South Sudan
2014 CHF Standard Allocation Project Proposal

for CHF funding against Consolidated Appeal 2014

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 2014 First Round Standard Allocation
This section should be filled by the cluster Coordinators/Co-coordinators before sending to cluster partners. It should provide a brief articulation of Cluster priority activities and geographic priorities that the cluster will recommend for funding from the CHF in line with the cluster objectives highlighted in the CAP 2014.

Cluster Priority Activities for this CHF Round

- Maintain emergency primary health care services in targeted areas through the provision of basic equipment, drugs, medical supplies, basic lab equipment and supplies
- Support to key hospitals for key surgical interventions to trauma
- Provision and prepositioning of core pipelines (drug kits, RH kits, vaccines and supplies)
- Communicable disease control and outbreak response including supplies
- Support immunizations via fixed and mobile health clinics targeting returnees, displaced people, and other vulnerable groups including emergency mass vaccination campaigns
- Maintain surge capacity to respond to any emergencies
- Capacity building interventions will include:
    a. Emergency preparedness and communicable disease control and outbreak response
    b. Emergency obstetrical care, and MISP (minimum initial service package-MISP)
    c. Community based interventions including awareness raising, hygiene promotion, education and participation in health-related issues
    d. Trauma management for key health staff
- Support to referral system for emergency health care including medivacs;
- Support to minor rehabilitation and repairs of health facilities;
- HIV/AIDS awareness raising information dissemination, condom provision, PMTCT, PEP and standard precautions.

Cluster Geographic Priorities for this CHF Round

- Jonglei (Pibor, Pochalla, Ayod, Akobo, Fangak, Canal, Twic East)
- Warrap (Twic, Gogrial East, Tonj North, Tonj South and Tonj East)
- Northern Bahr El Ghazal (Aweil North, Aweil East, Aweil South and Aweil Central)
- Western Bahr El Ghazal (Raja)
- Lakes (Awerial, Rumbek North, Cueibet, Yirol East)
- Unity (Abiemnhom, Leer, Mayendit, Rubkona, Mayom, Koch, Panyijar and Pariang)
- Upper Nile (Renk, Ulang, Nasir, and Maban, Longechuk, Baliet and Malakal)

SECTION II

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

Requesting Organization
Relief International

Project CAP Code	CAP Gender Code
SSD-14/H/60404	1

CAP Project Title *(please write exact name as in the CAP)*
Support basic health services in Maban county

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	*Maban county (payams: Banashowa, JinMakda and Khor El Amer)*

Total Project Budget requested in the in South Sudan CAP	**US $750,000**
Total funding secured for the CAP project ***(to date)***	US $0

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)*
✓ IMA, 672,814(promised but not received). The grant support salary and limited program support and the activities concentrated in two payams. The CHF grant fill the gap to extend the service to the most remote villages of the county by supporting additional 3 payams and synergies the County health servies**.**

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)*

Catchment Population (if applicable)

	Number of direct beneficiaries targeted in CHF Project	Number of direct beneficiaries targeted in the CAP
Women:	5808	25,590
Girls:	3461	5152
Men:	6261	15,556
Boys:	3734	4755
Total:	19,264	**51,053**

Total population for Maban 77,990 (Host community 54,413 +Returnees 21,577+IDPS 2000)
Target Population: 39,970 Bananshowa, Jinmakda&Khor El Amer(13,622+11,488+7,466+5394 returnees+2000 IDPS)

IDPs and returnees in Maban county: Returnees 5,394 and IDPs 2000.

Targeted population:
Abyei conflict affected, IDPs, Returnees, Host communities, Refugees

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

Indicate number of months: 9 (Nine months)

1 July 2014 – 31 March 2015

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

Contact details Organization's Country Office	
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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]

Healthcare is essential for the improvement of the standard of living in any nation and primary healthcare is the focus for action since it can be made universally accessible through a community based approach to health service delivery. The major gaps in health care currently are the availability, accessibility, and efficient management of service provision. Despite the continuing efforts of humanitarian actors to support the strengthening of the country health system, South Sudan still has some of the worst health indicators in the world. According to [2]the South Sudan statistical yearbook 2010 in Upper Nile State the main health indicators <1 year fully immunized 28.5%, Maternal mortality rate is 2094/100,000 births, under 5 mortality rate 110/1000 live births, neonatal mortality rate 54/1000 live births, infant mortality rate 82/1000 live birth and contraceptives prevalence is 4.5%.With the existing limited coverage of primary health care service in Maban County, it is expected that the main health indicators are far below the above mentioned state level indicators. Continued low EPI coverage compounded by a weak cold chain system increases the potential for disease outbreak amongst children.

There has been limited progress in terms of both the access to basic and primary secondary health care, and the quality of health services received. When examined in terms of the six building-blocks of the WHO's 2007 framework for action on strengthening health systems, although all blocks are critically weak, the lack of a skilled health workforce, quality information on which to base decision-making, and adequate governance and leadership are particularly acute. There is a universal lack of basic education amongst the population in rural South Sudan and as a result, there is a continued need for the investment in human resources (for health) that has been seen throughout the duration of CHF support to the target facilities in Maban county. In addition, there is also a need to bring external expertise from the East African region to the health facilities, where sufficient training for national staff is necessary to ensure an adequate standard of patient care is feasible within the timeframes of pressing humanitarian need. However, since beginning its operations in Maban in 2006, RI has been helping to build the capacity of national staff in its facilities in the medium-term, in line with its commitment to health systems strengthening (HSS) and linking relief, rehabilitation, and development (LRRD) in South Sudan in general, particularly in Maban. While the ROSS MoH is slowly beginning to build in capacity, it has neither the financial resources, nor administrative capacity, particularly at the state- and county-level, to ensure adequate and equitable basic health service delivery.

The health situation across the Republic of South Sudan remains fragile and unpredictable. There are high risks of communicable diseases, floods and drought, low access to safe drinking water, food insecurity, and poor sanitation. Population displacements and movements secondary to internal and external conflict compounded the public health threats. The situation in Maban is different as there is no agency operating in the host community to provide essential health care services. As compared with other counties in Upper Nile, as most refugees coming from Blue Nile in Sudan are hosted in Maban, and end up competing with the host community for existing limited services. The recent data from a UNHCR survey shows that the total registered population was 182,455 (30,410 HH) as of November 03, 2013. When the already existing problems are compounded with an influx of more IDPs, it demands close

[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.

[2] South Sudan statistical year book 2010

attention and supervision of humanitarian agencies for active outreach and mobile basic health care service delivery.

Maban County borders with the ongoing conflict affected zones in Upper Nile State. Since the beginning of the crisis, the county has experienced an influx of IDPs (predominately Nuers) from neighboring counties, they have been targeting the payams of Banashowa and Bunj as a possible exit location from the conflict affected Counties. Consequently, Maban served during the crisis as a safe haven for many communities fleeing from Mellut, Renk, Palluche. There are still 1500-2000 IDPs in many parts of the county (Banashowa, Bunj, and Nurishan). Altogether, the current crisis has exacerbated many health problems in the county and the scarce resources received from RI and other partners are not enough to deliver quality services. The institutional capacity of the health staff needs to be urgently enhanced and physical infrastructure of the facilities needs to be strengthened, especially in the rural areas of Bugaya,Tonkaya, Poumki, Shatta, Jemam and Banshowa. As is typical in emergency settings, especially where populations are displaced from their homes, in addition to general primary health care needs, there are particular needs related to the heightened risk of exposure to HIV infection among vulnerable groups in Maban county. Disruption of social networks that safe-guard social behavior, heightened risk of sexual assault and gender based violence (including sexual exploitation), and the inaccessibility of HIV prevention commodities such as condoms, are all factors that may predispose vulnerable groups (particularly women and children) to HIV infection.

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.

Relief International (RI) is a humanitarian agency that provides emergency relief, rehabilitation, and development interventions throughout the world. RI has considerable experience in Maban, Upper Nile, South Sudan. RI has responded to emergencies in the country, providing emergency food aid, nutrition, and health services. RI is a health lead agency in the county and supports 13 health facilities to provide primary health care services to communities most in need in collaboration with the County Health Department. The targeted project areas include remote rural Payams and villages of Maban county;the IDPs in Bananshowa and Nureshin and the returnees and refuges in Bunj displaced from Blue Nile. While RI has been supported by an IMA grant, the grant does not cover all aspects of primary health care services, and primary health care services at this point need strengthening community based intervention and access to those who are in urgent needs, strengthen emergency preparedness and response capacity, improving the capacity of local health cadres and infrastructure rehabilitation.

The situation in Maban County demands on-going intervention to save lives of the most vulnerable groups, particularly children <5 and pregnant and lactating mothers The proposed project activities will help maintain the existing health sector and expand services to remote locations by providing basic health packages and emergency referral services in the target facilities and communities. Through a focus on maternal and child health (MCH) especially obstetric care, integrated management of childhood illnesses (IMCI) protocols, and EPI - RI will help to ensure the promotion of mother and child survival in its supported healthcare facilities while continuing to provide services in line with the Basic Package of Health Services (BPHS). Special focus will be in place to boost the coverage for measles vaccination through enhanced outreach activities and regular cyclic vaccination campaigns. Despite serious efforts by the MoH and RI, the uptake for MCH services is very low in the proposed project areas. As per the third quarter's reports from the health service data, ANC 1st stands at 47%, TT2 coverage at 15%, IPT2 at 12%, institutional delivery at <9%, DPT3 coverage at <34%, and family planning utilization is estimated at 1%. In addition to the acute shortage of certified midwives, RI has observed a huge need to intensify community education and social mobilization for the utilization of services. Therefore RI will strengthen community health structures and conduct extensive health promotion on common illnesses, MCH, nutrition, healthcare seeking behavior, and information on available services in the health facilities.

RI has a long history of ensuring emergency primary health care response interventions and responding to primary health care needs. RI will implement the proposed project within the framework of primary health care principles and in line with the Basic Package of Health Services (BPHS). The project will address these immediate needs through the provision of basic comprehensive health services according to RoSS, MoH standards, and guidelines at 7 facilities: Bugaya, Tonkaya, Liang, (through mobile unit), Poumki, Nilla and Shatta. Maternal and Child Health (MCH) will be given a special emphasis through implementation the integrated management of childhood illnesses (IMCI) protocols promoted by health staff and community leaders. Special focus will be in place to boost the coverage for measles and polio vaccination through enhanced outreach activities and regular cyclic vaccination campaigns.

RI will procure and distribute essential drugs, including emergency surgical and obstetric drugs, kits (including trauma kits), medical supplies, basic medical equipment, and laboratory supplies through direct supply and the MoH's supply chain (i.e. from CHD to facility level). In addition, RI will strengthen its partnerships with UNFPA and UNICEF to ensure the timely procurement and distribution of essential reproductive health and EPI supplies, including ensuring properly functioning and unbroken cold chains. RI, together with local MoH (CHD), plans to strengthen the emergency preparedness and response (EP&R) capacity of all supported health facilities and affected communities, to significantly contribute to the sector/cluster priority of controlling the spread of communicable diseases. As an organization, RI is committed to responding to all communicable disease outbreaks within 72 hours. This will, in the first part, be achieved through the training of facility staff and community members on disease surveillance, reporting and analysis. Diminished awareness by the community, very low immunization coverage, very low LLITN distribution and use and hygiene promotion are the needs identified and amenable to low-cost, short-term interventions in terms of communicable disease prevention and control. RI will also engage in case finding, treatment and health awareness raising for the prevention of common infectious diseases, e.g. cholera, meningitis, malaria, and other notable diseases. Finally, to ensure effective and timely response interventions, RI will preposition essential emergency supplies and kits (drugs, vaccines, IV fluids, tents, personal protective equipment (PPE)), as well as working through key coordination mechanisms such as the inter-agency outbreak control team and the OCHA inter-agency EP&R Task Force. Further, this project will help to reduce morbidity, mortality, and suffering among affected populations, focus on children and mothers through provision of Integrated basic Primary Health Care Services including under 5 clinic (IMNCI protocol), ANC, promotion of facility delivery and PNC services in all PHCC, and PHCUs, and comprehensive outreach centers.

The project will be facilitated through the participation of the user communities at all levels of project implementation and special

attention will be given to support skills transfer. These can be ensured by establishing village health committees, nomination and training of home health visitors/household promoters (HHPs), and the training of traditional birth attendants as per the basic package of health services. Additionally the project will work closely with local authorities, chiefs, women groups and humanitarian agencies in the area to emphasize the meaningful engagement of key stakeholders throughout all stages of the project cycle. This leads to enhanced skills in maintaining health facility services in their villages. As per the GOSS, MOH, and BPHS package, the community health committee will lead the basic health service activities within their payams, while HHPs are responsible for promoting individual and community behavior change and TBA's are responsible for promoting antenatal care as well as safe and clean delivery practice through institutional delivery. Through skills transfer and support, RI will foster these groups' mandates and ensure the long-term sustainability of proposed project outcomes.

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.

As detailed in section A, there is a clear, immediate need for humanitarian health interventions as indicated by the higher levels of morbidity and mortality rates and ratios, the very low levels of access and coverage of services, the ongoing armed conflicts and insecurity, the potential for an additional influx of IDPs and the frequent IDP/refugee/host community conflicts competition for water, grazing land, and other resources. All of these require coordinated, sustained and integrated preparedness and response activities in the county.

The CHF funding will be used to support addressing the health needs in the geographic area including the returnees. RI has secured some funding from CHF and IMA but the resources are not adequate to fund the full range of proposed activities, which have been designed to ensure they fit tightly with CHF policies and health cluster priorities for South Sudan in 2014. The funds requested for the CHF component of the project will be essential to complement the on-going basic health and EPR activities, and enable RI to fully contribute to the priorities of the cluster in the year ahead, to fill the funding gaps to continue, improve, and expand RI health work in all remote villages of Maban County.

RI proposes to co-finance the project under its secured grant with IMA in the county. The funds requested from the CHF component of the project will be essential to ensuring that the ongoing project is able to fully contribute to the priorities of the health cluster in the difficult year ahead. It is to fill the funding gaps to continue, improve, and expand RI health work in the county with emphasis on basic safety net health services, lifesaving interventions (including obstetrics) and emergency preparedness/response.

ii) Project Objective

State the objective/s of this CHF project and how it links to your CAP project (one specific geographical area, one set of activities or kickstart/support the overall project). Objective/s should be Specific, Measurable, Achievable, Relevant and Time-bound (SMART)

1. Promote sustainable primary health care approach and improve access to and coverage of Primary health care services to host communities, IDPs, and refugees;
2. Promote sustainable primary health care approach and improve access to and coverage of Primary health care services; Focus on children under 5 and PLW
3. Promote sustainable primary health care practices through strengthening of the capacity of health personnel and the improving the infrastructure along with enhancing capacity of beneficiary communities.
4. Establish strong mechanisms to predict and prevent infectious diseases outbreaks with participation of all partners including beneficiary communities.

iii) Project Strategy and proposed Activities

Present the project strategy (**what the project intends to do, and how it intends to do it).** There should be a logical flow to the strategy: activities should lead to the outputs, which should contribute towards the outcomes, which should ultimately lead to the project objective.
List the main activities and results 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).

All activities will be implemented in all five payams within the county and selected mobile outreach center in Banashowa. RI is a lead agency for health and nutrition program for Maban county and has food security and livelihood and IYCF promotion program in Maban and Longchuk county of Upper Nile state. RI is proposing to implement expansion of basic health services in the county in the following main approaches;

- RI will conduct community mapping exercise to identify the actual needs in all parts of the County, addressing the basic health needs of hard to reach areas through different innovative ways which can ensure community ownership. RI will take advantages of its holistic program approach expertise and acceptance at the community level to build strong community structure in line with the basic packages of health services. RI will ensure implementing approach to follow participatory approach, program integration, networking and skill transfer at all levels of project implementation process.
- Establishing the PHCUs in the selected areas based on the identified gaps through establishing community structures, creating capacity and empowers the community to take active part in the health care delivery system will be an integral part of the routine project activities.
- The project will focus on mothers and children, targeting them for services and giving decision making powers for women through exposing them to take active role in the project design, implementation process.

Main Activities

1. **Ensure effective delivery of comprehensive primary health care services with un-restricted and non-discriminatory access for women, men, girls, boys and vulnerable groups including ethnic minorities, returnees/IDPs/refugees.**

- Strengthening the existing health care system and service delivery mechanisms by staff training and infrastructural improvement;
- Rehabilitation/expansion/construction of three health facilities (in Banashowa, Poumki and Shatta) implemented;
- Recruiting, training and couching of health personnel for 7 health facilities where currently primary health care services are delivered by community health workers finalized;
- Provision of focused antenatal care and postnatal care as per MoH Guidelines;

- Adequate supply of drugs &Medical equipment to the county health facilities have been established;
- Comprehensive Mobile Outreach Program for curative and preventive health services in areas not covered by the existing facilities established;
- Monthly supportive supervision to health facilities (PHCU/PHCC) and on job staff training carried out;
- Proper functioning of referral networks as community-PHCU-PHCC-CH have been ensured;
- Strengthen the existing routine immunization services in static and outreach clinics, dry season campaigns
- Mass de-worming and Vitamin A supplementation campaigns carried out;
- Promotion of facility deliveries through improving the quality of care and using non-monetary incentives for TBA's and pregnant women
- Basic/refresher training for TBA's on delivery complications, prenatal and postnatal care.
- Proper case registration and reporting system established, timely collection morbidity reports ensured. The collected data analyzed and used for management decisions
- Refresher trainings on immunization and cold chain management, MISP, IMCI, HMIS, EmOC, clinical management of rape survivors, drug management and malaria case management .

2. Enhanced capacity and work with beneficiary community and through community structures to enhance capacity, ownership, participation and utilization of health activities/services focused on diseases of epidemic potential and high public health significance

- Designing community entry process in line with the existing community structure and community settlement patterns
- Re-vitalization/nomination of the community resource groups CHC, HHP and TBA's in operational areas
- Training of CHC and HHPs in all project support areas using the new training manual developed by MOH
- Distribution of items (non-monetary) incentives to community groups.
- Key health messages on malaria, diarrhea, ARI, HIV, TB, Malnutrition and reproductive health adopted from MOH IEC materials and will be used for health promotion
- Provision of targeted health messages using culturally acceptable methods like drama, songs, dance etc.
- Monthly and quarterly planning and report sharing meeting by CHC, HHP and TBA in all facility catchment area.
- Celebrating world sensitization/ Awareness days; safe mother hood, global hand washing and HIV/AIDS day
- Open rally awareness campaign in the market, churches, social events
- Conduct 4 sessions of FGD with traditional healers, elders, chiefs and church leaders to encourage early referrals of patients to the health facilities
- Regular health education on common health problems at health facilities, communities, churches, schools
- Strengthening the IDSR and epidemiological response system at community level by using community groups.

3. Coverage of targeted population with communicable disease outbreak prevention messages, epidemic investigation and response, and coordination for Emergency response increased

- Development of epidemic preparedness plans and identification of the resources for plans maintained. The Plans shared with all partners, staff training carried out, community awareness and mobilization ensured
- Preparation of emergency response plan and prepositioning of essential drugs in all health facilities
- Strengthening data collection and situation monitoring system for timely response for an outbreak
- Training of HHPs, elders and CHCs in all facilities catchment areas on potential outbreak diseases in the area (neonatal tetanus, measles, polio, cholera, meningitis, malaria and malnutrition)
- Improving the rapid assessment capacity of the project
- Training of health staff, CHD focal points on case management of diseases with potential outbreaks and submission of IDSR reports.

iv) Expected Result(s)/Outcome(s)

Briefly describe the results you expect to achieve at the end of the CHF grant period.

- 7 (100%) of targeted health service delivery points provide health care commensurate with MoH/WHO PHC standards.
- Health facility utilization rate is a minimum of 1 consultation per person per year
- 3,997(50%) <5 consultations in all facilities.
- 1360(85%) of children < 1 received DPT3/fully immunized
- 1279(80%) of expected pregnant women attended at least one ANC visit
- 1279(80%) of pregnant women receiving, TT vaccine, iron foliate, IPT 1&2 and deworming tablet as per the MoH guidelines
- Number survivors of SGBV receive clinical management of rape treatment
- 320(20%) expected deliveries are assisted by skilled healthcare worker
- 640(40%) of expected deliveries conducted in health facilities
- 18(F=8&M=10) health workers trained on immunization and cold chain management, MISP, IMCI, STI, EmOC, clinical management of rape survivors, drug management and malaria case management
- 3 Payams of the County covered by the PHC service
- 7195(90%) of under 5 children(boys, 3734 and girls 3461) will received Vitamin A, De-worming tablet and measles antigens
- At least 5(75%) of Community village Health Committees, HHPs and TBAs re vitalized/established and fully functional/supportive
- 1759(20%) of WCBA received knowledge when to seek care for common child hood diseases(ARI, Diarrhea, malaria and malnutrition) and home therapy of diarrhea
- 11,991 (30%) of the total population(5768 female and 6223 male) participate at least 1 session on disease prevention of common health problems
- 9 monthly joint supportive supervision will be conducted in 7 health facilities
- 5 comprehensive mobile outreach activities will be conducted in 8 selected locations
- At least 5 (75%) of supported health facilities are linked with functional/active trained HHPs and VHCs
- All 7 health facilities will get support from community contribution and involvement through direct support of the health care systems
- The existing IDSR and epidemiological reporting system improved in quality and coverage in all 7 health facilities

- 100% of prioritized diseases outbreak alerts in the operational area are investigated and responded to within 72 hours
- Outbreak response case fatality rates do not go beyond international desirable threshold for respective diseases
- 12 Health staff (F=6& M=6) and 66(F=34&M=32) community groups (VHC&HHPs) trained on prevention, control and management of diseases of epidemic potential in the operational area
- Maintenance of the county wide detailed emergency response plan

v) List below the output indicators you will use to measure the progress and achievement of your project results. Use a reasonable and measurable number of indicators and ensure that to the most possible extent chosen indicators are 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. Ensure these indicators are further used in the logframe.

SOI (X)	#	Standard 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(Women, Girls, Men, Boys)	19,264 (5808 women, 6261Men) girls 3461 and boys 3734
X	2.	# of >5 outpatient consultations	15,988 (80%) >5 (7690 women and 8298 Men)
X	3.	# of <5 outpatient consultations	3,997 (50%) <5 (1923 girls, 2074 boys)
X	4.	# of measles vaccinations given to < 5 in emergency or returnee situation (Girls, Boys)	7,195 (90%)- (Boys, 3734 and 3461 Girls)
X	5.	Number of births attended by skilled birth attendants	320(20%)
X	6.	Proportion of communicable diseases detected and responded to within 72 hours	100%
X	7.	Number of disease outbreaks detected	100%
X	8.	Number of disease outbreaks responded within 72 hours	100%
X	9.	% of pregnant women receiving at least 2nd dose of TT vaccination	85%(1359)
X	10.	Percentage DPT3 coverage in children under 1	85% (1360)
X	11.	# of survivors of SGBV receiving clinical care	100%
X	12.	# of direct beneficiaries from emergency drugs supplies (IEHK / trauma kit / RH kit / PHCU kits) Women	19,264

vi). Cross Cutting Issues

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

Gender:

Women are playing a vital role both in productive and reproductive activities though their contribution is overlooked due to the male dominance and patriarchy system. The planned project activities targets children's and mothers to be benefited from all components of the project.Specific emphasis will be placed on gender to ensure key gender issues are well considered and mainstreamed during project implementation monitoring, and evaluation. For example, RI will ensure that female and male representation will be balanced in village health committees, participation of home health promoters in health promotion and community mobilisation, and during recruitment of health and project support staff at various levels. RI will continue to encourage and proactively recruit female staff, in both counties where the level of literacy and tradition of females working outside the home is low. Through an activity focus on maternal health, RI will work to empower female decision-making for treatment seeking by facilitating male involvement and increasing health promotion activities at the community level.Tradtional birth attendants will also be supported through the core activity of referring complicated deliveries and high risk pregnancies (women) to the health facilities. RI will also ensure/recognize the full representation of women groups(women associations) in all project actvities which needs community level decision and engagement. RI will provide training for staff on Sexual and Gender Based Violence (SGBV) targeted at identifying potential cases and referring survivors for appropriate treatment and counseling. In light of the potential for increased incidence of SGBV related to potential conflict, insecurity, and mass population movements in 2014, RI will look to increase awareness amongst staff and communities regarding SGBV, with training targeted at appropriate and timely care seeking for rape victims

Environment: RI will understand that the effect of environmental deterioration will bring more food insecurity to complicate the nutritional attainment of children, pregnant and lactating mothers. The proposed project will therefore give emphasis to enhance environmental sustainability by closely working with the existing agencies to maximize the available environmental protection measures. The project promotes safe hygiene practices that contribute the contamination of the environment from human wastes, and medical disposal. The project promote LLITN usage as the main means of malaria prevention, this is environmentally sound approach other than other malaria preventions methods. Moreover, the management of medical waste will be given due attention at all levels of its generation. Clinical and cleaning staff will be trained on universal precaution to ensure appropriate segregation, sorting and storage of medical waste. RI will ensure that burial and/or burning are the ultimate waste disposal mechanism in the health facilities through renovation of existing incinerators and waste disposal pits.

Protection: Do No Harm approach (DNH) will be pursued the project to cater quality health services. In order to do that a team in RI will oversee and analyze the level of conflict sensitive issues while discharging the responsibilities. RI undertakes regular conflict monitoring analysis to reinforce security and stability. RI also ensures equal access to services by doing program awareness activities at all stages of program implementation.

HIV/AIDS: It is clear that HIV/AIDS is a daunting development challenge. It has been understood that there are limited awareness on HIV/AIDS. Awareness creation is therefore a key to RI's programming strategy across its program sites. RI will continue to take a community participatory approach to HIV/AIDS awareness and education. It involves health provider training and outreach strategies that are based on culturally relevant and appropriate messages. Methods will also be devised within the cultural context for outreach to women, men, and sexually active adolescents. RI is collaborating with the existing community partners and Village Health Committees and home health promoters (HHPs) to facilitate local participation in HIV/AIDS education. Awareness promotion will begin in the RI-supported health facilities and outreach sites. Anyone who suffers with opportunistic infections related to HIV/AIDS will automatically get medical attention and treatment in RI run health facilities, regardless of the cause of the diseases. If a patient

presents with symptoms that are suggestive of these diseases, they will be referred to the nearest diagnostic and ARV facility. RI will also provide HIV/AIDS awareness training for health and supportive staff to reduce stigma in the health facilities and ensure equal access to services.

vii) 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.

RI is proposing to implement the health project in the whole county; however special attention will be given to the payams where health infrastructure is very weak and have access problem. RI will bring extensive local and global experience and expertise in health care in emergency, transition and development contexts, as well as effective working relationships with local and government authorities in the targeted area.

The Project will be facilitated through participation of the user community at all levels of project implementation and special attention will be given for skills transfer. These can be ensured by establishing Village Health committee, nomination and training of house hold promoters (HHPs) and training of traditional birth attendants as per the basic package of health services, additionally the project team will closely work with local authorities, chiefs, women groups and humanitarian agencies in the area to emphasize the meaningful engagement of key stakeholders throughout all stages of the project cycle. This leads to enhanced skills in maintaining their health facilities service in their villages.

RI will employ a system where all stakeholders to participate in all cycle of project management including project implementation. Community leaders/representatives and government partners will play a major role to implement project activities. Moreover, RI will pursue an integrated strategy whereby the links between nutrition, health, food security, and water and sanitation activities are strengthening programs to have more synergies. The project will be implemented through the integration of existing health and nutrition activities that RI is providing. As a health lead agency RI is working closely with the County health department and sharing the same office in Maban, this facilitate day to day work related interactions, resource sharing and skill transfer. RI is also a member of health and nutrition coordination forum in the county under the umbrella of UNHCR in which all agencies working in host and refuge community have taking part, this coordination forums helps to share updates, respond jointly for emergency response, technical support, training and assessment exercises. The range of health components that will be implemented are

- Strengthening the existing health care service including rehabilitation/expansion/construction of the health facilities
- Adequate staffing for the required health cadres in all facilities
- Providing curative and preventive basic health care service(focused antenatal care as per MoH guideline, Immunization, facility/skilled delivery, IPT, micronutrient supplementation)
- Capacitating national staff through in service, CME and formal training
- Effective mobile outreach activities for curative and preventive services focused on areas not covered by the existing facilities
- Ensuring community referral network; community-PHCU-PHCC-Secondary health care, community sensitization and mobilization, community participation in resolving local health problems;
- Promote effective system of epidemic prevention and response measures in both: health system and community structures;
- Mass de-worming and Vitamin A supplementation campaign
- High level promotion of facility deliveries through improving the quality of care and using non-monetary incentives for TBA's and pregnant women;
- Preparation of emergency response plan and prepositioning of essential drugs in all health facilities;
- Strengthening data collection and situation monitoring system for timely response for an outbreak;

Building on more than seven years programming experience in Upper Nile state specifically in Maban county RI will continue to strengthen the accessible, equitable, and enduring health and nutrition care delivery structure it has helped to develop in the proposed project areas. This proposed project will be run through these vital healthcare facilities and linked with intensified community component. RI Nutrition and Health coordinators will be responsible to ensure the technical implementation of the project in line with national and international standards.

Bi-Weekly Reporting and Local Monitoring: At the onset of the program, RI's expatriate Health and Nutrition coordinators, in collaboration with other RI senior teams, will develop detailed performance monitoring and work plans to be used as key implementation guides by national staff at all RI target areas. These plans will form a basis of progress monitoring throughout the program period. Five major parameters will be assed in all monitoring activities like outputs, inputs, whether progress of activities are according to the objectives, decision making processes and context analysis. Put it differently, progress towards achieving deliverables and quality of services rendered will be monitored. Local staff and community workers will report to the RI PHC supervisors based in Bunj. Local staff and Home health promoters will be given opportunities for additional trainings, guidance. These promoters will be liaisons between remote communities in need and RI, and, over time, will develop skills and leadership capacities to be an effective part of both monitoring and service delivery. This is also a methodology that is building local skills in support of RI's sustainability and transition strategies.

Management Field Visits: Expatriate field visits to RI target sites are critical to monitor the quality and integrity of RI's programs in remote program locations. Security permitting, the expatriate Health and Nutrition coordinator, M & E Coordinator and senior local staff will visit remote locations for monitoring visits at a minimum on weekly basis. RI's Program Manager is required to spend 60% or more of his time at program sites. Senior country leadership, namely the Country Director and M&E Officer, will continue this practice during the CHF program period with routine and sometimes extended stays in the county to facilitate oversight, work plan and finance reviews, and course correction discussions. These oversight opportunities also promote the team building process within RI and routine community relations with key local leaders and line ministry partners. RI's local acceptance and permissions requirements, fundamental to ensuring field activities are occurring regularly. RI Desk officers (Based in Washington DC) and Regional Director based in Nairobi will pay visits at least once in the program areas as part of RI Global monitoring and capacity building program.

Coordination with other partners: RI teams at all levels will also coordinate with all health and nutrition partners working in similar areas or the same cluster to add value to the process. RI will closely coordinate with UNCHR, IMC, Medair and MSF and government authorities currently operating in the area. RI also coordinate with State and national level actors such as national MOH, State MOH, UNICEF, WHO and the cluster mechanisms, to enhance access to quality health and nutrition services for vulnerable communities, especially children and PLW. The project will be managed by a highly qualified Health and Nutrition Coordinators and the team of health and nutrition workers, community mobilizes, and community volunteers and also recruits additional staff as needed by the project. RI as a lead health agency for host communities in the county will provide coordination support to all partners.

viii) 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 are the monitoring institutional arrangements (e.g. monitoring team, monitoring schedule, updates to management etc.) and monitoring tools and technics will be used to collect data on the indicators to monitor the progress towards the results achieved. Please provide an indication of the frequency data will be collected and if there is already a baseline for the indicators or if a baseline will be collected.

3. Describe how you will analyze the data collected and report on the project achievements in comparison with the project strategy.
4. Ensure key monitoring and reporting activities are included in the project work plan (Section III)[3].

Monitoring: RI will monitor project performance and achievements at all levels of project implementation to determine whether the project objectives and expected outcomes have been met (in terms of scope, timeliness, quality, equity, and cost). This will be achieved in part through the monitoring of progress against the nine key indicators outlined above. A number of tools and methods will be used to monitor the delivery of health services at supported facilities and within target communities. Formal monthly supervision of health facilities will be carried out (using the MoH supervision checklists) to ensure good quality services are provided at all levels. The key stake holders & CHD representative will be invited, encouraged, and facilitated to participate in these monitoring visits. In each of the facilities, monthly mortality audits will be conducted in a participatory manner to review cases and identify best practice. Quarterly comprehensive audits of treatment and prescribing practices will be conducted in all facilities. These will be conducted through register review, consumption data analysis, and linked to exit interviews. Quarterly exit interviews will be conducted to assess demand-supply gaps, beneficiary satisfaction levels, and to improve service quality standards in general. In addition, to strengthen quality of care further, RI will introduce Accountability Framework to improve the quality and accessibility of services with community involvement in defining, implementing, and monitoring the quality improvement process. This process links quality assessment and improvement with community mobilization. Regular progress reports will be submitted as per the CHF requirements. Monthly health statistics and quarterly progress reports will be submitted to the respective State MoH and CHDs. RI will also ensure weekly IDSR/EWARN reports are submitted for integrated disease surveillance at the county, state and national level.

Management and Oversight: In terms of institutional structure and management capacity, the Country Director of RI based in Juba, South Sudan and the project senior staff team members based in Boma with regular support of health &Nutrition coordinators will maintain the overall leadership of the project. The health specialist at field level will work with a competent and internationally experienced management team comprised of three HQ East Africa desk members responsible for programs, operations and human resources. The senior management team at country level will undertake key policy and strategic decisions related to the project in consultation with the RI HQ, especially the RI East Africa Regional Office in Nairobi, Kenya. The regional manager is also responsible for doing all the monitoring and evaluation work of the respective projects at regional level. Periodic monitoring will be done in collaboration with SMOH, CHD, UN Agencies and INGO local representatives.

Field Visits: Regular/routine field site visits will be undertaken by the Technical Health Coordinator in collaboration with the Technical Nutrition Coordinator. Data and information on progress will be collated and/or reviewed during such visits and, where appropriate, follow up actions and plans discussed/developed. Periodic visits (monthly, quarterly or on need basis) will be conducted by the Technical Health Coordinator and the Country Director as well as by the Monitoring and Evaluation officer. Such visits will essentially be meant to assess progress in implementation and provide necessary technical, managerial and administrative back up to the field staff.

Reporting: Reporting of monitoring information will be done through activity and progress reports. The monthly reports will be done in line with the RI Internal reporting formats while the quarterly financial and narrative reports will be done in line with formats agreed with the funding organization. Regular progress reports will be submitted as per the CHF requirements. Monthly health statistics and quarterly progress reports will be submitted to the Health Cluster and other partners and copied to State MoH and CHDs. The monthly and quarterly statistics will include reporting on the performance of the intervention against the recommended Sphere Standard Performance Indicators and MoH and or WHO guidelines.

Evaluation Plan: The project has proposed to undertake periodic review of performance with the key stake holders at project and selected implementation sites to ensure our accountability for donors and beneficiary community. At the commencement of the project RI will organize the launching ceremony with key stake holders (represented by humanitarian agencies, CHD, SSRRC and beneficiary communities) to share the planned project activities and targets. Based on this, performance review sessions will be held quarterly, semesterly and annually with all key stake holders this exercise will be complemented by joint field visit.

Mid-Term Evaluation (Coverage survey) - This will be conducted after six months of the project start, to review the appropriateness of the project goal and outcomes; assess progress towards meeting the targets (with a goal of determining which targets need to be revised); assess the effectiveness and efficiency of the strategies adopted (e.g. appropriateness of activities and whether these need to be revised, whether they are cost-effective); and an analysis of the major challenges that have affected project implementation. The outcome of the mid-term evaluation will be used to make appropriate adjustments to improve project outcomes.

Supply Chain Management: RI documented procurement and supply chain management systems, which adheres to international principles and standards, will aid in management of this project. The Supply Chain Department will ensure competitive bidding processes, quality assurance, and internal capacity building for procurement of goods and services. RI supply chain management is an integral process of project cycle management. Through collaboration of Project Working Groups and the Supply Chain Management team, a forecast of goods and services needed for this project will be determined at the design and planning phase. Also, procurement and delivery aligned to project implementation and monitoring. This approach will enable RI to ensure improved quality for better delivery of services and accountability.

Accounting and Financial Management: RI maintains a centralized financial tracking and a monitoring unit within the Juba head office. The HQ uses the computerized accounting system (Sun Systems), a globally recognized system of accounting, which has sufficient flexibility to generate reports that meet varied donor needs. A standardized chart of accounts classifies transactions to project, expense, donor, and cost center codes. Transactions can therefore be tracked monthly for each recipient and donor using the system. RI has in place a Finance Manual, which outlines all the financial regulations, policies, and procedures. The finance unit will ensure that there is a strong internal control for proper accountability and transparency throughout all its country programs, also though regular Internal Audit Systems. Financial officers are seated at county, state, and national level offices to ensure that policies and procedures are properly followed.

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)
IMA(Not confirmed)	$672,814USD
Pledges for the CAP project	

[3] 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:

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. Follow the guidance and the structure (Goal, objective, outcome, outputs and activities) and the numbering. Add/remove lines according to the project strategy.

LOGICAL FRAMEWORK		
CHF ref./CRP Code: SSD-14/H/60404	**Project title:** Support basic health services in Maban county	**Organisation:** Relief Internationa (RI)l

Goal/Objectives/Outcomes/Outputs		Indicator of progress	Means of Verification	Assumptions and Risks
Goal/Impact (cluster priorities)	• Maintain emergency primary health care services in targeted areas through provision basic equipment, drugs, medical supplies, basic lab equipment and supplies • Provision and prepositioning of core pipelines (drug kits, RH kits, vaccines and supplies) • Support to minor rehabilitation and repairs of health facilities • HIV/AIDS awareness raising information dissemination, condom provision, PMTCT, PEP and standard precautions • Communicable disease control and outbreak response including supplies • Support immunizations via fixed and mobile health clinics targeting returnees, displaced people, and other vulnerable groups including emergency mass vaccination campaigns • Maintain surge capacity to respond to any emergencies • Capacity building interventions will include: a. Emergency preparedness and communicable disease control and outbreak response b. Emergency obstetrical care, and MISP (minimum initial service package-MISP) c. Community based interventions including awareness raising, hygiene promotion, education and participation in health-related issues d. Trauma management for key health staff	• Total direct beneficiaries(Women, Girls, Men, Boys) • Number of consultations, 5 years or older(Men, Women) • number of <5 consultations (male and female)-(Girls, Boys) • Number of measles vaccinations given to under 5 in emergency or returnee situation(Girls, Boys) • Number of births attended by skilled birth attendants • Proportion of communicable diseases detected and responded to within 72 hours • Number of disease outbreaks detected • Number of disease outbreaks responded within 72 hours • % of pregnant women receiving at least 2nd dose of TT vaccination • Percentage DPT3 coverage in children under 1 • Number survivors of SGBV receive clinical management of rape treatment • Number of direct beneficiaries from emergency drugs supplies (IEHK / trauma kit / RH kit / PHCU kits	• Supportive supervision reports • Periodic review meetings • Static health clinics Morbidity, ANC FP & EPI reports, community health and outreach program report • IDSR data • Training reports • Drug supply reports • Logistic reports	• Timely disbursement of funds • Sufficient and adequately qualified staffs are available to run the project. • There is cooperation with the local authorities • The Ministry of Health continues to strengthen its presence and role at national, state and county level. • Security situation is stable enough allowing humanitarian access

CHF project Objective	• 1.To promote sustainable primary health care approach and improve access to and coverage of primary health care services; • 2.To enhance the quality of health services through the delivery of an integrated basic package of high-impact health services • 3.To strengthen the capacity of health personnel and the County Health Department along with enhancing capacity of beneficiary communities • 4. To integrate HIV prevention and awareness raising activity into primary health care system			
Outcome 1	• 7(100%) of targeted health service delivery points provide health care commensurate with MoH/WHO PHC standards; • Health facility utilization rate is a minimum of 1 consultation per person per year; • 3997(50%) <5 (1923 girls, 2074 boys) consultation in all facilities; • 1360 (85%) <1 received DPT3/fully immunized; • 1279 (80%) of expected pregnant women attended at least one ANC visit; • 1279 (80%) of pregnant women receive TT vaccine, iron folate, IPT 1&2 and deworming tablet as per the MoH guidelines; • All survivors of SGBV receive clinical management of rape treatment; • 320 (20%) expected deliveries are assisted by skilled healthcare worker; • 640 (40%) of expected deliveries conducted in health facilities; • 18 (F=8&M=10) health workers trained on immunization and cold chain management, MISP, IMCI, EmOC, clinical management of rape survivors, drug management and malaria case management and following the clinical protocols;	• Number of targeted health service delivering points providing health care commensurate with MoH/WHO PHC standards. • Health facility utilization rate progress (it is a minimum of 1 consultation per person per year); • Number and % of children < 1 received DPT3/fully immunized • Number and % of expected pregnant women attended at least one ANC visit • Number and % of expected pregnant women attended at least four ANC visit • Number and % of pregnant women receiving, TT vaccine, iron foliate, IPT 1&2 and deworming tablet as per the MoH guideline • Number survivors of SGBV receive clinical management of rape treatment • Number of expected deliveries are assisted by skilled healthcare worker • Number and % of health workers trained on immunization and cold chain management, MISP, IMCI, EmOC, clinical management of rape survivors, drug management and malaria case management	• Supportive supervision reports • Periodic review meetings • Static health clinics Morbidity, ANC FP & EPI reports, • Community health and outreach program reports • IDSR data • Training reports • Drug supply reports • Patient exit interview • Success stories	• Timely disbursement of funds ensured • Sufficient and adequately qualified staffs are available to run the project. • Cooperation with the local authorities and RI health team ensured • The Ministry of Health continues to strengthen its presence and role at national, state and county level. • Security situation is stable enough allowing humanitarian access

Output 1.1	• 7(100%) of targeted health service delivery points provide health care commensurate with MoH/WHO PHC standards. • Health facility utilization rate is a minimum of 1 consultation per person per year • 3997(50%) <5 (1923 girls, 2074 boys) • 18(F=8&M=10) health workers trained on immunization and cold chain management, MISP, IMCI, EmOC, clinical management of rape survivors, drug management and malaria case management .	• 100% of targeted health service delivery points provide health care commensurate with MoH/WHO PHC standards. • Health facility utilization rate is a minimum of 1 consultation per person per year • Number and % of expected pregnant women attended at least one ANC visit • Number and % of expected pregnant women attended at least four ANC visit • % of pregnant women receiving, TT vaccine, iron foilate, IPT 1&2 and deworming tablet as per the MoH guideline • Number of # survivors of SGBV receiving clinical care. • Number of births attended by skilled birth attendants	• • Supportive supervision reports • Periodic review meetings • Static health clinics Morbidity, ANC FP & EPI reports, community health and outreach program report • IDSR data • Training reports • Drug supply reports • Patient exit interview • Success stories	• Timely disbursement of funds are ensured • Sufficient and adequately qualified staffs are available to run the project. • There is cooperation with the local authorities and RI health team • The Ministry of Health continues to strengthen its presence and role at national, state and county level. • Security situation is stable enough allowing humanitarian access
Activity 1.1.1	Rehabilitation/expansion/construction of the 7 health facilities has been carried out			
Activity 1.1.2	Recruitment and training of health staff for all the seven health facilities has been carried out			
Activity 1.1.3	Training on immunization and cold chain management, MISP, IMCI, HMIS, EmOC, clinical management of rape survivors, drug management and malaria case management has been carried out			
Activity 1.1.4	Curative consultations for <5 and >5 patients			
Output 1.2	Strengthening the existing routine immunization services in static, outreach and accelerated campaign programs	• Number of health workers trained on immunization and cold chain management, MISP, IMCI, EmOC, clinical management of rape survivors, drug management and malaria case management • Number and% of children < 1 received DPT3/fully immunized • Number and % of pregnant women receiving, TT vaccine, iron folate, IPT 1&2 and deworming tablet as per the MoH guideline	• Training reports, • Immunization reports • Health facility reports • Monitoring reports	• Immunization materials are available • Timely disbursement of funds ensured • Security situation is stable enough allowing humanitarian access
Activity 1.2.1	Immunization services for children < 1 and for pregnant women			
Activity 1.2.2	Strengthening the existing routine immunization service in static, outreach and accelerated campaign programs			
Activity 1.2.3	Support the national polio campaigns in the operational area			
Activity 1.2.4	Mass de-worming and Vitamin A supplementation campaign, high level promotion for services			
Output 1.3	Provision of Antenatal and Post natal services, and services for deliveries in health facilities/ or with assistance of health personal. Provision of services to survivors of SGBV.	• Number survivors of SGBV receive clinical management of rape treatment • number and % expected deliveries are assisted by skilled healthcare worker • number and % of expected deliveries conducted in health facilities	• Health facility reports, • Weekly and monthly reports	• Drugs and midwifery materials are available • Training of health staff (TBA, midwives) have been conducted • Timely disbursement of funds ensured • Security situation is stable enough allowing humanitarian access
Activity 1.3.1	Provision of ANC, Delivery and PNC services			
Activity 1.3.2	SGBV receive clinical management of rape treatment and counseling			
Activity 1.3.3	pregnant women receiving, TT vaccine, iron foliate, IPT 1&2 and deworming tablet as per the MoH guideline			
Activity 1.3.4	High level promotion of facility deliveries through improving the quality of care and using non-monetary incentives for TBA's and pregnant women			
Activity 1.3.5	Comprehensive Mobile outreach program for curative and preventive service focused on areas not covered by the existing facilities			

Outcome 2	• Quality and coverage of the existing IDSR and epidemiological reporting system improved in all 7health facilities • 100% of prioritized diseases outbreak alerts in the operational area are investigated and responded to within 72 hours • Outbreak response case fatality rates do not go beyond international desirable threshold for respective diseases • 12 Health staff (F=6& M=6) and 66(F=34&M=32) community groups (VHC&HHPs) trained on prevention, control and management of diseases of epidemic potential in the operational area	• 100% of prioritized diseases outbreak alerts in the operational area are investigated and responded to within 72 hours • Outbreak response case fatality rates do not go beyond international desirable threshold for respective diseases	• Supportive supervision reports • Periodic review meetings • Static health clinics Morbidity, ANC FP & EPI reports, community health and outreach program report • IDSR data • Training reports • Drug supply reports • Epidemic report	• Timely disbursement of funds ensured • Sufficient and adequately qualified staffs are available to run the project. • Cooperation with the local authorities and RI health team has been ensured • The Ministry of Health continues to strengthen its presence and role at national, state and county level. • Security situation is stable enough allowing humanitarian access
Output 2.1	• Staff training on case management, outbreak response and IDSR reporting has been carried out	• All supervisors (100%)of the health units have been trained on IDSR reporting • 100% of health staff have been trained on case management according to SSudan protocols	• Training reports • Weekly and monthly IDSR reports • Outbreak investigation reports • Monitoring reports	• Timely disbursement of funds ensured • Security situation is stable enough allowing humanitarian access
Activity 2.1.1	Trainings of health staff, CHD focal points on IDSR reporting has been carried out			
Activity 2.1.2	Trainings of health staff, CHD focal points on case management of diseases with potential outbreaks reporting has been carried out			
Activity 2.1.3	Regular submission of IDSR weekly and monthly reports according to MOH requirements carried out			
Output 2.2	• Activities for developing and implementing county wide detailed emergency response plan carried out	• In all 7 facilities 100% health staff and community groups(VHC&HHPs) trained on prevention, control and management of diseases of epidemic potential in the operational area • Maintenance of detailed emergency response plan has been ensured in all 7 facilities	• Training reports • Weekly and monthly IDSR reports • Outbreak investigation reports	• Timely disbursement of funds ensured • Sufficient and adequately qualified staffs are available to run the project. • Security situation is stable enough • allowing humanitarian access
Activity 2.2.1	Preparation of emergency response plan and prepositioning of essential drugs in all health facilities			
Activity 2.2.2	Improving the rapid assessment capacity of the project staff with focus on diseases outbreaks			
Activity 2.2.3	Training of HHPs, elders and CHCs in all facilities catchment areas on potential outbreak diseases in the area (neonatal tetanus, measles, polio, cholera, meningitis, malaria and malnutrition			
Activity 2.2.4	Strengthening data collection and situation monitoring system for timely response for an outbreak			

Outcome 3	• All 3 payams of the County covered by the community based health care service • At least 5 (75%) of Community village Health Committees, HHPs and TBAs re-vitalized/established and fully functional/supportive • 1759 (20%) of WCBA received knowledge when to seek care for common child hood diseases(ARI, Diarrhea, malaria and malnutrition) and home therapy of diarrhea • 11,991(30%) of the total population(6223 Men and 5768 female) participate at least 1 session on disease prevention of common health problems	• At least 75% of Community village Health Committees, HHPs and TBAs re-vitalized/established and fully functional/supportive • Maternal knowledge when to seek care for common child hood diseases(ARI, Diarrhea, malaria and malnutrition) and home therapy of diarrhea increased by 30% from baseline	• Supportive supervision reports • Periodic review meetings • Static health clinics Morbidity, ANC FP & EPI reports, community health and outreach program report • IDSR data • Training & health education reports • VHC,HHP and TBAs report • FGD report	• Timely disbursement of funds ensured • Sufficient and adequately qualified staffs are available to run the project. • There is cooperation with the local authorities • The Ministry of Health continues to strengthen its presence and role at national, state and county level. • Security situation is stable enough allowing humanitarian access
Output 3.1	• Activities to Improve in community contribution and involvement through direct support of the health care systems have taken place	• At least 75% of supported health facilities are linked with functional/active trained HHPs and VHCs • All 7 health facilities will get support from community contribution and involvement through direct support of the health care systems	• FGD minutes • Supportive supervision reports • Health facility reports • Community meetings reports	• Timely disbursement of funds ensured • Sufficient and adequately qualified staffs are available to run the project. • There is cooperation with the local communities and Relief International's health team • The Ministry of Health continues to strengthen its presence and role at national, state and county level. • Security situation is stable enough allowing humanitarian access
Activity 3.1.1	Designing community entry process in line with the existing community structure and community settlement patterns			
Activity 3.1.2	Re-vitalization/nomination of the community resource groups CHC, HHP and TBA's in operational areas			
Activity 3.1.3	Training of CHC and HHPs in all project support areas using the new training manual developed by MOH			
Output 3.2	• Activities to raise awareness of communities, skills and knowledge building have taken place	• Knowledge of disease prevention of common health problems among general population increased by 20% from baseline	• Focus group discussions • Monitoring reports • Community meeting reports • Small scale survey reports	• Timely disbursement of funds ensured • Sufficient and adequately qualified staffs are available to run the project. • There is cooperation with the local authorities • The Ministry of Health continues to strengthen its presence and role at national, state and county level. • Security situation is stable enough allowing humanitarian access
Activity 3.2.1	Distribution of items (non-monetary) incentives to community groups.			
Activity 3.2.2	Monthly and quarterly planning and report sharing meeting by CHC, HHP and TBA in all facility catchment area			
Activity 3.2.3	FGD with traditional healers, elders, chiefs and church leaders to encourage early referrals of patients to the health facilities			
Activity 3.2.4	Regular health education on common health problems at health facilities, communities, churches, schools			

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. Please insert as well the key monitoring activities to be conducted during the project implementation (collection of baseline, monitoring visits, surveys etc.)

Project start date:	**1 July 2014**	**Project end date:**	**31 March 2015**

Activities	**Q3/2014**			**Q4/2014**			**Q5/2014**					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
OUTPUT 1: Coverage and access to quality community and facility based health care services in 7health facilities in all 6 paymas of the county												
Activity 1.1 Regular supportive supervision(on job training) to PHCU staff	X	X	X	X	X	X	X	X	X			
Activity 1.2 Under 5 and above 5 consultation and health education	X	X	X	X	X	X	X	X	X			
Activity 1.3 Provision of immunization service in static, outreach and accelerated campaign program	X	X	X	X	X	X	X	X	X			
Activity 1.4 Provision of ANC, Delivery and post natal care	X	X	X	X	X	X	X	X	X			
Activity 1.5 Support the national polio campaign in the operational area			X	X	X							
Activity 1.6 Training on immunization and cold chain management, MISP, IMCI, HMIS, EmOC, clinical management of rape survivors, drug management and malaria case management		X	X		X			X				
Activity 1.7 Comprehensive Mobile outreach program for curative and preventive service focused on areas not covered by the existing facilities		X	X	X	X	X	X	X	X			
Activity 1.8 Periodic supply of drugs &Medical equipment to the PHCUs	X			X		X						
Activity 1.9 Procurement of program supplies												
Activity 1.10 Rehabilitation/expansion/construction of the health facilities	X	X	X									
OUTPUT 2: Ownership, participation and utilization of health activities/services focused on diseases of epidemic potential and high public health significance enhanced												
Activity 2.1 Re-vitalization/nomination of the community resource groups CHC, HHP and TBA's in operational areas	X	X	X									
Activity 2.2 Training of CHC and HHPs in all project support areas using the new training manual developed by MOH		X	X	X								
Activity 2.3 Provision of targeted health messages using culturally acceptable methods like drama, songs, dance etc.		X	X	X	X	X	X	X	X			
Activity 2.4 Monthly and quarterly planning and report sharing meeting by CHC, HHP and TBA in all catchment area.			X	X	X	X	X	X	X			
Activity 2.5 Celebrating world sensitization/ Awareness days; safe mother hood, and HIV/AIDS day				X					X			
Activity 2.6 FGD with traditional healers, elders, chiefs and church leaders to encourage early referrals of patients to the health facilities				X	X	X	X					
Activity 2.7 Regular health education on common health problems at health facilities, communities, churches, schools	X	X	X	X	X	X	X	X	X			
Activity 2.8 Education of key health message on malaria, diarrhea, ARI,HIV, TB, Malnutrition and reproductive health	X	X	X	X	X	X	X	X	X			
Result 3: County based emergency preparedness plan prepared, staff and community resource Group capacitated and Emergency preparedness and response capacity in the County (Maban) enhanced												
Activity 3.1 Preparation of emergency response plan and prepositioning of essential drugs in all health facilities	X	X	X									
Activity 3.2 Strengthening data collection and situation monitoring system for timely response for an outbreak	X	X	X	X	X	X	X	X	X			
Activity 3.3 Training of HHPs, elders and CHCs in all facilities catchment areas on potential outbreak diseases in the area (neonatal tetanus, measles, polio, cholera, meningitis, malaria and malnutrition)		X	X									
Activity 3.4 Improving the rapid assessment capacity of the project	X	X	X	X	X	X	X	X	X			
Activity 3.5 Training of health staff, CHD focal points on case management of diseases with potential outbreaks and IDSR		X	X									
Activity 3.6 Weekly submission of IDSR report	X	X	X	X	X	X	X	X	X			

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