Leer, Rubkona, Mayom, Koch, Mayendit, Pariang, Panyijar)
7. Upper Nile (Renk, Ulang, Nassir, Maban, Longechuck, Baliet)
8. Eastern Equatoria (Kapoeta North, East, Lopa)

Project details

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

Requesting Organization	
Universal Network for Knowledge and Empowerment Agency (UNKEA)	
Project CAP Code	**CAP Gender Code**
SSD-13/H/52572/R/16068	1
CAP Project Title *(please write exact name as in the CAP)*	
Provision of basic Primary Health Care Packages to the vulnerable Returnees, host community and IDPs	

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

State	**%**	*County/ies (include payam when possible)*
Upper Nile	100%	*Nasir County (Nasir, Jikmir, Kierwan, Kuetrengke Payams)*

Total Project Budget requested in the in South Sudan CAP	US$333,305
Total funding secured for the CAP project *(to date)*	US$:0.00

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

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

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

	Number of direct beneficiaries targeted in CHF Project	**Number of direct beneficiaries targeted in the CAP**
Women:	7,301	8,243
Girls:	8,842	13,114
Men:	4,714	7,119
Boys:	7,692	8,992
Total:	**28,549**	**37,428**

Indirect Beneficiaries

59,700 women/girls/boys/men

Catchment Population (if applicable)

201,002 according to 2008 census

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

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

Universal Network for Knowledge & Empowerment Agency (UNKEA)	6 Months (1 October 2013 to 31 March 2014)

Contact details Organization's Country Office	
Organization's Address	P.O Box: 504, Juba South Sudan Munuki Payam along Gudele road at ICCO Compound
Project Focal Person	*Bojo Samuel* *Samuel.bojo@unkea.net* *+211 955 033 927*
Country Director	*Simon Bhan Chuol,* *unkea.southsudan@gmail.com* *Unkea.sudan@yahoo.com* *simon@unkea.net* *+211 955 295 774, +211 917 976 984* *www.unkea.net*
Finance Officer	*David Dak Deng* *David.dak@unkea.net* *deng_dak@yahoo.co.uk* *+211 910 485 494*

Contact details Organization's HQ	
Organization's Address	Nasir County, Upper Nile State Republic of South Sudan, P.O Box: 504 Juba
Desk officer	*Esther Lubba Mogga* *Esther.lubba@unkea.net* *info@unkea.net*
Finance Officer	 *Fidel Matajora Christopher* *Tel: +211956595627* *+211921163938* *Email.chrispaluru@gmail.com*

SECTION II

A. Humanitarian Context Analysis

Briefly describe (in no more than 300 words) the current humanitarian situation in the specific locations where CHF funded activities will be implemented. Provide evidence of needs by referencing assessments and key data, including the number and category of the affected population[1]

Jikmir, Nasir, Kuetrengke and Kierwan payams of Nasir County are the densely populated payams with total populations of 28,614, 43,696, 23,093 and 31,791 (2008 HH census) most of whom are nomadic pastoralists.
Humanitarian emergencies in these payams are fueled by inter communal violence, cattle raids and floods resulting in to high populations movements and displacements.

According to OCHA assessment report for 2013, the total number of IDPs, food insecure populations and returnees in Nasir County has been projected at 11,910, 24,800 and 718 respectively. Jikmir, Nasir, Kuetrengke and Kierwan payams accommodate about 5,157, 3,157, 2,300 and 2,014 IDPs and returnees respectively

The Murle armed groups attack in Toalori payam in Ulang County left 13,000 IDPs (OCHA and inter- agency assessment). 9,500 are settled in Kuetrengke and 3,500 in Nasir payams. In January 2013, about 2,500 people were displaced by inter clan conflicts between the Gaguang and Gajiok in Jikmir and Kierwan payams

The increase in population has resulted in increased demand for basic health services in these payams.
In the last three months (April, May and June) the total clinical consultations in the four health facilities of Jikmir, Torpuot, Kierwan and Mandeng were 1,289, 2,310 and 1,843 respectively.

Communicable diseases such as malaria, pneumonia, diarrhea, dysentery and injuries have been some of the common ailments. Sexual exploitation, rape, early marriages and pregnancies among IDPs and returnees are some of the worst forms of sexual and gender based violence (SGBV) increasing the risk of STIs and HIV/AIDS. Most children under 5 among returnees and IDPs have not been fully immunized

With a health care system struggling to overcome the challenges of limited number of skilled health workers, poor road infrastructure limiting accessibility to health facilities and weaker referral services due to lack of ambulance services, this increase in the number of IDPs and returnees is likely to overwhelm the current funding capacity of UNKEA.

B. Grant Request Justification

Briefly describe (in no more than 300 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.

This funding is requested to support UNKEA's accelerated response initiative (ARI) by providing emergency health services to vulnerable IDPs, returnees and host communities in 4 fixed health facilities and 3 additional fixed outreach sites in Nordeng, Batik and Kuerengke PHCUs. This funding will sustain and prevent rapture in providing continued humanitarian health assistance to the vulnerable IDPs, returnees and host communities. ADRA and IMA are not providing any financial support to 4 UNKEA health facilities that is Jikmir PHCC, Kierwan PHCU, Mandeng PHCU and Torpuot PHCU and all the staffing are covered under CHF

Scaling up provision of basic clinical consultations and treatment of common ailments such as malaria, diarrhea, pneumonia and basic surgical services will reduce morbidity and mortality. Scaling up immunization services, vitamin A supplementation, deworming, IPT, clinical management of SGBV survivors, provision of safe and clean deliveries will enhance maternal, neonatal and child health. Improving the basic health facility infrastructure through minor repairs and maintenance, supply of essential laboratory equipment and reagents as well as skills training for health workers will improve the quality of basic package of health services. Accelerating grass root level community awareness will contribute to reduction in spread of communicable diseases

With 10 years existence in Nasir County, UNKEA has a strong community's support and acceptability making its programmes cost effective and sustainable through working with community volunteers. UNKEA has viable working relationship with its government, NGOs and donor partners such as CHD, UNICEF, SMoH, ADRA and MSF in supporting the health care system in Nasir County.

Through partnership agreement with PSI and Maristopes International (MSI), UNKEA is receiving a non cost supply of ACTs and RDTs for management of malaria, oral contraceptives and condoms for family planning and STIs/HIV prevention among IDPs, returnees and SGBV survivors. As a lead agency, UNKEA is the principle recipient of the emergency fund from the ACT alliance for procurement and supply of NFIs for IDPs and returnees in Upper Nile. As a long term plan, UNKEA has submitted a proposal to UNICEF for scaling up an integrated Maternal, Neonatal and Child Health Project (IMNCHP) in Nasir County.

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.

Expanding the number of supported health facilities from 4 to 7 will increase the provision of basic package of health services to many beneficiaries. Supporting recruitment and enhanced kills training of health workers to provide clean and safe deliveries and management of childhood illnesses as well responding to health emergencies like basic surgical interventions. Strengthening appropriate referrals among health facilities would enhance skilled birth attendants. Conducting minor health facility improvements, supply of essential drugs and medical supplies, relief items such as RH kits and LLTNs, procurement and supply of basic clinical, BEmONC and laboratory equipment will enhance the effectiveness and efficiency of the health facilities and increase utilization.

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

Supporting active community mobilizations and sensitizations, conducting EPI out reaches services would scale up awareness on SGBV as well as EPI (measles vaccination).

ii) Project Objective

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

I. To provide basic packages of health (curative and preventive) including emergency referral services to IDPs, returnees and host communities in Nasir County.
II. To prevent and control the spread of communicable diseases through community level awareness, active case detection and management.
III. To strengthen the capacity of health facilities, health workers and communities to response to emergencies including minor surgical interventions.

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).

1) Provision of clinical consultations and treatment in all health facilities
2) Distribution of LLTNs to pregnant and lactating women in all locations
3) Provision of preventive services such immunization, Deworming, iron folate, IPT and vitamin A supplementation to under pregnant and lactating women.
4) Provision of focused family planning services to all women of child bearing age in all health facilities
5) Provision of health education to pregnant and lactating mothers
6) Prevention and management of SGBV in all locations
7) Provision of antenatal and reproductive health services such as family planning, BEmONC and SGBV) in all health facilities.
8) Minor improvement of health facilities (fixing shutter, locks, painting, extension of MCH veranda in Jikmir, Mandeng, Kierwan and Torpuot
9) Basic laboratory and essential equipment of Jikmir PHCC
10) Distribution of pipeline commodities such as drugs, RH kits, clinical, EPI and BEmoNC equipment to all facilities.
11) Training of 30 health workers on IDSR, RH (BEmONC, Family Planning, clinical management of SGBV), (Malaria, pneumonia, diarrhea), Trauma management (basic surgical procedures) , EPI , maintaining of ANC services,
12) Conducting 24 community outreach mobilizations and awareness campaigns on prevention of communicable diseases in all the project locations
13) Conduct 24 outreach immunizations campaigns every months in all project locations

iv). Cross Cutting Issues

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

UNKEA through this project will address cross-cutting and mutually reinforcing thematic activities in the community. Community level mobilizations and sensitization of community leaders to address the root causes of SGBV fueling the spread of HIV/AIDS and other sexually transmitted infections, unwanted pregnancies will be undertaken. Equal participation and empowerment of both men and women in addressing urgent health concerns, SGBV, RH, HIV/AIDS, poor hygiene and sanitation practices especially open defecation, hand washing practices, domestic waste management, health seeking behaviors will be incorporated. UNKEA will ensure that community leaders such as chiefs, home health promoters and traditional healers as well as birth attendants are used as change agents during health promotions such as use of LLTNs, family planning, immunizations, nutrition, protection of water points, use of latrines, hands washing and safer sex behaviors. The various thematic issues e.g. environmental conservation, poor health seeking behaviors and practices, will be scripted in form of dilemmas to be enacted by the artists, song and dramatists and role played in a public place 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 will lead to a behavior change.

v) Expected Result/s

Briefly describe (in no more than 100 words) the results you expect to achieve at the end of the CHF grant period.

Building the capacity of the health workers through skills training, well equipped and functional health facilities with strong emergency referral system, well informed communities and adoption of good health seeking behaviors through health education, increased access to basic emergency curative and preventive health services will results to a significant reduction in morbidities and mortalities associated with communicable diseases among the vulnerable IDPs, returnees and host communities in Nasir, Jikmir, Kuetrengke and Kierwan Payams of Nasir County .

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)	
			Male/boys	Female/girls
(X)	1	Clinical consultations provided to 5 years or older	164	255
(X)	2	Clinical consultations provided to <5	269	309
(X)	3	<5 receiving of de-wormers	3846	4421
(X)	4	< 5 being vaccinated (measles and DPT3)	1923	2210
(X)	5	ANC 3rd visits		730

(X)	6	ANC IPT2 second dose		730
	7	Deliveries conducted by skilled attendants		2190
	8	Proportion of communicable diseases detected and responded to within 48 hours	80%	80%

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.

Provision of basic package of health and nutrition services will be done in at all 7 health facilities. UNKEA will include a mixture of innovative approach using community outreach events during which health education on prevention and control of communicable disease such as malaria, HIV/AIDS, TB, Kala azar, diarrhea is given, children under five immunized, dewormed and given vitamin A supplementation. Screening of under five, pregnant and lactating women for SAM and MAM will be done as a rider activity

Improvement and equipment of health facility infrastructure will be under taken. Minor repairs, renovations, expansions through fixing windows, locks, painting, and equipment of health facilities with furniture, basic laboratory, BEmONC, EPI and clinical equipment and hand washing facilities will be undertaken .The government will supply essential drugs and UNKA covers gaps (ACTs, FP commodities, LLTNs, basic clinical, laboratory, EPI, BEmONC equipment)

Building strong referral system where patients are identified and referred from community to health facilities and among health facilities will be enhanced. UNKEA will continue to maintain its speed motor boat and provide fuel to support the CHD ambulance for referral of pregnant women and under five

Capacity building through technical staff training and supportive supervision staff will be a key component of quality management system through improving efficiency and effectiveness of health facilities. On the job competence based trainings tailored to the needs of communities will be undertaken together with regular supervisory visits using the QSC of the MoH.

Effective health information and management system will be enhanced to ensure that data is used for informing decision making in the course of implementing the project. UNKEA will ensure that data is effectively captured, analyzed, disseminated and utilized by all stakeholders (government, donors and partners) at all stages of the project implementation.

Community involvement through recruitment and training of community leaders and community health educators (HHPs, TBAs and CHWs) on prevention and control of SGBV, communicable diseases such as malaria, HIV/AIDS, Malnutrition, promotion of LLTNs, hand washing, use of latrines, protection of water source will be used to enact health promotion and protection in the communities.

Collaboration and coordination will be key in implementing the project. UNKEA will however, initiate and promote dialogue and collaboration with it partners such as line ministries of health, NGOs, the communities and local authorities.

vii) Monitoring and Reporting Plan

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

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

Through previous operational experience in health programs, UNKEA has developed strong skills in identifying and measuring appropriate indicators, in data collection and analysis, and in partnering with donors and other agencies to coordinate the dissemination of that information. UNKEA will ensure the prompt and accurate collection of information and compile the results for data analysis and program evaluation according to the goal, objectives, and indicators of the program. The following initiates will be adopted to incorporate the activities in this proposal into the current monitoring plan.

A planning and orientation workshop will be conducted in August 2013 at the beginning of the project. This will ensure that UNKEA has good data with which to measure progress against work plan during the intervention. This is necessary due to the regular movement of IDPs/returnees in the targeted areas and lack of reliable data on the target group available with which to compare project progress. UNKEA planning workshop will be held in order to ensure that all staffs understand the proposal and work plan well, to formulate individual staff work plans, which will tie performance to agree upon timelines for compiling monitoring information and reporting.

The logical framework will provide the basis for monitoring the project indicators. The output indicators will be measured using program records and reports.

The Health and Nutrition Advisor will be responsible for the overall planning, monitoring and reporting of activities as per the log frame and work plan. This will include regular visits to all sites in the Program, monitoring of staff activities, compiling and analyzing program records, assessing external variables, tracking changes and making modifications to the program or work plan accordingly in order to ensure the attainment of objective. He will coordinate the health and nutrition programme, attend the nutrition and health cluster technical working groups and ensure that relevant information is factored into programme implementation and share

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

UNKEA's progress reports with all partners. The Executive Director will ensure that planed these activities take place. He will also attend sectoral working group and coordination meetings, ensure the relevant information is factored into program implementation and share UNKEA's progress and statistical information with other agencies where appropriate. UNKEA will continue to build the operational capacity of project staffs in monitoring and reporting in the project cycle management (PCM) and maximize their participation in all activities.

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

The accuracy and consistency of the data will be assured through the use of standardized data collection tools duly protected for reliability, completeness, and consistency and approved. The Project Manager and Health and Nutrition Adviser will make monthly and quarterly visits to the project sites to monitor and verify reported information as well as project compliance with set guidelines and benchmarks. This wills involve data quality audits in randomly selected project sites done on quarterly basis that will form part of project data quality assurance and quality control. All collected data will be stored electronically and manually to ensure its security as part of control and safety measure.

Reporting

This will be both an individual role of the project staff as well as the entire team. UNKEA will provide monthly, quarterly and end of Project progress reports as against work plan, budget and targets indicated in the proposal. Health workers will at the primary health facilities will send monthly reports to the project Manager who will then review for consistency and accuracy. The Project manager then send these reports to the Health and Nutrition Advisor based in Juba to review such reports for consistency and accuracy. The Health and Nutrition Adviser will share these reports with the County Director who will approve and send to the donor using the relevant reporting format. Efforts will be made to ensure that the report capture project narrative and financial aspects of the proposed project's work plan and budget and targets. UNKEA will adhere with specific donors reporting formats and guidelines.

A database for recording beneficiary information and mapping trends across the implementation locations will be created and the information is to be disseminated to the DHIS, SMoH, GOSS MoH and other stakeholders on regular basis. Project deliverables will be monitored through monthly, quarterly and annual progress reports that should include success stories. Health facility reports will be sent using the DHIS to the CHD and SMoH. Health facilities will send reports in hard copies using the MoH data collection forms and loaded to the DHIMS.

The project will be reviewed at mid-point and at the end through a joint plan. UNKEA will conduct a midterm review after three months of implementation. In these reviews, stakeholders at the state, county and national levels will be engaged in discussing the findings and production of their recommendations (part of the data quality audit).

UNKEA will develop tools to capture data from community workers (TBAs, MCHWs and HHPs). Monitoring tools will include data gathering and analysis based on attendance records, drug distribution records and training reports which will feed into the Indicator Performance Tracking Table (IPTT). The IPTT will allow the project to track progress towards results on a monthly, quarterly basis, although some indicators will only be updated on bi-annual basis throughout the project period. This will enable early identification and action to address program challenges that help in ensuring timely implementation of planned activities. In addition routine collection and analysis of programme data will allow UNKEA to regularly share results with the SMoH, CHD, donors and the local (community) authorities to identify and address potential challenges such as default rates.

A community level assessment survey tool will be developed to assess community engagement/satisfaction levels and the value attached to UNKEA services. Field staff will be holding regular meetings with the health authorities at state, County and Payam (community) levels to review progress. Partner meetings will focus on implementation progress, lessons learned and proactive ways forward. These meetings will allow UNKEA to address implementation and M & E concerns and challenges in partnership with the health authorities and community leaders at multiple points throughout the project, allowing for UNKEA to adjust its implementation and monitoring strategies as necessary and thus increasing the likelihood of success.

A score-card monitoring system will be developed to monitor the progress against key indicators for each health facility. The M & E plan will include building the capacity of project staff through focused M & E trainings. An evidence-based evaluation approach will be employed to assess the overall effectiveness and impact of the program.

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)
Non cost pipeline supply of ACTs and RDTs by PSI, July 1st. 2013	In-kind
Non Cost pipeline supply of family planning commodities by Maristopes International (MSI), July, 1st. 2013	In-kind
Pledges for the CAP project	
	0

SECTION III:

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/52572/R/16068	**Project title:** Provision of basic Primary Health Care Packages to the vulnerable Returnees, host community and IDPs	**Organisation:** UNKEA

	Cluster Priority Activities for this CHF Allocation:	Indicators of progress:	How indicators will be measured:	
Overall Objective	*What are the Cluster Priority activities for this CHF funding round this project is contributing to:* 1. Total direct beneficiaries (women, girls, men and boys). 2. Clinical consultations and treatment of 5 years or older. 3. Measles vaccinations given to under 5 in emergency or returnee situation. 4. Number of <5 consultations (male and female). 5. Number of births attended by skilled birth attendants. 6. Proportion of communicable diseases detected and responded to within 48 hours. 7. Number of antenatal clients receiving IPT2 second dose. 8. Number of health facilities providing components of BPHS. 9. Number survivors of SGBV receive clinical management of rape treatment. 10. Number of direct beneficiaries from emergency drugs supplies (IEHK/ trauma kit/RH kit/PHCU kits). 11. Proportion of emergencies supplied with core pipeline kits. 12. Number of health workers trained in MISP/communicable diseases/ outbreaks/IMCI/CMR. 13. Total indirect beneficiaries.	*What are the key indicators related to the achievement of the CAP project objective?* • # of Clinical consultations carried out. • # of male and female patients >5 treated • # of male and female under 5 in emergency/returnee situation given measles vaccination and dewormed • # of male and female patients (under <5) consulted. • # of births attended by skilled birth attendants. • Proportion of communicable diseases detected and responded to within 48 hours. • # of antenatal clients receiving IPT2 second dose.	*What are the sources of information on these indicators?* • County Health Department records. • Health facility records • Distribution records • Field reports	• Security stability in the project area • Uninterrupted funding and supply of relief items and drugs • Continued community and acceptability and support • Commitment and support of partners to the project • Continuous accessibility to project sites

Purpose	**CHF Project Objective:** *What are the specific objectives to be achieved by the end of this CHF funded project?* 1. To provide basic packages of health (curative and preventive) including emergency referral services to IDPs, returnees and host communities in Nasir County 2. To prevent and control the spread of communicable diseases through community level awareness campaigns, active case detection and management 3. To strengthen the capacity of health workers and communities to response to emergencies	**Indicators of progress:** • *What indicators will be used to measure whether the CHF Project Objectives are achieved. Indicators may be quantitative and qualitative.* • # of returnees, IDPs and HC provided with curative and preventive health services. • Common ailments caused by communicable disease are managed at health facilities. • Community level awareness campaigns undertaken. • Outbreaks detection and responded to within 71 hours. • Community mobilizers trained on health education • Health workers trained on management of cases.	**How indicators will be measured:** *What sources of information already exist to measure this indicator? How will the project get this information?* • Registration forms • Health facility records • Awareness campaign checklists • Training and supervision checklists • County Health Department reports • Project assessment 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?* • Security stability in the project area • Uninterrupted funding and supply of relief items and drugs • Continued community and acceptability and support • Commitment and support of partners to the project • Continuous accessibility to project sites
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.* • Minor ailments managed at all health facilities. • Communities adopt positive health seeking behaviors. • Health workers well equipped to provide curative and preventives services in all health facilities	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged outcomes?* • # of clinical consultations conducted at health facilities. • # of community members reached with health education through outreach campaigns • # of health workers trained on management of cases at health facilities.	**How indicators will be measured:** *What are the sources of information on these indicators?* • Health facility records • End of project assessment report • County Health Department records	**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?* • Security stability in the project area • Uninterrupted funding and supply of relief items and drugs • Continued community and acceptability and support • Commitment and support of partners to the project • Continuous accessibility to project sites
	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.* **I.** Clinical consultations undertaken and treatment provided. **II.** LLTNs distributed **III.** Preventive services (immunization, deworming, iron folate, IPT and vitamin A supplementation) provided. **IV.** Focused family planning services provided.	**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.* • # of Clinical consultations provided to 5 years or older. • # of Clinical consultations provided to <5. • # of >5 years receiving of de-wormers.	**How indicators will be measured:** *What are the sources of information on these indicators?* • Facility consultation registers • Distribution checklists • Health facility activity checklists • Health outreach activity	**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?* •

	V. Routine health education provided **VI.** (a) SGBV cases prevented **VI.** (b) SGBV cases managed **VII.** Reproductive and antenatal health services provided. **VIII.** Health Facilities improved by fixing of shutters, locks, painting and extension of veranda. **IX.** PHCCs equipped with basic laboratory equipment and reagents. **X.** Pipeline commodities (Drugs, RH kits, clinical, EPI and BEmoNC equipment) distributed. **XI.** Health workers trained on IDSR, RH, IMCIs, EPI and Scaling of ANC services. **XII.** Community health promoters trained on health promotion and protection. **XIII.** Community outreach mobilizations and awareness campaigns conducted. **XIV.** Outreach immunization campaigns conducted.	• # of >5 being vaccinated (measles and DPT3). • # of >5 receiving Vit. Supplementation. • # of Clients who received HIV counseling and testing. • # of ANC 3rd visits • # of Pregnant and lactating women given health education in all facilities. • # of Pregnant and lactating women receiving iron/ folate. • # of ANC IPT2 second dose • # of Deliveries conducted by skilled attendants. • # of Deliveries referred for CEmOC • Family planning acceptor rate in women of child bearing age. • % of SGBV survivors being managed in health facilities. • Proportion of communicable diseases detected and responded to within 48 hours. • # of Health workers trained in IMCIs/IDRS/HMIS/RH (FP, SGBV, BEmONC), EPI, focused ANC services. • # of Community members (HHPs, TBA and VHCs) trained on health promotion. • # and % of community members reached with health education through community level outreach in all project locations. • # of health facilities equipped with basic equipment and essential drugs. • # of health facilities provided with supportive supervision using QSC • Health facilities repaired and maintained.	checklists • Facility rehabilitation contract/report. • Training checklists	

	Activities: *List in a chronological order the key activities to be carried out. Ensure that the key activities will results in the project outputs.* 1. Provision of clinical consultations and treatment in all health facilities. 2. Distribution of LLTNs to pregnant and lactating women in all locations. 3. Provision of preventive services such immunization, Deworming, iron folate, IPT and vitamin A supplementation to under pregnant and lactating women. 4. Provision of focused family planning services to all women of child bearing age in all health facilities. 5. Provision of routine health education to pregnant and lactating mothers. 6. Prevention and management of SGBV in all locations. 7. Provision of antenatal and reproductive health services such as family planning, BEmONC and SGBV) in all health facilities. 8. Minor improvement of health facilities (fixing shutter, locks, painting, extension of MCH veranda in Jikmir, Mandeng, Kierwan and Torpuot. 9. Equipment of Jikmir PHCC with basic laboratory equipment and reagents. 10. Distribution of pipeline commodities such as drugs, RH kits, clinical, EPI and BEmoNC equipment to all facilities. 11. Training of 30 health workers on IDSR, RH (BEmONC, Family Planning, Syndrome management of STIs, clinical management of SGBV), IMCIs (Malaria, pneumonia, diarrhea), Trauma management (basic surgery procedures) , EPI, Scaling of ANC services. 12. Training of 40 community health promoters (24 members of VHCs, 8 HHPs and 8 TBAs) on health promotion and protection. 13. Conducting 24 community outreach mobilizations and awareness campaigns in all the project locations. 14. Conduct 24 outreach immunizations campaigns every month in all project locations.	**Inputs:** *What inputs are required to implement these activities, e.g. staff time, equipment, travel, publications costs etc.?* Relief items/equipment committed to support the project (LLTNs) Funds ($150,000) Commitment of technical and support staff	-Facility consultation registers -Distribution checklists. -Health facility activity checklists -Health outreach activity checklists -Facility rehabilitation contract/report. -Training checklists	**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?* • The health facilities remain accessible throughout the life time of the project. • Security situation remains stable during the implementation of the project • There is available funds for the running of project activities throughout the year • Funds are released on time • Community members/ PLW are willing and take health related messages. • Prices for building materials such as cement remain stable during the period the project is implemented. • Health facilities are well staffed with the qualified and experienced medical personnel. • The community is involved in the delivery of project activities early enough. • Government is interested and supports NGO activities.

PROJECT WORK PLAN

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

Project start date:	**1 October 2013**	**Project end date:**	**31 March 2014**

Activities	**Q3/2013**			**Q4/2013**			**Q1/2014**			**Q2/2014**			**Q3/2014**		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Activity 1: project staff salaries and purchase of office, field (training/support) supplies				x											
Activity 2: Provision of clinical consultations and treatment in all health facilities				X	X	X	X	X	X						
Activity 3: Distribution of LLTNs to pregnant and lactating women in all locations				X	X	X	X	X	X						
Activity 4: Provision of preventive services such immunization, Deworming, iron folate, IPT and vitamin A supplementation to under pregnant and lactating women.				X	X	X	X	X	X						
Activity 5: Provision of focused family planning services to all women of child bearing age in all health facilities.				X	X	X	X	X	X						
Activity 6: Provision of basic health education to pregnant and lactating mothers				X	X	X	X	X	X						
Activity 7: Provision of antenatal and reproductive health services such as family planning, BEmONC and SGBV) in all health facilities.				X	X	X	X	X	X						
Activity 8: Minor improvement of health facilities (fixing shutter, locks, painting, extension of MCH veranda in Jikmir, Mandeng, Kierwan and Torpuot.					X										
Activity 9: Provision of laboratory and essential basic equipment of Jikmir PHCC					X										
Activity 10: Distribution of pipeline commodities such as drugs, RH kits, clinical, EPI and BEmoNC equipment to all facilities.					X		X								
Activity 11: Training of 30 health workers on IDSR, RH (BEmONC, Family Planning, Syndrome management of STIs, clinical management of SGBV), (Malaria, pneumonia, diarrhea), Trauma management (basic surgery procedures) , EPI, Scaling of ANC services.					X										
Activity 12: Conduct 24 outreach immunizations campaigns every month in all project locations.					X	X	X	X	X						
Activity 13: Monitoring and supervision				X	X	X	X	X	X						
Activity 14: Donor reporting				X	X	X	X	X	X						
Activity 15: End of project assessment										X	X				