South Sudan
2012 CHF Standard Allocation Project Proposal
Proposal for CHF funding against Consolidated Appeal

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 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 proposal should explain and justify the activities for which CHF funding is requested and it 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. 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. Partners should also fill and submit to cluster coordinator/ co-coordinator the CHF Allocation Matrix (Excel template).

SECTION I:

CAP Cluster	**Health**

CHF Cluster Priorities for 2012 First Round Standard Allocation
This section should be filled by the cluster Coordinators/Co-coordinators before sending to cluster partners. Provide a brief articulation of Cluster priority activities and geographic priorities that the cluster will recommend for funding from the CHF.

Cluster Priority Activities	**Cluster Geographic Activities**
➢ Continuation of basic frontline services in high risk counties ➢ Increased emergency preparedness activities ➢ Continuation of support for agencies able to provide surge capacity	High risk/hotspot counties

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

Requesting Organization	**Project Location(s)** (list State, County and if possible Payam where CHF activities will be implemented)
International Rescue Committee	Northern Bahr el Ghazal – Aweil Center, Aweil East, Aweil North, Aweil West Counties (100%)
Project CAP Code SSD-12/H/46249/5179	
CAP Project Title Basic and Emergency Primary Health Care Services for Northern Bahr el Ghazal and Unity states.	

Total Project Budget in South Sudan CAP	**Amount Requested from CHF**	**Other Resources Secured**
US$4,323,518	US$ 400,000	US$1,888,800

Direct Beneficiaries	
Women:	32,054
Men:	27,087
Girls:	30,960
Boys	31,840

Total Indirect Beneficiary
330,000
Catchment Population (if applicable)
Not applicable

Implementing Partners (Indicate partners who will be sub-contracted if applicable and corresponding sub-grant amounts)	**Project Duration** (max. of 12 months, starting from allocation date)
None	**Start Date (mm/dd/yy):04/01/2012** **End Date (mm/dd/yy): 10/31/2012**

Address of Country Office	**Address of HQ**
Project Focal Person: Ashleigh Lovett, Grants Coordinator Email & Tel: Ashleigh.Lovett@rescue.org; +211 955 933 726 E-mail Country Director: Susan.Purdin@Rescue.org E-mail Finance Officer: david.ndungu@rescue.org Address: Hai Malakal Juba	E-mail Desk Officer: Leah.Spigelman@Rescue.org E-mail Finance Officer: Getenet.Kumssa@Rescue.org Address: 122 East 42nd Street, 12th floor New York, NY 10168

SECTION II

A. Humanitarian Context Analysis

Briefly describe (in no more than 500 words) the current humanitarian situation in the specific locations where CHF supported activities will be implemented. Provide evidence of needs by referencing assessments and key data, including the number and type of the affected population[1]

After nearly 40 years of continuous fighting, South Sudan gained its independence on July 9, 2011, becoming the newest nation in the world. While it was expected that this would bring opportunities to the South Sudanese people, economic shocks, increased tribal conflict, fighting with northern Sudan and worsening food security situations restricted improvement of the socioeconomic status of the people of South Sudan. The shutdown of oil production is expected to worsen the situation as oil contributes 98% of the government revenue. Austerity measures put in place to cope with the decreased revenue will have a significant impact on the economy, deepening poverty and fuelling insecurity.

Since October 2010, 364,166 spontaneous and organized returnees have returned to South Sudan[2] with Northern Bahr el Ghazal (NBeG) State receiving the second highest number of returnees – 69,010[3]. As the memorandum of understanding between the Governments of Sudan and South Sudan expires on April 8, it is anticipated that an additional 300,000 people will return from northern Sudan before the beginning of the rainy season. NBeG State is expected to host some of these returnees. Additionally, the persisting tension and troop buildup over Abyei has increased the possibility of fighting that may lead to further displacement of people within NBeG. Overall, the increase in the population of NBeG has strained the state's already inadequate health services and left many people without access to health care.

A 2012 International Rescue Committee (IRC) survey estimated the crude mortality rate in Aweil East and Aweil Center Counties of NBeG to be 14 deaths per 1,000 live births each year. High disease prevalence, especially for preventable diseases such as malaria, diarrhea, respiratory tract infections and measles, continue to affect the population. In 2011, NBeG suffered from a measles outbreak and surge in malaria cases. Recurrent flooding during the rainy season led to a rise in diarrheal diseases. In the past, NBeG has been affected by both cholera and meningitis outbreaks. The increase in returnees has also made the population of NBeG vulnerable to outbreaks.

Although immunization coverage in NBeG has improved, the desired 95% coverage to offer herd immunity to the population has yet to be achieved. From the findings of the above mentioned 2012 survey, it was estimated that measles vaccination coverage is at 66%, DPT3 coverage at 65% and only 44% of children are fully vaccinated. These factors contribute to NBeG State having the highest under 5 mortality rate among the 10 states in South Sudan – an estimated 170 deaths per 1,000 live births.[4]

The maternal mortality rate (MMR) in NBeG is estimated at 2,162 per 100,000 (2006 Sudan Household Health Survey), the highest among the South Sudanese states. A 2012 IRC KPC survey found that 70% of women still deliver at home with only 35% of women accessing ante-natal care (ANC) more than once. Although these statistics have improved, there is need for continued intervention to save the lives of women in NBeG.

B. Grant Request Justification

Briefly describe (in no more than 500 words) how proposed activities support the agreed cluster priorities and the value added by your organization

South Sudan has some of the region's lowest health indicators, with NBeG consistently ranking lowest among the 10 states. A high number of returnees and internally displaced persons (IDPs) entering the state further strain the already weak and inadequate health system.

Currently, the IRC operates 15 facilities which provide essential, life-saving health services in 4 of NBeG State's 5 counties. Between January and December 2011, these 15 health facilities served 121,941 patients, providing 51.8% of the health care in the state and making the IRC the largest health care provider in the area. 2011 saw improvements in immunization coverage for children under five, an increase in facility deliveries, timely and efficient health response to the emergencies experienced in the state, and increased capacity of the county health departments (CHDs); however, state health indicators remain low and demonstrate that there is still work to be done in order to improve general health care provision.

It is crucial that the IRC continues to deliver essential health care services in NBeG and support the government to prepare for and respond to health emergencies. Since South Sudan's independence, donors have begun to revisit their strategies and plan to transition their programming from emergency response to development in 2013. Therefore, there is a need for agencies such as the IRC to fill gaps in basic health service provision until the new funding implementation mechanisms are launched.

In addition, the projected influx of returnees and IDPs as a result of the expiry of the interim period memorandum of understanding, the possibility of flooding and outbreaks in the state and continued violence in the border regions makes the proposed work even more vital. To address these issues, interventions must meet the need for on-going and improved service provision while also building the capacity of the government to deliver said services. This intervention addresses critical health needs in NBeG State, including high maternal and childhood deaths, high morbidity and mortality from diseases such as malaria, measles, diarrhea, acute malnutrition and acute respiratory infection and continued health emergencies due to natural and man-made disasters that threaten lives.

The IRC has been operating in South Sudan since 1989 and draws on a long history of community consultation and quality

[2] IOM 2011 Returnees Update.
[3] Ibid.
[4] Ibid.

programming to inform its work. The IRC's reputation is outstanding among the international humanitarian community in South Sudan and the organization is recognized as a leader in the health sector. The IRC maintains an excellent working relationship with the Government of the Republic of South Sudan (RoSS) at all levels. During program implementation, the IRC ensures that interventions are accessible for all, including host, returnee and IDP populations, to ensure that they do not harm to the affected populations and that they consistently meet South Sudan Health Cluster indicators and other international standards. The IRC has effectively delivered health services during its emergency response to flooding and the recent influx of returnees and has made improvements to the State's existing services that it will build on in the proposed program.

C. Project Description (For CHF Component only)

i) Purpose of the grant

Briefly describe how CHF funding will be used to support core humanitarian activities

The new Government of the RoSS has made efforts to improve the health of its citizens; however, a lack of resources continues to impede the realization of the objectives of these efforts. Government expenditure on health has reduced over the past 5 years from 7.9% in 2006 to 4.2% in 2010[5]; and total public health expenditure per capita is currently estimated at U.S. $10[6]--well below the global target of U.S. $34[7]. An estimated 70% of people are without access to health care and the situation has worsened with the recent influx of returnees with NBeG recording the second highest numbers (International Organization of Migration Returnee Update, September 2011). These migrations stretch the already weak health systems in these areas, leaving some without any access to care. The IRC has provided basic and emergency health services in NBeG with a utilization rate of 0.38 consultations per person per year and proposes to continue to provide basic health services to the population through its current 15 supported health facilities in Aweil East, North, Center and West Counties. Additionally, the IRC will continue to respond to the influx of returnees and IDPs and any emergencies that may arise during the implementation period as well as support the State Ministry of Health (SMoH) by building its capacity to take over basic, primary and emergency health services.

Preventable diseases, such as diarrhea, malaria and respiratory tract infections, continue to be the most common causes of morbidity. In 2011, malaria remained the main cause of morbidity and mortality (41,902 cases), closely followed by respiratory tract infections (38,158 cases) and diarrhea (12,864 cases). In 2011, the IRC in NBeG experienced a surge in malaria cases in the areas where it operates with a case fatality rate of less than 0.01% - lower than the World Health Organization (WHO)'s 1% threshold. Inadequate supply of anti-malarial drugs to treat the cases, however, created a challenge during response. Stock ruptures are still common in NBeG. The current drug supply chain system is based on a 'push' system where standard kits are meant to be provided on a quarterly basis not considering morbidity or consumption differences. However, since January 2011, the state has only received two quarterly drug orders from the centralized MoH supply chain and this supply was inadequate for the existing health facilities. Unexpected increases in disease burden, such as malaria, further exacerbate this situation.[8] The current uncertainty over funding for essential drugs either from donors or the government worsens the situation. The IRC proposes to establish buffer stocks of essential medicines and supplies.

From February 2011 to December 2011, NBeG State experienced a widespread measles outbreak leading to 530 people requiring hospitalization, 95% of whom were children under five. The increased number of consultations on account of this outbreak led to a major strain in health services. Analysis of the data shows low vaccination coverage and an influx of returnees were the likely causes of the outbreak. Aweil East and Aweil Center Counties had the highest number of cases (54% and 37% respectively). The IRC participated in a mop-up campaign that targeted all 5 counties in NBeG, achieving a measles vaccination coverage rate of 91% of the under 5s targeted. The immunization coverage more than doubled in 2011 due to the strategies put in place by the IRC. The routine data showed a marked increase in both the number of children vaccinated for DPT3 (3,731 in 2011 compared with 1,627 in 2010) which was confirmed by the IRC's 2012 survey that estimated level of coverage at 66% compared with 30% in 2010 for the same antigen To protect children against these preventable deadly diseases, it is necessary to continue to strengthen routine vaccination activities utilizing both static and outreach sites, ensure uninterrupted supply of the vaccines and provide health education and maintenance of cold chain systems that will maintain the vaccine potency.

To date, NBeG State has received the second highest number of returnees from northern Sudan in the country. During the influx in early 2011, the IRC attended to 16,038 cases through its mobile clinics, underscoring the need for clinical health care for returnees as they settle into their new homes. Furthermore, many returnees have not been immunized against common diseases—a contributing factor in the measles outbreak experienced in NBeG in 2011. In addition, NBeG continues to be affected on a yearly basis by flooding leading to massive displacement. These, together with other threats from communicable diseases such as cholera and meningitis, underscore the importance of emergency preparedness and response. The IRC plans to respond to such crises as well as provide mobile clinics on a needs basis.

South Sudan has an estimated MMR of 2,054 per 100,000 - one of the highest in the world--with NBeG having the highest MMR among the 10 states (2,162/100,000). Of deliveries conducted, 2 out of 5 children die at birth (Sudan Demographic and Health Survey 2006). Over the last 4 years, ANC visit rates have improved to 30% (Abridged South Sudan Household Survey 2010); however, only 12.3% of women deliver at a health facility with 46% of deliveries conducted by a skilled birth attendant. In 2011, the IRC attended to 7,849 women for their first ANC visit in NBeG. A survey carried out by IRC in January 2012 shows ANC coverage for second ANC visits at 35%. In 2001, the IRC tripled the 2010 number with 649 facility deliveries which contributed to reducing the number of home deliveries to 70% in its target locations in NBeG. At present, the contraceptive prevalence rate (CPR) is nationally at4.5% with the unmet need at 23.9%. The IRC has had more than 100 new acceptors of modern FP methods with an estimated

[5] Ministry of Finance and Economic Planning, Southern Sudan 2010.
[6] Ministry of Health Sector Development Plan 2011-2015 (unpublished).
[7] *Macroeconomics and Health: The Way Forward in the Africa Regions.* The Commission of Macroeconomic and Health: WHO (June 2003).
[8] South Sudan Health Cluster Meeting (September 2011).

CPR at 8.5%. Based on these successes, the IRC intends to increase coverage of these services to improve the health of women. A recent assessment of South Sudan conducted by the South Sudan Health Non-Governmental Organization (NGO) Forum found that most counties are severely constrained in terms of staffing, office space, finances and operational capacity.[9] In all counties in NBeG State, less than 50% of the positions in the CHDs have been filled and only 50% of current staff have the necessary qualifications and skills for their positions, as specified in the South Sudan Health Policy.[10] The IRC proposes to support the CHDs through trainings and mentorship and continue to advocate for recruitment to fill up the vacant positions.

Although the IRC has initiated village health committees (VHCs) in some facilities, a significant number of communities still lack these groups. The IRC health monitoring team witnessed the disintegration of some committees as a result of the VHC members' lack of clear roles and responsibilities, an expectation of payment for participation and a generally low level of motivation for involvement. Without VHCs, there is reduced community involvement in the planning and implementation of health activities which decreases health facility utilization. In addition, the absence of such committees has contributed to the current weakness of community awareness activities. The IRC sees the formation of standard VHC guidelines, training of VHC leaders/members on the roles and importance of the committees and strong community involvement in selecting motivated VHC members as key to improving this situation and creating more sustainable VHCs. To increase participation in VHCs, members should be elected by their community to promote community ownership and community members should be more involved in VHC activities, including campaigns and health promotion.

ii) Objective

State the objective/s of the project. Objective/s should be specific, measurable, achievable, relevant and time-bound (SMART)

Objective 1: To continue provision of and increase access to quality basic primary, reproductive and preventive health care services among returnee, host and conflict-affected communities;

Objective 2: To strengthen the capacity of the CHDs and the SMoHs to take over leadership and implementation of healthcare systems and emergency response activities in the targeted areas; and

Objective 3: To respond to emergency health needs for both man-made and natural disasters including communicable disease control.

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.

The IRC plans to continue to provide primary health care services at the 15 IRC-supported health facilities - 3 primary health care clinics (PHCCs) and 12 primary health care units (PHCU) - in NBeG. Activities include safe motherhood activities for pregnant women, immunization of children, provision of curative services for men, women, boys and girls and encouragement of male involvement in health care. Included among the planned activities, the IRC will:

1. Provide consultations at all 15 supported health facilities (static and mobile) which are appropriate/ adapted to the needs of patients of all ages and both sexes. The IRC will ensure adequate staffing at the health facilities, conduct refresher trainings on Integrated Management of Childhood Illnesses (IMCI) to improve skills in managing diarrhea, acute respiratory infections and malaria in children and provide supportive supervision. The IRC targets increase the utilization rates to more than 0.4 consults per person per year.
2. Provide in-patient services at the PHCCs with separate rooms for men and women.
3. Provide expanded program for immunization (EPI) services at all 15 supported health facilities as well as outreach campaigns for children under 5. The program will target to improve the coverage of all antigen to reach more than 80% of the under one children.
4. Strengthen linkages with traditional birth attendants (TBAs) and improve referral networks to reach pregnant women. This will initially target the catchment areas of the three PHCCs supported by this program.
5. Provide antenatal, postnatal and emergency obstetrics care to pregnant women and family planning services to men and women, focusing on family planning methods for both women and men at all 15 health facilities. During emergencies, the IRC will ensure implementation of the Minimal Initial Services Package (MISP) as early as possible in the response. The IRC targets to increase antenatal care from the current 35% of second visits to more than 50%.
6. Strengthen reproductive health community awareness through women's and men's support groups. These groups will be created at all the PHCCs.
7. Strengthen surveillance and Health Management Information System (HMIS) in NBeG from the facility to county and state levels to be able to report public health data disaggregated by age and sex. The IRC will support the implementation of Integrated Disease Surveillance and Response (IDSR) across its supported facilities and conduct trainings at the county and state level on emergency preparedness and response and early warning systems. This will be done in coordination with the MoH and WHO. Additionally, the IRC will support the roll out of the District Health Information Systems (DHIS) system at its 15 health facilities.
8. Conduct trainings on identified capacity gaps for the NBeG MoH staff at all levels. Support the CHDs and the SMoHs with coordination, roll-out of policies and planning for health services. The IRC targets to train more than 60 health staff.
9. Procure and preposition buffer stocks of essential drugs and supplies to ensure immediate response during emergencies.
10. Conduct community health education and awareness-raising activities on priority public health diseases, targeting women, girls and boys.
11. Operate mobile clinics and outreach services to inaccessible areas and crisis affected populations.

iv). Cross Cutting Issues

Briefly describe how cross-cutting issues are taken into consideration (i.e. gender, environment, HIV/AIDS)

Gender

The IRC's proposed programming strives to address the impact of gender on health care choices and related decision-making in all

[9] Presentation by Ivor Morgan at the NGO Forum. (July 13, 2011).
[10] IRC Capacity Building Assessment Report (July 2011).

aspects of its service delivery and community outreach activities. Through work with VHCs and community members, the IRC will continue to promote women's active participation in community-level leadership and management structures and work to ensure that women form half or more of the members in any VHC. Through community mobilization and dialogue efforts, the IRC will also seek to work with men to increase male awareness of and involvement with women's and children's health.

At the IRC-supported health facilities, women seeking reproductive health (RH) services will be examined by female staff in separate consultation rooms to increase their privacy. In 2011, the IRC increased the utilization of RH services, such as ANC and post-natal care (PNC) visits and facility-based deliveries as well as family planning, by improving the quality of services provided and the behavior change activities targeting women as the primary and men as the secondary audiences. Based on these 2011 successes, the IRC plans to increase the quality and scale of RH services to women in NBeG for the coming year.

Environment
The IRC program will ensure safe disposal of medical wastes at its health facilities through the use of an incinerator and a pit for sharps at all the supported health facilities. Safety boxes will be used at all the health facilities. In addition, compost pits will be used to burn the rubbish.

HIV/AIDS
The IRC will provide health education on HIV/AIDS at all its supported health facilities. The message will be mainly on abstinence, being faithful and the use of condoms. In addition, the IRC will ensure that condoms are available. The IRC will ensure universal precautions are adhered to at all 15-supported health facilities to reduce the likelihood of occupational HIV/AIDS transmission. Cases suspected to have HIV/AIDS will be counseled and referred for testing at the state hospital where treatment is currently available and where confidentiality of such information is respected.

Protection Mainstreaming
The 'protection and promotion of rights' is a core principle in the IRC's programming, guiding all of the agency's work. As such, the IRC seeks to incorporate protection principles into all of its programming. Such principles include ensuring meaningful access to program services, prioritizing the safety and dignity of beneficiaries, ensuring meaningful participation of, and consultation with, beneficiaries and recognizing the needs and capacities of vulnerable groups.

These principles will be reflected in all aspects of program implementation. Furthermore, several project components - such as the static and mobile health clinics, community outreach and engagement and mobilization efforts - seek to address potential protection concerns by bringing access to health care to remote and vulnerable communities. Through the support of VHCs in the catchment areas of each supported health facility, the IRC also aims to ensure the meaningful participation of beneficiaries in health service delivery and decision making.

To improve the knowledge of health staff on protection issues, every training conducted with this funding will include a session on protection mainstreaming. A separate training on protection mainstreaming will also be organized for the IRC's health program managers. These steps will facilitate the identification and resolution of specific protection concerns faced by the health team. Additionally, a checklist will be developed as a tool for use by health staff during supervision and monitoring visits to verify practices and service delivery against protection indicators and, whenever possible, a protection monitoring officer will join monitoring visits.

v) Expected Result/s

List below the results you expect to have at the end of the CHF grant period, and provide no more than five indicators you will use to measure the extent to which those results will have been achieved. At least three of the indicators should be out of the cluster defined Standard Output Indicators.

- Women, men, boys and girls from the collective returnee, host, and crisis-affected communities in NBeG have access to appropriate and quality health care at the 15 IRC-supported health facilities.
- The provision of antenatal, delivery, postnatal and FP services has contributed to a reduction in the number of maternal deaths/deaths of pregnant women.
- The capacity within the SMoH to deliver health services has been strengthened through trainings and coaching.
- IRC immunization services have been scaled up, specifically targeting the needs of children, through static and outreach sites to improve coverage of DPT, OPV, measles and Vitamin A. This will contribute to a reduction of childhood mortality from immunizable diseases.
- The IRC will continue to promote women's active participation in community-level representation and efforts to ensure that women form half or more of the members on any VHC. This will promote local ownership of the health services and ensure most of the community's needs are addressed.
- The knowledge and awareness of men and their involvement in women's and children's health is increased through men's support groups, meetings with leaders and a couple oriented approached to RH care.

	Indicator	Target (indicate numbers or percentages)
1	Number of under 5 consultations	26,173
2	Number of measles vaccinations given to under 5 in emergency or returnee situation	17,500
3	Number of births attended by skilled birth attendants	420
4	Number of health workers trained in MISP / communicable diseases / outbreaks / IMCI / CMR	60
5	Number of health facilities providing BPHS	15
6	Number of antenatal clients receiving IPT2 second dose	2,100
7	Communicable disease outbreaks detected and responded to within 72 hours	100%

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 sites in NBeG while coordinating with the SMoH and CHD in NBeG and the respective counties.

vii) Monitoring Plan

Describe how you will monitor progress and achievements of the project.

The IRC will use the RoSS' MoH data tools and supplement them with the IRC's own tools where no tools exist to record health events in its primary health care program. The data collected will be fed into the MoH surveillance system to support surveillance, health planning and program management. IDSR data will be compiled weekly and submitted to the relevant CHDs and the SMoH. The data on morbidity, maternal and child health and immunization will be compiled monthly and entered into DHIS with a copy submitted to the SMoH. Quarterly data quality audits will be undertaken to ensure integrity and credibility of the routine data reported. The analysis of the data on a monthly basis will inform program decision making as it pertains to progress made in the implementation process. Analysis on a quarterly basis will inform decision making on program strategies in terms of best practice and review of lessons learned in the course of implementation.

Routine monitoring visits, monthly by the program staff and quarterly jointly with the CHDs, will be conducted at the health facilities to ensure that services are in line with national treatment protocols, quality standards are upheld and a proper application of the skills and concepts covered during in service trainings is conducted. 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 and formal trainings, the IRC will build the CHDs' monitoring and evaluation skills.

E. Committed funding

Please add details of committed funds for the project from other sources including in-kind supports in monetary terms (USD)

Source/donor and date (month, year)	**Amount** (USD)
Stichtling Vluchteling (November 2011 – July 2012)	388,800
U.S. Government Office of Foreign Disaster Assistance (February 2012 – January 2013)	1,500,000

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.

LOGFRAME		
CHF ref. Code: SSD-12/H/46249/5179	**Project title:** Basic and Emergency Primary Health Care Services for Northern Bahr el Ghazal State	**Organisation:** International Rescue Committee

Overall Objective: *What is the overall broader objective, to which the project will contribute? Describe the expected long-term change.* Decrease morbidity, mortality and vulnerability of crisis affected populations for preventable and treatable illnesses and the impacts of conflict and natural disasters in NBeG.	**Indicators of progress:** *What are the key indicators related to the overall objective?* • Crude Mortality Rate	**How indicators will be measured:** *What are the sources of information on these indicators?* • KPC Survey	
Specific Project Objective/s: *What are the specific objectives, which the project shall achieve? These relate to the immediate effect of the intervention measured at the end of the project.* Objective 1: To continue provision of and increase access to quality basic primary, reproductive and preventive health care services among returnee, host and conflict-affected communities; Objective 2: To strengthen the capacity of the CHDs and SMoHs to take over leadership and implementation of healthcare systems and emergency response activities in the targeted areas; and Objective 3: To respond to emergency health needs for both man-made and natural disasters including communicable disease control.	**Indicators of progress:** *What are the quantitative and qualitative indicators showing whether and to what extent the project's specific objectives are achieved?* • Utilization Rates • Supervision Visits per quarter • Number of emergencies responded to in NBeG State	**How indicators will be measured:** *What are the sources of information that exist and can be collected? What are the methods required to get this information?* • HMIS Report • Supervision report • Program reports	**Assumptions & risks:** *What are the factors and conditions not under the direct control of the project, which are necessary to achieve these objectives? What risks have to be considered?* • The Government of the Republic of South Sudan at all levels is willing to be active participants in the delivery of primary health care in NBeG. • The humanitarian impact of seasonal natural disasters (flooding, droughts, and outbreaks) and local conflicts is minimal. • There is continuous supply of drugs from the Ministry of Health. • The political environment remains peaceful.
Results - Outputs (tangible) and Outcomes (intangible): • *Please provide the list of concrete DELIVERABLES - outputs/outcomes (**grouped in Workpackages**), leading to the specific objective/s:* 1.1 Community in targeted location utilize primary health care services 1.2 Women have increased access to quality safe motherhood services in the targeted locations 1.3 Children under 5 have better immunization services 1.4 The knowledge on positive health behaviors is increased	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged results and effects?* • Number of health facilities supported • Number of skilled birth attended deliveries; IPT 2 coverage	**How indicators will be measured:** *What are the sources of information on these indicators?* • Program reports • HMIS report	**Assumptions & risks:** *What external factors and conditions must be realised to obtain the expected outcomes and results on schedule?* • The Government of the Republic of South Sudan is willing to be an active participant in delivery of primary health care in NBeG. • Communities are willing to change their behaviors. • Political environment remains peaceful

2.1 Increase in the utilization of data for decision making at the state and county level 2.2 Increase in implementation of national policies at the state and county levels 3.1 Community get timely care during communicable disease outbreaks 3.2 Community affected by crisis continue to access quality primary health care services 3.3 SMOH and partners have improved coordination at all levels	• Number of measles vaccination for children under 5 in returnees and host communities • Number of people reached with health messages at health facilities and in the communities • Number of health facilities submitting monthly reports to the county/states • Number of health facilities providing BPHS • Communicable disease outbreaks detected and responded to within 72 hours • Number of mobile clinic service provided • Number of monthly coordination meetings	• Immunization reports • Awareness raising monthly reports • DHIS summaries from the county/state program reports • Supervision reports • Outbreak reports/ IDSR reports • Program reports • Coordination minutes	
Activities: *What are the key activities to be carried out (**grouped in Workpackages**) and in what sequence in order to produce the expected results?* Activities 1.1.1 Provide consultations at all 15 supported health facilities (static and mobile) which are appropriate/adapted to the needs of patients of all ages and both sexes. 1.1.2 Provide in-patient services at the PHCCs with separate rooms for men and women. 1.2.1Strengthen linkages with traditional birth attendants (TBAs) and improve referral networks to reach pregnant women. 1.2.2 Strengthen reproductive health community awareness through women's and men's support groups.	**Inputs:** *What inputs are required to implement these activities, e.g. staff time, equipment, mobilities, publications etc.?* • Health staff at the facilities • Vehicles • Stationery • Medical equipment • Other equipment such as computers, office furniture, etc. • Drugs and medical supplies • Operational support • Funding • MOH participation		**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?* • Funding is available to support the activities. • The Government of the Republic of South Sudan is supportive of the program. • There is a peaceful environment for implementation.

1.2.3 Provide antenatal, postnatal and emergency obstetrics care to pregnant women and family planning services to men and women. 1.3.1 Provide expanded program for immunization (EPI) services at all 15 supported health facilities as well as outreach campaigns for children under 5. 1.4.1 Conduct community health education and awareness-raising activities on priority public health diseases, targeting women, girls and boys. 2.1.1 Strengthen surveillance and Health Management Information System (HMIS) in NBeG from the facility to county and state levels to be able to report public health data disaggregated by age and sex. 2.1.2 Conduct joint quarterly supervision visits to all the supported health facilities. 2.1.3 Conduct trainings on identified capacity gaps for the NBeG SMoH staff at all levels. 2.2.1 Roll-out of policies and planning for health services by making them available at state and county level. 3.1.1 Implementation of Integrated Disease Surveillance and Response (IDSR). 3.2.1 Operate mobile clinics and outreach services to inaccessible areas and crisis affected populations. 3.2.2 Procure and preposition buffer stocks of essential drugs and supplies to ensure immediate response during emergencies. 3.2.3 Ensure implementation of the Minimal Initial Services Package (MISP) as early as possible in the response. 3.3.1 Support the CHDs and the SMoHs coordination efforts.			

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.															
Activity	**Q1 / 2012**			**Q2 / 2012**			**Q3 / 2012**			**Q4 / 2012**			**Q1. / 2013**		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Result 1.1 Community in targeted location utilize primary health care services															
Activity (1.1.1) Provide consultations at all 15 supported health facilities (static and mobile) which are appropriate/ adapted to the needs of patients of all ages and both sexes.				X	X	X	X	X	X	X					
Activity (1.1.2) Provide in-patient services at the PHCCs with separate rooms for men and women.				X	X	X	X	X	X	X					
Result 1.2 Women have increased access to quality safe motherhood services in the targeted locations				X	X	X	X	X	X	X					
Activity (1.2.1) Strengthen linkages with traditional birth attendants (TBAs) and improve referral networks to reach pregnant women				X	X	X	X	X	X	X					
Activity (1.2.2) Strengthen reproductive health community awareness through women's and men's support groups.				X	X	X	X	X	X	X					
Activity(1.2.3) Provide antenatal, postnatal and emergency obstetrics care to pregnant women and family planning services to men and women.				X	X	X	X	X	X	X					
Result 1.3 Children under 5 have better immunization services															
Activity (1.3.1) Provide expanded program for immunization (EPI) services at all 15 supported health facilities as well as outreach campaigns for children under 5.				X	X	X	X	X	X	X					
Result (1.4) The knowledge on positive health behaviors is increased															
Activity (1.4.1) Conduct community health education and awareness-raising activities on priority public health diseases, targeting women, girls and boys.				X	X	X	X	X	X	X					
Result (2.1) Increase in the utilization of data for decision making at the state and County level															
Activity (2.1.1)Strengthen surveillance and Health Management Information System (HMIS) in NBeG from the facility to county and state levels to be able to report public health data disaggregated by age and sex.				X	X	X	X	X	X	X					
Activity (2.1.2) Conduct joint quarterly supervision visits to all the supported health facilities.						X			X						
Activity (2.1.3) Conduct trainings on identified capacity gaps for the NBeG MoH staff at all levels							X			X					
Result 2.2 Increase in implementation of National policies at the State and County levels															
Activity (2.2.1) Roll-out of policies and planning for health services by making them available at state and county level				X	X	X	X	X	X	X					
Result (3.1) Community get timely care during communicable disease outbreaks															

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.															
Activity	**Q1 / 2012**			**Q2 / 2012**			**Q3 / 2012**			**Q4 / 2012**			**Q1. / 2013**		
Activity (3.1.1)Implementation of Integrated Disease Surveillance and Response (IDSR)				X	X	X	X	X	X	X					
Result (3.2) Community affected by crisis continue to access quality primary health care services															
Activity (3.2.1)Operate mobile clinics and outreach services to inaccessible areas and crisis affected populations				X	X	X	X	X	X	X					
Activity (3.2.2) Preposition buffer stocks of essential drugs and supplies to ensure immediate response during emergencies.						X	X								
Activity (3.2.3) Ensure implementation of the Minimal Initial Services Package (MISP) as early as possible in the response.				X	X	X	X	X	X	X					
Result (3.3) SMOH and partners have improved coordination at all levels															
Activity (3.3.1) Support the CHDs and the SMoHs coordination efforts.				X	X	X	X	X	X	X					

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