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)

SECTION II

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

Requesting Organization	
International Rescue Committee	
Project CAP Code	**CAP Gender Code**
SSD-13/H/55421/5179	2A

CAP Project Title *(please write exact name as in the CAP)*
Basic and Emergency Primary Health Care Services in Northern Bahr el Ghazal and Unity States

Project Location(s) - list State and County (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)*
Northern Bahr el Ghazal	90%	Aweil East, Aweil South, Aweil Center, Aweil North
Unity	10%	Panyijiar

Total Project Budget requested in the in South Sudan CAP	US$ 5,206,533
Total funding secured for the CAP project ***(to date)***	US$ 3,616,421

Funding requested from CHF for this project proposal	US$ $250,000
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:	42,768	86,959
Girls:	23,760	48,559
Men:	28,512	55,373
Boys:	23,760	48,559
Total:	**118,800**	**239,450**

Indirect Beneficiaries

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

Catchment Population (if applicable)

In accordance with MoH guidelines, the catchment population for a PHCU is 15,000 and 50,000 for a PHCC. This project targets 15 facilities (11 PHCCs and 4 PHCUs). Therefore 11x50,000 +

4x15,000 = 610,000 people

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

CHF Project Duration (12 months max., earliest starting date will be Allocation approval date)
5 months (1 Oct 2013 to 28 Feb 2014)

Contact details Organization's Country Office	
Organization's Address	Hai Cinema, Juba, South Sudan
Project Focal Person	Jody Yasinowsky Email: Jody.Yasinowsky@Rescue.org Tel: +211 (0) 0954290147
Country Director	Wendy Taeuber Email: Wendy.Taeuber@Rescue.org Tel: +211 (0) 956438790
Finance Controller	Gabriel Munga Email: Gabriel.Munga@Rescue.org Tel: +211 (0) 959000668

Contact details Organization's HQ	
Organization's Address	122 East 42nd Street, New York, NY 10168-1289
Desk officer	Doreen Chi Email: Doreen.Chi@rescue.org Tel: +1 212 551 3073
Regional Controller	Getenet Kumssa Email: Getenet.Kumssa@Rescue.org Tel: +1 212 551 3073

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]

In 2012, Northern Bahr el Ghazal (NBeG) and Unity states experienced high population growth, receiving 12,936 and 11,973 returnees, respectively (OCHA, Jan 2013), and internal displacement of over 56,000 people due to inter-communal fighting, cross-border conflict and flooding (OCHA, Nov 2012). In January 2013, aerial bombardments along the border displaced 8,000 people in NBeG (WHO Humanitarian SitRep). In Unity State, recent cattle raids in Panyijiar County caused 27 casualties and displaced 638 households (OCHA, December 2012). In both states, the rainy season displaces large numbers of people and renders many communities inaccessible. Resupplying markets is also a serious challenge, leaving communities without food and with spoiled harvests. Limited access to lifesaving surgical interventions (nearest hospital is in Leer) also has a devastating impact on families.

The State Ministries of Health (SMoH) lack the resources and skills to respond to rapid and frequent displacements. Returnees and internally displaced persons are exposed to serious health risks as they often live in temporary settlements far from health facilities and are without financial means. The UN estimates an influx of 200,000 returnees in 2013 in South Sudan.

NBeG and Unity also face risks of disease outbreaks. Many returnees have not been immunized against communicable diseases, which contributed to the measles outbreak in Aweil East County during April 2013. With many areas inaccessible during the rainy season, immunization coverage remains a challenge. According to an IRC survey, only 61.7% of children under five in NBeG received measles vaccination. During the rainy season in 2012, an over 10,000 case increase in malaria cases occurred compared to 2011, straining SMoH's supply chain.

Maternal mortality rates remain critical, with NBeG having the highest rate in the country: 2,182 deaths per 100,000 people (SSHHS, 2010). Although much has been achieved, significant gaps in antenatal coverage still require urgent attention, with only 32.4% of deliveries attended by skilled birth attendants (IRC survey 2013).

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.

The IRC supports 35 facilities across NBeG and Unity, with funding from CHF and Health Pooled Fund, which focuses on providing minimal health services. Across the 35 facilities, the IRC has been able to maintain services but is experiencing a funding shortfall to sustain services for vulnerable communities, especially for maternal and child health.

The IRC has sought funding to facilitate the process of consolidating all health facilities in each county under the direct management of the County Health Department (CHD). If outside funding is secured, coverage through CHD will increase to 43 facilities throughout Unity and NBeG. The proposed CHF activities will support the maintenance of the existing safety nets in these counties and for IDPs in Aweil North County.

In line with Health Cluster priorities 1-4, CHF funding will provide surge capacity to maintain coverage in maternal and child health care, easing the potential humanitarian consequences of reduced services. The IRC will ensure adequate infection control measures at the facility level to reduce cross-infection and contamination. The emergency referral system will be strengthened to reduce under five and maternal mortalities. For example, in Aweil Center County, seven maternal deaths occurred in the past six months at the government-run Aroyo clinic due to lack of basic emergency obstetric and neonatal care and a nonexistent referral system for mothers to Aweil Civil Hospital, 61km away. During that period, three children under five died at the same facility from easily treatable causes, such as malaria, pneumonia and diarrhea. This county is further disadvantaged by the lack of any reliable transportation and communication.

CHF funding will also be used to support the CHDs and a population of 610,000 vulnerable people in emergency preparedness and response, in line with the Health Cluster priorities 5-8.

C. Project Description (For CHF Component only)

i) Contribution to Cluster Priorities

Briefly describe how CHF funding will be used to contribute to the achievement of the cluster priority activities identified for this allocation.

Priority 1: Provision of drug kits, medical supplies, reproductive health kits, vaccines and related supplies to facilities in high risk areas

The IRC will provide surge capacity to 15 facilities across four counties (Aweil East, Aweil South, Aweil Center and Panyijiar) and IDPs in Aweil North County to meet the basic and life-saving health needs of the most vulnerable. Safe motherhood activities will be supported at the targeted facilities, through refresher trainings for staff and provision of supplementary reproductive health (RH) supplies at the facilities. RH kits will be provided through collaboration and coordination with the United Nations Population Fund (UNFPA) while vaccines will be provided by the State Ministry of Health (SMoH).

Priority 2: Strengthen or reestablish PHCCs and PHCUs in the affected areas including provision of basic equipment and related supplies to ensure essential basic curative services

Through this CHF funding, the IRC will provide basic medical equipment to 15 health facilities (11 PHCCs and 4 PHCUs). In flood

[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.

affected areas, the IRC will support the health facilities to run mobile clinics and outreach posts on a needs basis to provide basic curative services to communities unable to access the health facilities.

Priority 3: Maintain or strengthen medical referral services for emergency cases
The IRC will support the CHD to run ambulance services in Aweil East and Aweil South Counties and will provide a new ambulance for Aweil Centre County. Under CHF Round 1 2013 funding, Panyijiar County received a boat ambulance. The IRC will support the four counties to run the ambulance services through monthly cash allocations for maintenance and fuel costs. Also, the Aweil Centre County CHD will be provided with Thuraya phone and airtime to ensure communication between CHD and Aweil Civil Hospital. In Panyijiar, the IRC will continue to support referrals to Leer County Hospital through the boat ambulance. Referrals from communities and PHCUs to PHCCs will be enhanced by engaging communities' participation in use of local means or stretchers for transporting such patients.

Priority 4: Support vaccination campaigns to the vulnerable communities while maintaining the expanded program for immunization
To make better use of the cold chain at Warpei PHCC, a Thuraya phone will be provided to ensure communication between the IRC, CHD, Warlang and Jaac PHCUs. Given floods and frequent cattle raids, Panyijiar communities are constantly moving, affecting beneficiaries' ability to access routine health services and attend scheduled appointments. Therefore vaccination outreaches will be organized at their new settlements. During National Immunization Days and mobile clinics, logistical and financial support will be provided to the CHDs, and vaccinators will be appointed to join the exercise in order to ensure greater coverage within the four target counties.

Priority 5: Strengthen communicable disease control, prevention, and emergency response capacity including provision of outbreak investigation materials and training of key staff
The IRC will conduct a household KPC assessment for long lasting insecticide-treated net (LLITN) utilization in two counties and follow up with a community health education and mobilization campaign based on the assessment findings. Hygiene promotion and awareness-raising on relevant topics affecting the communities will be conducted at the facilities and during outreach services. Specific attention will also be paid to infection control and adherence to Universal Precautions (UP) at the health facility level, by ensuring a safe and clean environment and by providing sufficient supplies, personal protective equipment and refresher training on UP.

When health related emergencies do occur, the IRC will participate in initial rapid needs assessments and investigations together with the CHD and other partners. Based on the results, the IRC will provide technical support to the CHDs to develop action plans, and assist in the implementation of these plans. Depending on the type of emergency, this may involve mass vaccination campaigns, establishing oral rehydration treatment (ORT) corners and commencing mobile clinics in areas with an acute increase in population. The IRC will also ensure the implementation of the minimum initial services package (MISP) for reproductive health during any acute emergency.

Priority 6: Maintain surge capacity for emergencies and surgical interventions
Through this CHF funding, the IRC will support BEmONC services at 11 PHCCs by addressing any key staffing gaps. The midwives and MCHWs will receive refresher trainings so that they are able to attend to obstetric and new born emergencies and ensure timely referral for cases requiring comprehensive emergency obstetric and neonatal care (CEmONC).

Priority 7: Conduct training on emergency preparedness and response to all levels
CHF funding will be used to strengthen emergency preparedness at the community, county and state levels, through capacity building of health staff, CHD and SMoH members in emergency preparedness and response (EP&R). Communities, through existing VHCs, facility staff and other key stakeholders, will receive training on public health risks and ways to mitigate the effects of outbreaks and displacements or isolation due to flooding, making them more resilient to shocks. The CHDs and SMoH will be supported in contingency planning, refresher training on EPR, integrated disease surveillance and response (IDSR) and initial needs assessments. County EPR teams formed under CHF Round 1 funding will be supported with the provision of vehicles, motorbikes, fuel and per diem. Based on the local context, medical supplies will be prepositioned prior to the onset of the rainy season.

Priority 8: Provide logistical support to prepositioning of core pipeline supplies to high risk areas
The IRC will support the four CHDs to preposition necessary drugs and medical supplies to facilities that are hard to reach, before expected upsurge of cases for certain diseases. Identified risks in these counties are: outbreaks (acute watery diarrhea (AWD), measles, meningitis, and surges in malaria cases), displacements caused by insecurity (Aweil North, Aweil East, Panyijiar) and flooding in all target counties.

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

Objective 1. Access to quality maternal and child health care services among returnees, conflict-affected, displaced and host communities is maintained through February 2014

Objective 2. County Health Departments (Aweil East, Aweil South and Aweil Centre) are strengthened to prepare and respond to public health emergencies by the end of February 2014

Objective 3. Public health emergencies related to displacements caused by flooding, insecurity or disease outbreaks (AWD, measles, meningitis, malaria) are responded to in a timely manner through February 2014

iii) Proposed Activities
List the main activities to be implemented with CHF funding. As much as possible link activities to the exact location of the operation and the corresponding number of direct beneficiaries (broken down by age and gender to the extent possible).

Objective 1: Access to quality maternal and child health care services among returnee, conflict-affected, displaced and host communities is maintained through February 2014

- Support maternal and child health care services at the 15 supported facilities in four counties.
- Support 8 mobile clinics and outreaches for communities not accessing health facilities reaching 800 beneficiaries.
- Conduct on-the-job training of 30 CHWs / MCHWs at 15 health facilities on ANC, PNC and referral for delivery.
- Provide equipment and supplies for maternal healthcare at 15 facilities.
- Conduct health education and hygiene promotion sessions at the community level, reaching 10,000 people.
- Conduct a household KPC assessment on LLIN utilization in the two counties.
- Support referral of patients from communities to health facilities and from facilities to hospitals (500 hospital referrals).
- Procure ambulances for Aweil Center County for emergency obstetric cases and other acute emergencies.
- Support ambulance running costs for four counties.
- Procure 25 portable stretchers to support community referral systems.
- Procure 2 Thuraya phones for Aweil Centre County and Warlang and Jaac PHCUs.
- Provide protective clothing and items in 15 health facilities.

Objective 2: County Health Departments (Aweil East, Aweil South and Aweil Centre) are strengthened to prepare and respond to public health emergencies by the end of February 2014

- Provide county level training for EPR teams (40 participants).
- Assist and guide CHDs in procuring buffer stocks for 15 health facilities.
- Preposition buffer stocks for essential drugs at 15 facilities.
- Assist CHDs with drug and medical supply transportation to health facilities every month.
- Support the CHDs in surveillance and timely weekly reporting.

Objective 3: Public health emergencies related to displacements caused by flooding, insecurity or disease outbreaks (AWD, measles, meningitis, malaria) are responded to in a timely manner through February 2014

- Participate in joint needs assessments and suspected outbreak investigations.
- Support four CHDs in coordination and implementation of emergency response.
- Respond to health emergencies according to identified needs.
- Provide refresher trainings for 39 health workers on case management of diseases with epidemic potential.

iv). Cross Cutting Issues

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

The impact of this project on the **environment** will be limited by use of proper disposal mechanisms for medical and non-medical waste, through incineration and fenced disposal pits. Project activities for infection control and universal precautions will contribute to improved sanitary environments. The IRC will also ensure that facilities are adequately staffed by cleaners that maintain the general cleanliness of the facilities.

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

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

v) Expected Result/s

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

By February 2014, the IRC expects that:

1. Coverage of maternal and child health services will not decline below the current facility utilization rate of 0.4;
2. Women have improved access to quality emergency reproductive health care services through 11 functional BEmONC centers;
3. All 15 IRC-supported health facilities in NBeG and Unity have infection control plans in place, updated and adhered to by facility staff;
4. Three CHDs have and are implementing EPR plans, with timely response to health related emergencies; and
5. All suspected outbreaks are responded to within 48 hours of notification, limiting the total number of cases.

List below the output indicators you will use to measure the progress and achievement of your project results. At least three of the indicators should be taken from the cluster defined Standard Output Indicators (SOI) (annexed). Put a cross (x) in the first column to identify the cluster defined SOI. Indicate as well the total number of direct beneficiaries disaggregated by gender and age.

SOI (X)	#	Output Indicators (Ensure the output indicators are consistent with the output indicators that will be used in the results framework section III of this project proposal).	Target (indicate numbers or percentages) (Targets should be disaggregated by age and sex as per the standard output indicators list and add-up to the number of direct beneficiaries identified page 1)
x	1.	Total direct beneficiaries, disaggregated by age and sex	42,768 women, 23,760 girls, 28,512 men and 23,760 boys (all health interventions, trainings, health education)
x	2.	Number of measles vaccinations given to under 5 in emergency or returnee situation	1000 girls, 1000 boys
x	3.	Number of births attended by skilled birth attendants	700

	4.	Number of county updated EPR plans available	4
x	5.	Proportion of communicable diseases detected and responded to within 48 hours	100%
x	6.	Number of health workers trained in MISP / communicable diseases / outbreaks / IMCI	39 health workers (70% men, 30% women)

vi) Implementation Mechanism

Describe planned mechanisms for implementation of the project. Explain if it is implemented through implementing partners such as NGOs, government actors, or other outside contractors.

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

vii) Monitoring and Reporting Plan

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

1. Explain how will you measure whether a) Activities have been conducted, b) Results have been achieved, c) Cross-cutting issues have been addressed, and d) Project objectives have been met
2. Indicate what monitoring tools and techniques 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].

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

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

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

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

D. 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)
CHF Round 1 2013: 1 April 2013 – 30 September 2013	**500,000**
HPF phase 2 Unity State – 1 July 2013 – 31 December 2015	**1,438,916**
HPF Bridge funding Unity State: 1 January – 30 June 2013	**549,132**
HPF Bridge funding NBeG State: 1 January – 31 August 2013	**2,006,083**
Stichting Vluchteling Foundation: 1 November 2012 – 31 July 2013	**282,829**
CHF Round 2 2012: 1 November 2012 – 28 February 2013	**142,500**
Pledges for the CAP project	

[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.

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/55421/5179	**Project title:** Basic and Emergency Primary Health Care Services in Northern Bahr el Ghazal and Unity States	**Organisation:** International Rescue Committee

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:* 1) Provision of drug kits, medical supplies, reproductive health kits, vaccines and related supplies to facilities in high risk areas 2) Strengthen or reestablish PHCCs and PHCUs in the affected areas including provision of basic equipment and related supplies to ensure essential basic curative services 3) Maintain or strengthen medical referral services for emergency cases 4) Support vaccination campaigns to the vulnerable communities while maintaining the expanded program for immunization 5) Strengthen communicable disease control, prevention and emergency response capacity including provision of outbreak investigation materials and training of key staff 6) Maintain surge capacity for emergencies and surgical interventions 7) Conduct training on emergency preparedness and response t all levels 8) Provide logistical support to prepositioning of core pipeline supplies to high risk states	**Indicators of progress:** *What are the key indicators related to the achievement of the CAP project objective?* • Utilization rate (maintained at 0.4) • Percentage of public health emergencies investigated within 48 hours. • Number of consultations at mobile clinics/outreach (target 5,000 in 6 months)	**How indicators will be measured:** *What are the sources of information on these indicators?* • MoH registration book • Weekly IDSR reports, rapid assessment reports • Patient registration books at mobile clinics or outreach posts	

Purpose	**CHF Project Objective:** *What are the specific objectives to be achieved by the end of this CHF funded project?* • Access to quality maternal and child health care services among returnee, conflict-affected, displaced and host communities is maintained through February 2014 • County Health Departments are strengthened to prepare and respond to public health emergencies by the end of February 2014 • Public health emergencies related to displacements caused by flooding or insecurity and disease outbreaks (AWD, measles, meningitis, malaria) are responded to in a timely manner through February 2014	**Indicators of progress:** *What indicators will be used to measure whether the CHF Project Objectives are achieved. Indicators may be quantitative and qualitative* • Utilization rate 0.4 • Number of CHDs with updated EPR plans available • Case fatality rates of communicable diseases which have caused outbreaks are within WHO standards	**How indicators will be measured:** *What sources of information already exist to measure this indicator? How will the project get this information?* • Patient registers, population census 2008 data • Training reports, CHD workplans, • Line-listing reports, IDSR weekly reports, patient registers	**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 project area remains accessible during the project period (security, roads passable) • There are no significant unexpected political or economic shocks • Inflation remains stable
Results	**Results - Outcomes (intangible):** *State the changes that will be observed as a result of this CHF Project. E.g. changes in access, skills, knowledge, practice/behaviors of the direct beneficiaries*. 1) Coverage of maternal and child health services does not decline as result of repeated bridge funding 2) Women have better access to quality emergency reproductive health care services 3) Universal precautions are adhered to by trained staff at all supported health facilities 4) CHDs proactively identify and organize a response to outbreaks 5) Outbreaks are contained timely and geographically, limiting excess morbidity and mortality	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged outcomes?* 1.1 Percentage of DPT 3 among all children < 1 (target 2,612 in 6 months, baseline 2,473). 1.2 Percentage of ANC1 visits among expected pregnancies (target 82% in 5 months, baseline 82%) 2. Number of deliveries conducted by skilled birth attendant (target 700 facility deliveries in 5 months, baseline 650) 3. Percent of supported facilities with maximum score for infection control during supervision (target 80% of facilities during 5 months, baseline TBD) 4. Number of CHDs with updated EPR plans available (target 3 CHDs, baseline 0) 5. Percent of suspected outbreaks responded to within 48 hours of notification (target 90%)	**How indicators will be measured:** *What are the sources of information on these indicators?* • EPI reports • ANC registers • Delivery registers • Supervision checklists • EPR plans • Rapid assessment reports • IDSR reports • Emergency response reports	**Assumptions & risks:** *What factors not under the control of the project are necessary to achieve the expected outcomes? What factors may get in the way of achieving these objectives?* • The project area remains accessible during the project period (security, roads passable) • The MoH protocol for EPI remains in place • Continuous vaccines and drugs supply from MoH • Staff levels are maintained • CHDs are present and functional • IRC maintains support to Panyijiar County facilities through HPF after June. • The applied population data and its composition are realistic
	Immediate-Results - Outputs (tangible): *List the products, goods and services **(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.*	**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, disaggregated by	**How indicators will be measured:** *What are the sources of information on these indicators?* • Patient registration	**Assumptions & risks:** *What factors not under the control of the project are necessary to achieve the expected outcomes? What factors may get in the way of achieving these objectives?* • The project area remains accessible during the project period (security, roads passable)

	1) All 15 health facilities provide primary health care services in line with the BPHS 2) All 11 supported PHCCs are able to provide all the components of B-EmONC services in managing common complications in pregnancy and delivery. 3) All 15 supported facilities in NBeG and Unity have infection control plans in place, updated and adhered to by facility staff 4) Four CHDs have EPR plans in place and implemented, with timely response to health related emergencies 5) All suspected outbreaks are responded to within 48 hours of notification	age and sex (target 177,130, baseline 162,930 excl emergency response) • Percentage of PHCCs with trained midwifes, availability of drugs and equipment[3] to perform all 7 B-EmONC signal functions, in place (target 100%) • Number of health workers trained in universal precaution and infection prevention (target 80 health workers) • Percentage of supported facilities with infection control plans in place (target 90%) • Number of CHDs with updated EPR plans available (target 3) • Proportion of communicable diseases detected and responded to within 48 hours (target 90%) • Number of measles vaccinations given to under 5 in emergency or returnee situation (target tbd)	books • Supervision reports • Stock reports facility • HR records and training reports • Training reports • Supervision reports • CHD EPR plans • Assessment reports • EPI reports, outbreak response reports	• Staff levels are maintained • CHDs are present and functional • Community midwives (18months training) are considered as skilled birth attendants • Expect at least one emergency situation during project implementation (measles outbreak, AWD, or mass displacements by floods or insecurity) • IRC maintains support to Panyjiar County facilities through HPF after June • The applied population data and its composition are realistic
	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) Provide maternal and child healthcare services at the 15 supported facilities in four counties 2) Conduct mobile clinics and outreaches for communities not accessing health facilities 3) Conduct on-job training of CHW or MCHWs at PHCUs on ANC, PNC and referral for delivery 4) Provide equipment and supplies for maternal healthcare based on needs 5) Conduct health education and hygiene promotion sessions at community level 6) Conduct a household KPC assessment on LLITN utilization in the two counties 7) Referral of patients from communities to health facilities and from facilities to hospitals 8) Procure purpose-made ambulances for Aweil Centre County 9) Support ambulance running costs for four counties 10) Procure portable stretchers to support community referral system	**Inputs:** *What inputs are required to implement these activities, e.g. staff time, equipment, travel, publications costs etc.?* • Staff, equipment, drugs and medical supplies, stationeries • Supervisor, training tools, travel • RH materials and equipment • Facilitators, venue, refreshments, accommodation, transport, per diems, stationeries and training tools • Staff, transport, IEC materials • Facilitators, venue, refreshments, accommodation, transport, per diems, stationeries and training tools • Motorboat, fuel, maintenance, jetty rental, guard, driver • Facilitators, venue, refreshments, accommodation, transport, per diems, stationeries and training tools • Medical supplies, drugs, storage box, cupboard. • Facilitators, venue, refreshments, accommodation, transport, per diems, stationeries and training tools		**Assumptions, risks and pre-conditions:** *What pre-conditions are required before the project starts? What conditions outside the project's direct control have to be present for the implementation of the planned activities?* • Project area remains accessible to the organization (politically, security, geophysically) • Staff levels are maintained • Economy remains relatively stable without significant inflation • CHDs are present and functional • Community midwives (18 months training) are considered skilled birth attendants • Expect at least one emergency situation during project implementation (measles outbreak, AWD, or mass displacements by floods or insecurity) • IRC maintains support to Panyjiar County facilities through HPF after June

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

	11) Procure Thuraya phones for Aweil Centre and Warlang and Jaac PHCUs 12) Provide protective clothing and items in 15 health facilities 13) County-level refresher training for EPR teams 14) Assist and guide CHD to procure buffer stocks for essential drugs for 15 facilities 15) Preposition buffer stocks of essential drugs at 15 facilities 16) Assist CHDs in transport drugs and medical supplies to health facilities every month 17) Support CHDs in surveillance and timely weekly reporting 18) Participate in joint needs assessments and suspected outbreak investigations 19) Support CHDs in coordination and implementation of emergency response 20) Respond to health emergencies according to the needs 21) Refresher trainings for health workers on case management of diseases with epidemic potential	• Staff, transport, stationeries, assessment tools if applicable • Transport, stationeries, assessment tools • Transport, staff-per diems, drugs and supplies, stationeries, furniture, IEC materials • Facilitators, venue, refreshments, accommodation, transport, per diems, stationeries and training tools		

PROJECT WORK PLAN

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

Project start date:	**1 October 2013**	**Project end date:**	**28 February 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: Provide maternal and child healthcare services at the 43 supported facilities in four counties				x	x	x	x	x							
Activity 2: Conduct mobile clinics and outreaches for communities not accessing health facilities				x	x	x	x	x							
Activity 3: Conduct on-job training of CHW or MCHWs at PHCUs on ANC, PNC and referral for delivery				x	x	x	x	x							
Activity 4: Provide equipment and supplies for maternal healthcare based on needs				x	x	x	x	x							
Activity 5: Conduct health education and hygiene promotion sessions at community level				x	x	x	x	x							
Activity 6: Conduct a household KPC assessment on LLITN utilization in the two counties				x											
Activity 7: Referral of patients from communities to health facilities and from facilities to hospitals				x	x	x	x	x							
Activity 8: Procure purpose-made ambulances for Aweil Centre and Aweil South Counties				x											
Activity 9: Support ambulance running costs for four counties				x	x	x	x	x							
Activity 10: Procure portable stretchers to support community referral system				X											
Activity 11: Procure Thuraya phones for Aweil Centre and Warlang and Jaac PHCUs				x											
Activity 12: Provide protective clothing and items in 15 health facilities				x	x	x	x	x							
Activity 13: Rehabilitate placenta pit and incinerator in selected PHCCs					x										
Activity 14: County level refresher training for EPR teams						x									
Activity 15: Assist and guide CHD to procure buffer stocks for essential drugs for 15 facilities				x											
Activity 16: Preposition buffer stocks of essential drugs at 15 facilities				x											
Activity 17: Assist CHDs in transport drugs and medical supplies to health facilities every month				x	x	x	x	x							
Activity 18: Support CHDs in surveillance and timely weekly reporting				x	x	x	x	x							
Activity 19: Participate in joint needs assessments and suspected outbreak investigations				x	x	x	x	x							
Activity 20: Support CHDs in coordination and implementation of emergency response				x	x	x	x	x							
Activity 21: Respond to health emergencies according to the needs				x	x	x	x	x							
Activity 22: Refresher trainings for health workers on case management of diseases with epidemic potential					x	x									