JOINT PROGRAMME/PROJECT DOCUMENT
OF THE UN FUND FOR RECOVERY RECONSTRUCTION AND DEVELOPMENT IN DARFUR

Commence Upgrading and Rehabilitating the Existing Health Facilities and Basic Health Services in selected return sites in the five states of Darfur

November 2015, Khartoum

WHO, UN Habitat, UNFPA and UNICEF

DDS Pillar:	II. Reconstruction
Programme title:	**Commence Upgrading and Rehabilitating the Existing Health Facilities, and basic health services in selected return sites in the 5 states of Darfur**
Programme outcome Foundational and Short term activities:	4.5 "Increased access to and utilisation of comprehensive health and nutrition services" 6.7 "Basic services are provided in return sites

Lead Agency	WHO
Participating Agencies	UN-Habitat, UNFPA, UNICEF

Programme Duration:	18 months
Anticipated start/end dates:	January 2016 to June 2017
Total estimated budget*:	Direct costs: $ 12,100,000 Total costs (includes ISC 7 % for implementing agencies) ; 12,947,000 Cost including 1% for Management Agency; 13,068,000

UN organisations	National Coordinating Authorities
Andrew Cox, Chief, Office of the Executive Direction Signature UN Habitat Date & Seal	Replace with: Name of Head of Partner: Signature Name of Institution Date & Seal
Dr Anshu Banergee Signature World Health Organisation Date & Seal	Name of Head of Partner: Signature Name of Institution Date & Seal
Mrs. Sharareh Amirkhalili Officer in Charge Signature UNFPA Date& Seal	Name of Head of Partner Signature Name of Institution Date & Seal

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1. Executive Summary

The decade long conflict in Darfur displaced around 2.3 million people (corresponding to almost a third of its population), mainly forced to flee to the major cities thus contributing to an accelerated urbanisation process. The formation of internally displaced people (IDP) camps and gatherings, and the migrations to urban areas created huge environmental threats, particularly due to the growing need of wood for producing fired bricks, which is accelerating the deforestation process in an already fragile ecosystem. Such a phenomenon implies an enormous pressure on the government and the urban fabric in providing the necessary services to the new settlers who, in some cities, doubled the existing urban population. The majority of the IDPs are located less than 60 km from their areas of origin and still unable or unwilling to return until security stabilises, land ownership issues resolved, and access to basic services and livelihood opportunities improves.

Overall, the Darfur States health services are weak, inefficient and inequitable due to a variety of interlinked factors. Insecurity, remoteness, poor working conditions and lack of sustainable incentives policy determined a high staff turnover, with most qualified medical officers migrating to larger cities or outside of Darfur. The inadequate deployment and retention, with hospitals of any kind concentrating 42% of skilled workers and almost 60% of physicians' resulted in severe understaffing of rural health facilities. The 2010 health facility survey indicated that 77% of the existing health facilities have been affected by conflict, 67% need rehabilitation and 10% need complete reconstruction. One third of health facilities operate in precarious dwelling built of traditional material, only 29% of them have safe water and 32% have electricity (2012 PHC service mapping MOH/WHO). The situation is worst in rural areas, especially in the return sites where the infrastructure and functionality of health facilities have been severely affected by the pre-conflict neglect and conflict destruction; furthermore in many return villages; there are no functional health facilities and people are forced to walk or drive long distance to the nearest health facility to receive medical treatment.

The project is designed to answer to the above-mentioned needs, contributing to the achievement of the long-term goal of the health and nutrition recovery strategy for Darfur and to objective 4 of Darfur Development Strategy (DDS) Foundational and Short Term Activities Pillar II "Increased access and utilisation of comprehensive health and nutrition services, privileging vulnerable and disadvantaged population groups" and to objective 6 "Successful social and economic reintegration of returnees" . Twenty facilities have been selected, four in each of the five states of Darfur under the objective 4 (sub-objective 4.5); they require the heaviest workload, are closer to large population settlements and accessible for the implementing agencies. Ten health facilities have been prioritised under the objective 6 (sub-objective 6.7); they are close to the returnees communities in rural settings and been selected in close coordination and synergic with other sectors' prioritisation of return sites, so as to facilitate the implementation of the concept of "hubs for services" and augment the return packages – one hub serving a cluster of villages/communities where return is ongoing and security improved.

To avoid duplication with the DRA on-going and planned health rehabilitation/upgrading and construction projects, several consultative and planning meetings have been held with DRA Minister of Health in Khartoum and El Fashir, and with the relevant DRA staff in all five Darfur states. All selected sites/health facilities (including return sites) are included in the Federal Ministry of Health (FMOH) health facilities mapping and human resources plans. This is an essential condition to ensure that they will receive further funding for functioning, and are eligible for inclusion into the states' revolving stock and health insurance schemes. To promote collaboration and wide agreement, the joint teams that conducted the recent assessment of the health facilities targeted by this project included, besides the involved UN agencies' staff, representatives from states' ministries of health (SMoH), Federal Ministry of Health (FMoH) and Darfur Regional Authority (state level).

The focus will be on infrastructure rehabilitation and/or extension using environmental-friendly technologies, and functional upgrading of health facilities, though filling in the identified gaps in terms of service delivery package, medical equipment and supplies, and human resources availability and skills.

In close consultation with pillar II lead and co- lead an agreement has been reached to merge the commencement of rehabilitation of existing health facilities project with the second health project, "Basic services are provided in return sites "The merging of these two projects makes sense as both are focusing on the re-activation/establishment of health services as soon as possible through physical but also functional rehabilitation of health centres with a focus on; a) sustainability; b) alignment to the MOH standards for health package/population covered, and to the DDS standards for rehabilitation and construction of public infrastructures with strong consideration of environmental issues;c) improvement of the local economy; d) a strong community involvement approach aiming to build the sense of ownership and enhance long-term sustainability.

The merging of the two health project will result in several major benefits; a) taking advantage of the UN Habitat, WHO, and UNFPA expertise and organisational structures and staff involved in the rehabilitation of the health facilities thus reducing the overall operational costs for the implementation of both projects; b) UN Habitat, the lead agency for the P2B project "Redesign and Construction of Administrative Buildings in selected Localities using Stabilised Soil Blocks" will be in charge of the structural rehabilitation component of health projects targeting both rural and return sites, promoting not only the synergies between various proposals for site selections (especially return site prioritisation) but also ensuring the consistent use of SSB and a standardised design and building standards (MOH) across all reconstruction/ constructions works of health facilities; c) promote the alignment with MOH standards for health packages/catchment size thus contributing to longer term sustainability in general rural as well as return prioritised sites; d) enhanced interlinks between the two health proposals (rural and return sides) will strengthen the "hub for services " agreed approach for return sites, but also support the establishment/strengthening the integrated locality (district) health care system in line with the long-term FMOH strategy, where the small rural health facilities (BHU, PHC) from return sites hubs will be backed-up by well-functioning rural hospitals rehabilitated/revitalised under the P2E project.

The rural hospitals that are the first-tire referral facilities for at least five return service hubs (and health facilities) have been prioritised for the" Commencement of the rehabilitation of health facilities" project. This approach will maximise the impact of the project targeting the health facilities in return sites.

This project will be jointly implemented by the World Health Organisation (WHO), the United Nations Human Settlements Programme (UN-Habitat), the United Nation Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA) in partnership with the competent authorities, namely: the Darfur Regional Authority, the Federal Ministry of Health, the 5 Darfur State Ministries of Health (SMOHs) and the 5 States Ministries of Planning and Urban Development (SMPUDs). The NGOs supporting some of the targeted health facilities will also be involved in project implementation. The collaboration with Darfur three Academies for Allied Medical Sciences will be instrumental for filling in the urgent human resources needs.

By the end of the project it is expected that around 2.9 million people (1,62million female and 580,000 children bellow 5 years of age) in 30 locations in five Darfur states, including a significant number of returnees, will benefit from increased access to quality health and referral services.

WHO and UN-Habitat will make use of their experience and lessons learned during the implementation of similar projects in Darfur. The physical planning, architectural design and construction/rehabilitation components for the infrastructural rehabilitation and upgrading of targeted health facilities will be jointly achieved by UN-Habitat together with the relevant counterparts in Ministry of Health (MOH) and State Ministry of Planning and Urban Development (SMPUD). Of particular focus will be mainstreaming the use of environmental-friendly, affordable and durable construction techniques as well as solar energy. This would be accompanied by on-the-job training for unemployed youth on the production and application of SSB and other construction trades; carpentry, steel fixing, and plumbing, aiming that the newly introduced technologies will stimulate the local economic activities providing longer-term livelihood opportunities for youth in rural settings and augmenting the return packages in return sites. The programme will also engage private sector in the rehabilitation/reconstruction initiatives through contracting local supplies and contractors who will increase their capacities to cope with the economic recovery and reconstruction of Darfur.

Through extensive consultations strong synergies have been created with; 1. UNICEF led P2C project "Increased Access to and Use of Sustainable Water, Sanitation and Hygiene (WASH) Services" to ensure that targeted health facilities in rural areas and return sides will be linked to sustainable and affordable water supply; 2. with UNDP led P2D project "Providing Access to clean Energy Services in Darfur Region" to support the installation of solar panelled electric power supplies for all targeted health facilities. Contributing to the implementation of the concept of "services hubs" for return areas along and synergic with the P2G project "Promotion of sustainable return and reintegration of IDPs and refugees of Darfur" which has been the basis for the selection of the health facilities in return areas.

WHO, UNICEF and UNFPA will implement activities aiming to enable the delivery of the required health services in line with the MOH standards (according with their categorisation) in all rehabilitated health facilities. This will entail provision of necessary medical equipment, medical supplies and furniture, besides a solid intervention for human resources development through institutional formation of new health skilled cadres. Establishing the necessary conditions for sustainable functioning after the end of the project has been at the core of the project strategic planning through extensive consultations with local and federal health authorities. The benefits will be magnified by increased community involvement in the project progress monitoring through a functioning Community Health Worker (CHW) and Health Committees networks in targeted rural and return areas. The capacity and experience of NGOs that support the service delivery in several targeted Health Facilities (HF) will be put at use, by integrating their support into mainstream operations.

The project activities have been developed based on the DDS's recommendations for Foundational and Short Term Activities (FaST) and they will provide skills, processes, basic infrastructure, and lesson-learned to support further recovery/developmental health programing. Two recommended critical health sector assessments/studies (under sub-objectives 4.1.1 and 4.1.2 under DDS) that will provide the essential information for further programming have been already completed: 1) The assessment and mapping of the existing and required health facilities by state, with the provision of a sequenced and costed plan for rehabilitation, upgrading and construction; and Review of the pharmaceutical supply arrangements and identification of measures to increase availability of affordable and quality medicine. ; The "Feasibility study of expanding access to health care through subsidised enrolment into National Health Insurance (NHI)" has been funded by WB has been also finalised.

We are requesting that the USD 500,000 allocated for these activity under the DDS / Pillar II Foundational and Short Term activities be reprogramed for the component "Provision of health services in return sites" infrastructure project. In addition, based on the planning document for FaST projects (first tranche), sub-objective 6.7, health sector should receive around USD 1.6 million instead of USD 1 million (initial concept paper for return sites health project), thus an additional USD 0.6 million need to be added to the health infrastructure project

UN-Habitat, UNFPA, UNICEF, and WHO will apply the 3E framework methodology to analyse the value for money (Economy, Efficiency and Effectiveness); to ensure optimal use of resources to achieve the intended results. The implementing agencies will capitalise on their already well-established operations and partnerships in Darfur states.

2. Situation Analysis

For more than one decade, Darfur region has suffered from a prolonged armed conflict; socio-economic and health indicators are therefore worse than the country average.

2.1 Socio-economic context

The population estimates for 2012 provided by the five SMOH gives just above **9 million people to the region,** and **a population density of 18 people per km², from 8 in North to 45 in South Darfur**. Some 2,4 (2015) million internally displaced people (IDP) are living in one of the almost 100 IDP camps and gatherings scattered across Darfur region. At least half the IDPs are living in the outskirts of the five state capitals, making a substantial percentage of the sub-urban population. Urban areas and IDP camps have in common

high population density and usually the presence of large concentrations of destitute people**. Such phenomenon implies an enormous pressure on the government and communities in providing and accessing the necessary services to the new settlers**. The eventual settlement of presently displaced people, with camps absorbed into poor urban periphery, and facilitated return to areas of origin are critical factors in deciding the future pattern of service delivery. In many cases returnees seek locations **where there is access to basic services and livelihood options**. Insecurity and uncertainty about land-ownership, the lack of services and infrastructure as well as livelihood opportunities in the rural areas being the main factors negatively influencing the decision to returns.

2.2. Environmental and energy context

The formation of camps and the migration to urban areas create huge environmental threats, particularly due to the growing need of wood for producing fired bricks which accelerates the deforestation and desertification process in an already fragile ecosystem. According to the Darfur Development Strategy (DDS) report from a thematic working group on Natural Resource Management, the widespread and severe destruction of forest reserves is alarming and a situation that will take many years of concerted planning and regeneration efforts to reclaim forest cover. There is an urgent need to use alternative construction solutions less damaging for the environment.

Electricity is another challenge for Sudan as the power sector suffers from poor infrastructure and frequent outages**.** Only 36% of the population, mainly in urban areas, has access to electricity. Most of the Sudanese rural communities are not connected to the grid, and are also by-passed by the petroleum supply pipelines, thus mainly relying on biomass. Many villages connect small generators to the ubiquitous diesel-powered irrigation pumps. The vast majority of the health facilities, including large hospitals rely on electric power supplied by generators, but this way of generating electricity is inefficient and expensive, thus unreliable, and causes environmental problems[1]. On the contrary, Sudan has a high potential for solar energy use with an average solar insulation in the country of roughly 6.1 kW^2h/ m2/day. Solar energy systems are however barely used in Sudan.

2.3. Current health system situation

Overall, the Darfur States health services are weak, fragmented, inefficient and inequitable due to a variety of interlinked factors. Insecurity, remoteness, poor infrastructure and working conditions and lack of incentives policies in Darfur determines a high turnover of staff in the SMOHs health facilities, with most qualified medical officers migrating outside of Darfur. According to the *Darfur Health Facility Survey (2012 MOH/WHO) report*, there are 9,200 workers in the formal health facilities of Darfur, of which 7,500 are skilled. NHIF, and the private facilities have 16% of all skilled workers, and almost 1/4 of the Medical Officers. The inadequate deployment and retention, with hospitals of any kind concentrating 42% of skilled workers and almost 60% of physicians, resulted in severe understaffing of rural health facilities. The same survey indicated that 77% of health facilities have been affected by conflict, 67% need rehabilitation and 10% need complete reconstruction. One third of health facilities operate in precarious dwelling built of traditional material, only 29% of them have safe water and 32% have electricity. The situation is worst in rural areas and in the return sites where the infrastructure and functionality of health facilities are severely affected by the pre-conflict neglect and conflict destruction. In many of return (or potential return) sites the existing health facilities suspended the activities not only because of the physical damages but also because of lack of qualified health staff willing to work in these locations. The situation is partly related to insecurity and war and the situation should be addressed in wider context of Darfur to increase motivation.

Many rural clinics do not provide the services implied by their category and run with no laboratory, transfusion, radiology, or basic surgical services, reducing their ability to diagnose and treat, especially emergency cases, and increased number of referrals. **Only 19% of primary health care services provide the**

[1] From the concept note "Alternative Energy and Green Economy project" by UNEP, UNDP and Ministry of Environment and Physical Planning, 31/05/2012.

[2] From the Renewable energy and energy efficiency partnership, clean energy info portal: http://www.reegle.info/countries/sudan-energy-profile/SD#renewable_energy

MOH standard minimum health care package; 66% of rural hospitals (RH) offer basic emergency obstetric and neonatal care, and only 32% of them provide comprehensive emergency obstetric care; 31% have laboratories and 23% operate X ray machines (2012 PHC service mapping – MOH/WHO). Reproductive health service coverage within the functioning PHC facilities ranges within 52% in North Darfur to 82% in West Darfur.

According to the Maternal Death Review Report of 2013 (Sudan FMOH/UNFPA Report), the functionality of health facilities in Darfur region shows the lowest percentage in East Darfur (8 – 10%) and the highest in West Darfur (70 – 75%) while in Central Darfur it is 30 to 50% and in South Darfur 60 to 70%. Urban centres are better served than rural areas with access ranging from 58-78%. The proportion of skilled birth attendance is around 55%. Approximately 74% of women have access to ante-natal care (ANC), but only 21% of deliveries take place at health facility level and as low as 18% of all postpartum women receive postnatal care.

In spite of an extensive training for community midwifery there are still shortages of qualified registered midwives, which continue to negatively impacts maternal mortality rates. Several reports also note that many women continue to seek care from traditional birth attendants rather than trained practitioners. Indeed, a survey of 881 mothers in Darfur in 2009 revealed that over 50% of respondents were assisted during delivery by untrained birth attendants. Access to emergency obstetrics care (EOC), and especially comprehensive EOC is very limited for rural remote communities and is a main contributor to high maternal mortality. The vast majority of the Darfur rural hospitals that should be able to provide at least life-saving caesarean section, blood transfusion and post-operatory care, are lacking the necessary skilled personnel (trained medical doctors, scrub nurses, anaesthesia and laboratory technicians, etc.), medical equipment, and continuous electric power supply.

Additionally, socio-cultural factors play a significant influence on the health status of women in Darfur and in Sudan in general. Early marriage, a common practice is a significant factor in high maternal mortality rates, as is the practice of female genital mutilation/cutting (FGM/C) which can contribute to obstructed labour and fistulas. FGM/C in particular is a widespread practice in Sudan, with 89% of women between the ages of 15-49 having undergone some form of FGM/C (2006 household health survey), with the highest rates reported in South Darfur at 71% and lowest. West Darfur (46%).

Communicable diseases accounts for the majority of morbidity and mortality causes amongst children. There are frequent outbreaks of meningococcal meningitis, acute watery diarrhoea, dengue fever, malaria, acute jaundice syndrome while a whole range of neglected tropical diseases remain endemic. Darfur is facing a re-emergence of vaccine-preventable diseases such as diphtheria, measles, whooping cough and meningitis. In 2012-2013 there was a large scale outbreak of Yellow fever affecting 35 localities of Darfur region with the total number of suspected cases was 849 which included 171 deaths (case fatality rate of 20.1%).

Tertiary care is provided in Darfur by three large hospitals in the capitals of North, South and West Darfur, as well as some smaller, specialised units in El Fashir and Nyala, but the scarcity and high costs of transportation, combined with poor- condition roads, insecurity and cultural barriers leads to significant delays in referral of severely ill patients. **Economically marginalised and conflict affected women are disproportionally affected** with a higher rate of maternal morbidity and mortality in the crisis prone areas of Darfur and the Protocol Areas. In 2013, 40% of the total number of maternal deaths occurred in conflict affected areas according to the Maternal Death Review Report of 2013 (Sudan FMOH/UNFPA Report). According to statistical estimates 89% of maternal deaths in Darfur occurred in the hospital, reflecting not only the poor capacity of Darfur hospitals to treat emergencies, but also delays of reaching appropriate health care.

According to the Health Facility Survey in Greater Darfur carried out during April-June 2013, Central Darfur has the worst accessibility to Primary Health Care facilities, but the best for hospitals (although some of those may be just Family Health Centres). South Darfur has almost 300,000 people per hospital, almost double than North Darfur.

Table 1: Comparative access to public network, by state

				FUNCTIONING			POP/WRKNG PHC	POP/RH	AVGE RADIUS
LOCALITY	POP. 2012	AREA (km^2)	Pop density	FHU	FHC	RH/SH	FACILITY	FACILITY	PHC FAC.
Central Darfur	1,022,741	47,370	22	23	20	8	23,785	127,843	19
East Darfur	1,022,734	49,725	21	76	16	5	11,117	204,547	13
North Darfur	2,507,911	296,420	8	106	80	15	13,483	167,194	23
South Darfur	3,485,826	77,575	45	167	51	12	15,990	290,486	11
West Darfur	1,247,506	32,090	39	51	22	6	17,089	207,918	12
EAST DARFUR	**9,286,718**	**503,180**	**18**	**423**	**189**	**46**	**15,174**	**201,885**	**16**

There is a significant horizontal and vertical fragmentation caused by the multiplicity of service providers and supporting agencies and authorities, multiple disconnected vertical programs for control of communicable diseases, supply channels, subsidy regimes, restrictions and information flows. This fragmentation generates service gaps and overlaps, as well as causing and being an effect of poor management system and practices.

Pharmaceuticals absorb a big portion of total health expenditure, largely paid for by households. Free medicines are provided mainly to the displaced (mainly provided by national and international NGOs), and for selected maternal and child health services and pharmaceutical shortages are frequent. The retails prices are high and of sub-standard quality, and inadequate prescriptions are common.

In conclusion, in Darfur region multiple barriers related to service availability and quality, geographical, cultural, financial, gender and security based factors disrupt the delivery as well as utilisation of health services. These are hampering communities' access to health services disproportionally impacting on the health status of the most vulnerable, women and children.

2.4. Institutional context

Urban planning process in Sudan involves three levels: **the national level**, which is headed by the National Council for Physical Planning in charge of overall politics, **the State level**, headed by the Ministry of Physical Planning and Public Utilities (MPPPU), that recognises differences between urban and rural areas, operate on land uses and subdivisions, density control, supply of major basic services (health, education, wash, etc.) and the **local level**, in charge of localities, which acts on revenue collection, public services, local infrastructures, building and sanitation control in charge of MPPPU branch. All levels works complementary following budgets, coordinated by MPPPU departments, public services corporations and localities. In practice the disconnection and lack of capacity transfer between central planning and local agendas is evident.

Greater Darfur network of health facilities is managed by a variety of institutions:

- The MoH owns all public facilities, where government-hired staff is deployed. Usually, the MOH - with support from UN agencies - manages directly the facilities that do not have support from other partners.
- Other government institutions, such as the Ministries of Defense and Interior, also own and manage health facilities, usually hospitals. In South Darfur, they act like semi-private institutions, providing free care to those entitled (military/police and their families) and fees-for-service for other users.
- NGOs are providing support to 216 health facilities owned by the MoH. Mostly funded by humanitarian donors, they tend to concentrate in and around IDP camps. With some exceptions, NGOs support individual facilities and not locality systems.
- The National Health Insurance Fund (NHIF) is present in 35 localities of all Darfur states, where it runs 70 health centres mainly concentrated in urban settings. Most of the buildings hosting NHIF health centres belong to the SMoH.
- The number of private providers (above single practices run by physicians working in the public sector) is multiplying with hospitals, clinics, laboratories and pharmacies recently opening almost exclusively in state capitals.

2.4. Necessary interventions for the achievement of the planned results

The project is designed to contribute and create the foundation for the achievement of the long-term goal of the health and nutrition recovery strategy for Darfur; "Progressively restructure the health and nutrition arena, now a patchwork of disparate elements that emerged in response to multiple stressors, into a coherent, effective, efficient and equitable service delivery system." The identified gaps and deficiencies are significant and addressing them constitutes a giant endeavour. Taking into account the dire baseline, on the backdrop of significant limiting factors such as poor implementation capacity, and hostile environment (insecurity and unpredictable instability), a sequenced/three-pronged health nutrition recovery strategy for Darfur has been endorsed by the MOH and DRA.

The project is in line with many measures included into the first prong health recovery strategy. Maximising the outputs of the existing health and nutrition services by filling gaps, upgrading assets, expanding services, boosting productivity, and improving quality of health services in rural areas and in selected return sites is the overall objective of proposed project.

The focus will be on infrastructure rehabilitation, as well as functional upgrading of health facilities with the heaviest workload and closer to vulnerable, conflict affected population settlements, including selected return sites.

In close coordination, the implementing UN agencies, DRA, SMOH and FMOH have defined a set of criteria for the selection of health facilities to be targeted by the proposed intervention. The selected sites are the ones where the needs are the highest, the implementation will positively impact on the largest number of vulnerable people, there is acceptable access to enable the implementation, supervision and monitoring, and they are included into the Darfur health recovery plan (Government commitment). For the selection of return sites, an additional essential criterion has been the synergy with the P2G project (Promotion of sustainable return led by UNDP) to contribute and complete the implementation of the hub for services approach in return sites. The planned interventions for the achievement of the project goal include:

- Rehabilitation, and infrastructural upgrading/expansion in line with the MOH standards of 15 rural health facilities (HFs), 5 referral hospital units and 10 HFs in return areas is carried out with environmental-friendly technologies, and taking into account other environmental considerations.
- Functional revitalisation and upgrading of targeted health facilities to attain the standards implied by their classification through filling in the identified gaps in terms of service delivery package, medical equipment and supplies, and human resources availability and skills. The main approach for addressing the acute shortages of qualified staff will be institutional training for creation of new health cadres from amongst local communities (including pastoral groups) aiming sustainability from a longer term perspective. To enable the immediate functioning of health facilities in return sites, medicines will be provided in initial stages of the implementation. Longer term solutions will be sought through integration of facilities into the state revolving stock and National Insurance schemes that could be a source for additional locally-generated incentives for medical staff. An adequate net-work of trained CHWs and their support in all targeted locations would create the fundament and is a pre- requisite for further development and implementation of sustainable community based health programs (health promotion and awareness, community based referral system, community mobilisation and community based surveillance), adding a strong preventive component to the health system.

3. Project strategies, including lessons learned and the proposed joint programme

3.1 Target population:

The project will focus on 20 localities of the 5 states of Darfur, mainly in rural areas and 8 return localities . The total number of people who will have improved access to essential health care through the implementation of the project is around 2.9million people.

Table 2: Geographical focus of the project

STATE	LOCALITY	FACILITY	POPULATION SERVED
Selected sites for commence upgrading and rehabilitating the existing health facilities; 4.5			
North Darfur	El Fashir	Regional hospital, operatory block and ICU	875,546
	Umkadada	Rural hospital	175,546
	Kutum	Rural hospital	150,000
	Shingnal tobaia	Rural hospital	92,000
South Darfur	Nyala	Regional hospital	3,600,000
	Um Labasa	PHCC	100,000
	Um Dafuq	PHCC	185,000
	Dimsu	PHCC	221,000
East Darfur	Yasin	PHC	250,000
	Ed-Da'ein	Regional hospital	1,500,000
	Asalaya	Rural hospital	250,000
	Sheria[3]	Rural hospital	450,000
West Darfur	El Geneina	Regional hospital	323,471
	Sirba	PHCC	94,530
	Morni	Rural hospital	140,339
	Beida[4]	PHCC	112,551
Central Darfur	Zalingei	Rural hospital	175,546
	Garsila	Rural hospital	165,546
	Bendisi[5]	PHCC	71,725
	Nertiti	Rural hospital	165,546
Total			2,799,329
Selected health facilities for the provision of basic health services in return areas; 6.7			
West Darfur	Serba	Aboremail PHCC	23,000
	Beida	Shushta BHU	5,000
	Habila	Tawang BHU	19,300
	Habila	Gobi PHCC	23,000
	Geneina (rural)	Anjemi BHU	4,800
Central Darfur	Wadi Saleh	Tanako BHU	6,800
	Wadi Saleh	Beiga PHCC	16,000
	Mukjar	Dambar BHU	6,000
East Darfur	Sheiria	Abu Dowimat BHU	6,300
To be determined			
Total			**110,200**
Grand Total			**290,952**

[3] The RH in Bendisi is the first level referral for the patients treated in the BHU Um Shegeira return site
[4] The PHH is the first level referral for the patients treated in the return site BHU Terbaida
[5] The PHC will be upgraded and became the first referral point for the health facility in Bendisis serving return communities

The calculation of total covered population does not include the catchment of Teaching State hospitals that will be only partly rehabilitated to enhance the capacity to deal with surgical emergencies (including obstetrical) referrals.

The targeted communities are highly vulnerable; 13 of the locations selected are areas where returns happened or is on-going or are the first-level referral sites for the selected health facilities covering the return sites, while other includes IDPs living with the host communities, and nomadic pastoral communities. Most of selected health facilities have been neglected for several years due to the conflict and consequent repeated population movements. In line with the concept of "hub for services", the selected health facilities in return sites will serve around 23 identified return communities.

Several components will produce a system-wide benefit such as; capacity of the states MOH for maintenance and repair of the medical equipment and piloting at a larger scale of solar energy use in different types of health facilities which will support further dissemination of the technology in Sudan. Besides, 150 unemployed youth from rural and return sites will have new skills in construction work and appropriate machines will be provided so this income generating opportunity can continue after the end of the project.

More than 360 people from within communities will be supported to follow the institutional formation in Allied Medical Science Academy for different medical categories, especially community nurses, anaesthesia assistant, X ray and laboratory technicians and EPI/nutrition agents, and CHWs that are in severe shortage..

3.4 Background/context: Contribution of the joint programme to the DDS

This project, through the infrastructural and functional upgrading and rehabilitation of health facilities will contribute to **the achievement of the second DDS Pillar, "Reconstruction"**, main objective: "to support the recovery and stabilisation of war-affected populations through the provision and rehabilitation of basic service facilities and structures".

The project will address objective 4,of pillar II Foundational and short term activities "Increased access and utilisation of comprehensive health and nutrition services, privileging vulnerable and disadvantaged population groups", in order to have "people with access to a basic package of health, nutrition or reproductive health services" and a) children immunised, b) pregnant women receiving antenatal care during a visit to a health provider, c) births (deliveries) attended by skilled health personnel and have pregnant/lactating women, adolescent girls and/or children under age five reached by basic nutrition services".

As mentioned in the briefing, the studies recommended under 4.1.1 and 4.1.2 sub-objectives have already been conducted and we requested the reprograming of the USD 500,000 allocated for them to the activities under the sub-objective 6.7.2 "Basic Services in return areas – Health facilities constructed/rehabilitated/upgraded; the reports of the studies are attached to the proposal.

It will contribute to the related objective output, which is to have "Facilities offering complete packages of health and nutrition services of acceptable quality, with particular attention to Return Locations (Urban and Rural)" through:

1) "The rehabilitation/renovation of health facilities (UN Habitat) particularly located in rural return location". (NB. DDS objective of 100 new Basic Health Units, 100 new Family Health Centres; this will also include provision of medical equipment to ensure functional upgrading (WHO, UNFPA,UNICEF)
2) "Health facilities appropriately-managed and staffed according to staffing plan" through institutional training to form new health cadres, and improving the skills of existing health personnel to done by WHO, UNICEF and UNFPA.

Besides, the selected health facilities located in areas of return, so the return communities access to health services will be enhanced, thus contributing to objective 6 "**Successful social and economic reintegration of returnees" and it is under objective 6.7 (6.7.2) "Basic services are provided at return sites "and health centres constructed/upgraded/rehabilitated.**

The project will further contribute to the sub-objective 6.8: (Livelihood and income generating activities promoted in return areas) of DDS II objective 6, as it will indeed provide unemployed youth with on-the-job training on the production and application of environmental-friendly and woodless construction technologies such as stabilised soil blocks and ferro-cement roofing, as well as on construction trades (plumbing, carpentry etc.), thus providing them with skills and job opportunities.

Promoting and piloting the use of solar energy technology is another environmentally-friendly component of the project. . In the longer term, it will participate to DDS Pillar II objective 3 of "increasing Darfur population's access to electricity". The development of solar energy will be done with the technical support of UNDP.

Synergies and complementarities will be ensured with other UN-Habitat, WHO, UNICEF, UNDP, and UNFPA activities in Darfur, as well as with UNOPS regarding the rehabilitation of roads, and water provision and solar energy for the targeted health facilities in rural as well as return locations.

3.3 Lessons Learned:

UN-HABITAT has considerable experience working in land, housing and community-based infrastructure in countries affected by acute and protracted crisis, as well as in and post conflict context. In Darfur, UN Habitat and WHO already implemented a joint health project in 2011 and 2012 involving construction and activation of new health facilities, using environmentally- friendly and cost-effective construction materials. Many valuable lessons-learned by both agencies have been incorporated into the design of the current project. These are summarised as follows:

1. Vulnerable groups within returnees and poor rural communities, particularly children, women, widows, people living with handicaps, and elders require special support to access and afford basic health and referral. Bringing quality, comprehensive health services closer to the communities is the best approach in removing the access barriers for vulnerable communities.
2. Similar approaches on housing and infrastructure development applied in Iraq, Pakistan, Somalia, among other countries, showed the importance of community mobilisation, involving local authorities, building of transitional social infrastructure, introducing new low-cost and environmental-friendly construction techniques (Stabilised Soil Blocks).
3. Introduction of alternative solutions in regards of water and electric power supply for health facilities that involves low-costs for running and maintenance is paramount to ensure sustainability in longer term. Without uninterrupted electricity and safe water, the health facilities can't provide a comprehensive and quality service package, and beside human resources availability, this is one of the major factors for sub-standard functioning of public health system in Darfur.
4. When addressing the human resources gaps, an approach that will promote sustainability and self-reliance is crucial to avoid creating dependency on external support. Advocacy with local government for longer term financial commitment to ensure all necessary staff-positions are including into the state human resources plans, focusing on institutional training for formation of new skilled health professionals from among local communities rather than mobilisation of staff from other health facilities are some of the good practices.
5. The issue of staff retention after completion of the project should be thoroughly t take into account the state policies, available financial resources (and allocations) and existing mechanisms for generating staff incentives. Integration of health facilities into revolving stock mechanism and expansion of the coverage of the National Health Insurance Funds need to be supported as mechanisms that can ensure incentives for staff, while preserving affordability of services for the majority of the population and for the most deprived. The most feasable approach is to complement the infrastructural and functional rehabilitation of health facilities across Darfur with a project subsidising the enrolment of poor families particularly targeting female headed households, in the National Health Insurance Fund (NHIF) based on the results of the pilot now under way in West and Central Darfur, whose results were due in January 2014,

6. To avoid wasting resources on medical equipment that will remain unused, their provision should match the availability of existing human resources and their skills and be backed up by improving the health staff skills on using the equipment, as well as r the maintenance engineering personal. This will have system-wide impact on the state health system capacity for maintenance of medical equipment.
7. It's crucial to mobilise and strengthen communities in all phases of projects development and implementation to promote sustainability and long benefits.
8. Information and outreach must be an ongoing activity, allocating specific time and resources for this purpose.

More specifically, the use of environmental-friendly techniques, introducing stabilised soil blocks in the context of Darfur provided strategic lessons:

1. ***Technical:*** the soil in most area of Darfur is appropriate for producing construction blocks. Stabilised soil mixed with a percentage of cement shows optimum results for plastering
2. ***Training/ Capacity building:*** Training of unemployed youth on the production and application of environmentally-friendly technology and other construction trades (plumbing, electrical installation, carpentry and steel forming) offers a source of livelihoods and job creation, which contributes to peace building. Previous experience demonstrated that the basic skills for production are acquired in a short time, and reaching remote villages and localities, thanks to well-designed, easy to transport, use and maintain SSB machines is feasible.
3. ***Economical:*** compared to fired bricks, SSB are 30% cheaper and are faster built
4. ***Social:*** Producing SSB is labour intensive. Test cases have shown much potential as a microenterprise activity.
5. ***Environmental:*** SSB have a positive impact through counteracting deforestation and reducing water usage.

3.4. The proposed joint programme:

The project is designed to help the Ministry of Health in the five states of Darfur to address the most urgent gaps on population health coverage and access to essential services while providing the basic capacity, infrastructure, processes and skills to support further design and implementation of developmental health programs. Careful prioritisation of the sites has been done to respond to the actual needs and demands of local conflict affected rural and return communities. The implementation of standardised service packages adapted to the size, location and type (rural /urban) of catchment population has been adopted in agreement with MOH to maximise the impact. Enhancing the sustainability of results and continuity of the delivery of agreed services packages has been the central element of the proposed intervention strategy.

This project will be jointly implemented by the World Health Organisation (WHO), the United Nations Human Settlements Programme (UN-Habitat), United Nation Children's Funds (UNICEF), and the United Nations Population Fund (UNFPA) in partnership with the competent authorities, namely: the Darfur Regional Authority, the Federal Ministry of Health, the 5 State Ministries of Health (SMOHs) and the 5 States Ministries of Planning and Urban Development (SMPUDs).

The four UN agencies, along with all federal and local stakeholders, first agreed on a set of criteria (attached to the proposal document) for the selection of health facilities to be targeted amongst the Darfur rural and return localities, so as to promote alignment of the proposed intervention to the DDS, maximise the impact, and increase the potential for successful implementation. A joint assessment of pre-selected health services/facilities has been conducted to identify and quantify the infrastructural and functionality related gaps that will need to be addressed to ensure the upgrading the level and quality of provided health services.

3.4.1. Overall objective

To contribute to the recovery and stabilisation of 2.9 million war-affected populations (including returnees) through the rehabilitation of basic health services.

3.4.2. Specific Objective

To increase the access to, and utilisation of comprehensive health and nutrition services privileging vulnerable and disadvantaged population groups (women, children, returnees, etc.) services through rehabilitation/construction and upgrading of 20 existing rural and referral health facilities, and of 10 health facilities in return locations in five Darfur states

3.4.3 Project outcome:

By 2017, around 2.9 (1,62million female and 580,000 children bellow 5 years of age) conflict-affected people in the 5 Darfur states have sustainable and affordable access to quality, comprehensive sustainable health services leading to improvements in their health status and decreased morbidity and mortality.

3.4.4 Project Outputs

i) By the beginning of implementation, the design and technical documentation for the physical and functional rehabilitation of the selected health facilities in the five states of Darfur are defined in line with the MOH standards and endorsed by relevant authorities.

ii) By 2017, 30 health facilities are rehabilitated and/or upgraded and constructed(20 rural and referral and 10 in return sites) in five Darfur states to enhance the quality of health services, and increase population coverage

iii) By 2017, the range and quality of services provided by the 30 targeted health facilities (20 rural and referral and 10 in return sites) are provided a standard package (according with their classification) through availability of adequate human resources skills combination and number.

iv) By 2017 health services quality and range are improved in the selected health facilities through procurement and delivery of medical equipment.

To achieve the agreed outcome and outputs, the tasks and responsibility for the implementation of activities have been divided amongst the four implementing agencies according to their expertise. UN-Habitat together with the relevant counterparts in MOH and SMPUD will support the physical planning, architectural design and construction/rehabilitation components for the infrastructural rehabilitation and upgrading of these facilities.

The MOH and WHO architectural standards will be used to promote best working conditions for delivery of all required services, as well as to ensure safe circuits of patients, medical material and waste (solid and liquid) in line with the MOH/WHO guidelines for infection prevention and environmental safety. Of particular focus will be the mainstreaming of the use of environmental-friendly, affordable and durable construction techniques, as well as solar energy. This will be accompanied by on-the-job training for unemployed youth on the production and application of SSB and other construction trade (carpentry, steel fixing, and plumbing). Coordination with WASH DDR project (lead by UNICEF) has been done seeking support for sustainable water supply for targeted health facilities. Almost all of the targeted health facilities are include into the UNICEF lead WASH project "Increased access to improved water sources and sanitation"

WHO, UNICEF and UNFPA will be focusing on enabling that all the required services are provided in line with the MOH standards for their categorisation; some health facilities will be upgraded to a higher category (PHC to be upgraded to RH level) in line with the Darfur health and nutrition recovery strategy's recommendations and health map for the rationalisation of HFs distribution.

The intervention deign is based on real needs for improved access to critical services for large vulnerable communities. This will entail provision of necessary medical equipment (including laboratory, X-Ray, surgical care, transfusion facility, etc.) medical supplies and furniture, beside a solid intervention for human resources development from institutional to on the job training and coaching. To enable rapid re-activation of the health facilities in return sites, initial support with medicines will be provided to promote their integration into state revolving stock mechanism to facilitate the sustainability of their supply mechanism. The benefits will be magnified by increased community involvement in the project progress monitoring and strengthening and expansion of the CHW network in targeted areas as a pre-requisite basis for future implementation of essential community based preventive activities focusing on maternal and child health.

The capacity and experience of NGOs that support the service delivery in few of the targeted HFs will be put at use, by integrating their support into mainstream operations and revision of their approach for support.

The division of tasks between WHO, UNICEF, and UNFPA is done based on their mandates and expertise. WHO will focus on revitalisation of curative, inpatient, emergency, surgical care, ancillary (lab, X Ray, safe blood transfusion), communicable diseases control, and surveillance and early warning components. UNFPA will work on the reproductive health services components; antenatal, safe delivery and postnatal care, post-abortion care, Emergency Obstetric and Neonatal Care (EmNOC), UNICEF will support the establishment of child health services using the Integrated Management of Childhood Illnesses (IMCI) approach (including necessary medical supplies for 6 months in return sites); establishment/strengthening the expanded programme for immunisation (return sites) and basic nutrition services, and contribute to the formation and skills building of CHWs on childhood illnesses, Infant and Young Child Feeding, community mobilisation for child health, and healthy nutrition.

The MOH/WHO protocols, and standards are the basis for collaboration with the three Darfur's Academies for Allied Health Sciences for development of new health professionals from within local communities to fill in the gaps.

3.5. Environment

Different sources estimate that a third of the forests in Darfur were lost between 1973 and 2006. Still, fired bricks continue to be the preferred construction material in Darfur and are widely used with serious environmental consequences. Due to the massive employment of IDPs in this industry, the returning IDPs have expressed the desire for burnt brick construction in all locations. Should every destroyed rural house be rebuilt in the traditional manner, utilising trees and grasses, then 12-16 million trees would be required. Burnt bricks require tons of firewood (7 MT/50,000 bricks) and major transport capacity for both the raw materials and the delivery of the finished product, all of which are highly destructive to the local environment.

Considering the pressure provoked by rapid urbanisation on an already fragile environment in Darfur, especially in terms of deforestation, the need for identifying alternative construction solutions aroused. UN-Habitat therefore introduced an ecologically friendly and low-cost building material, which has been applied in other countries of the African region: stabilised soil blocks (SSB). This woodless technology was successfully tested and resulted to be 30% cheaper than fired bricks, consuming half of the water and only 5 - 6% of cement. Sustainability aspects were taken into account by using manual press machines for producing the SSB (300 blocks of 30x15x10 cm can be produced per day through the labour-force of 5 people), which is also an income generation activity.

This technology has been very well received by the targeted communities and government officials, and represents one concrete solution to the multiple problems posed by rapid urbanisation. In this project on-the-job trainings will be delivered to youth, skilled masons, community members, implementing partners (NGOs), SMPUD staff for using environmental-friendly and woodless construction technologies such as stabilised soil blocks and ferro-cement roofing.

UN-Habitat will perform an Environmental Assessment (EA) for the construction component that will enable the identification of environmental concerns and risks in order to address them appropriately throughout the implementation. The following steps are to be taken:

- Environmental Screening: The project is subjected to review using different tools, including project screening lists and environmental impact identification lists to identify additional potential environmental risks.
- EA of project design, formulation and appraisal: This entails scoping, defining and establishing boundaries of environmental concerns, and engaging relevant stakeholders to identify priorities and issues to be addressed.
- Review of EA for project approval using specific criteria, and approval procedure based on defined national legislations and particular donors specific requirement.
- During Project implementation: Ensuring short and long term capacities in environmental planning for the project duration and beyond.

- During Monitoring and Evaluation: regular assessment using the environmental impact identification check list, and mentoring of field staff for improving the decision –making processes related to environmental planning and management. Ensure monitoring of and the adherence to the developed guidance and tools for monitoring of environmental impacts.

Generator produced electricity is almost the only sources of electric power in most of the rural settings of Darfur. This way of generating electricity is not only inefficient and expensive, but also causes environmental damage. Introduction of solar-powered electric supply in all targeted health facilities is a sustainable, feasible, and low cost in longer term solution to ensure continuous electricity supply in rural health facilities.

The environmental potential risks caused by the functioning of health facilities are well defined and included in the WHO/MOH guidelines for service provision for the protection of communities, patients, and health facilities staff against biological hazards, strict adherence to the WHO guidelines for the management of solid and liquid waste will be observed. The project will support the mitigation measures against negative environmental impact due to the project activities:

1. Proper infrastructure for the disposal of solid and liquid medical waste.
2. Improved knowledge and practices implemented by all staff on biological waste disposal and infection prevention.
3. Introduction of check list for infection prevention and environmental protection combined with supportive supervisions.

3.6 Human rights

Timely access to adequate health care is a human right and the implementation of the project will contribute to provision of critical health services for the vulnerable communities of Darfur, with emphasis on the availability of quality reproductive health information and services to better address the specific need of women and girls. The way the health services are delivered must respect the religious and ethical values, and the cultural backgrounds of the communities, while conforming to the recognised international standards.

3.7. Gender equality

As is the case in Darfur, women and children are the most affected groups during and after armed conflicts and disasters. For physiological and social reasons, women, girls, and female-headed households are more vulnerable than men to health problems. Early marriage and female genital mutilation/cutting (FGM/C) are common practices and significant contributing factors in high maternal mortality and morbidity rates. Reproductive health diseases represent a major, but preventable cause of death and disability among the women in Darfur. Failure to provide information, services and conditions to help women protect their health constitutes gender-based discrimination and a violation of women's rights.

The project is designed to mainstream the gender equity in all components of health service delivery, preventive, curative and managerial. Improves skills of human resources and availability of necessary diagnostic and treatment tools and means will allow upgrading the provided health services, bringing crucial services such as basic and comprehensive emergency obstetrical care closer to the communities, reducing the need for referral and travel with significant impact on child and women health and overall reduction of families' expenditure for health care. All targeted health facilities are integrated into the governmental public health system, and the provision of free of charge essential medication for children under five and reproductive health care is ensured by the distribution of medicines from the FMOH. For return site health facilities, the necessary medicines for 6 month through the project will facilitate the establishment and integration into state revolving stock mechanism, aiming to ensure immediate re-activation, prevent stock rupture and promote sustainability of supply chain

Promoting the availability of female cadre for all type of services as well as CHWs and community midwives from within existing pastoral communities will remove some of the cultural barriers and encourage better utilisation of available services by women and children. Reproductive health services backed up by adequate equipment, medical supplies and qualified female staff are included into the standard service delivery package. Continuous professional development of midwives and other skilled birth attendants on midwifery

skills, RH/ HIV/GBV integration issues, and field supervision and performance management will be supported so as the services are provided with full consideration for the local cultural barriers.

4. Feasibility, Value for Money, risk management and sustainability of results

4.1 Feasibility

In respect to the feasibility of implementing the project, the expected risks are considered minimal based on the analysis of the current situation and existing hazards. Although the security situation has improved in certain areas of Darfur especially the five state capitals of Darfur states, it will remain an overarching concern. Investing initially in relatively secure areas has been a criteria for project sites selections to facilitate smooth implementation. However, the volatility of the situation has the potential to affect the timely delivery of the project components.

The preparation of the scope of work and the risk assessment identified factors that can be addressed or do not pose a threat level beyond project tolerance. The site selection took into account not only the local security context, but also the situation of the access roads in terms of security and the impact of rainy season on access to the location. Once the risk levels have been determined as acceptable, WHO, UN-Habitat, UNICEF, and UNFPA will closely pursue their respective activities.

Although this is a challenging undertaking for UN-Habitat, WHO, UNICEF and UNFPA, the project remains feasible and realistic in scope, the risks associated with UN and stakeholders engagement are manageable and the integral partnerships brought about through the project will ensure its feasibility.

4.2. Value for money

UN-Habitat, UNFPA, UNICEF and WHO will apply the 3E framework methodology to analyse the value for money (Economy, efficiency and Effectiveness) to ensure the optimal use of resources to achieve the intended results. UNFPA, UNICEF and WHO will capitalise on their already well-established administrative and operational capacities and partnerships in Darfur states, and on the deployment of national and international staff and consultants to manage the project in the field with technical and managerial guidance provided by the International Heads of Programs from Khartoum.

Implementation and adherence to standards and guidelines, combined with intensive capacity building of relevant staff on treatment protocol, using and maintenance of medical equipment will aim ensuring that personnel, equipment and supplies are used to generate more and better outputs. The integration of different complementing services provided under the same roof (example, the EPI agent enabled to cover the also basic nutrition activities, integrated surveillance instead of only early warning), will also be key to boost efficiency and effectiveness.

4.3. Risk Analysis

See Table 3 Below.

4.4 Sustainability of results

The construction works will be done with environmental-friendly material, such as SSB, whose quality has been proven in previous UN-Habitat projects. The health facilities will be provided with cheap sustainable energy through the installation of solar panels, energy eliminating the unaffordable costs of generator produced electricity to enhance long term sustainability. One person in each health facility will be trained on the day by day maintenance of solar panels.

Providing at least 100 young people with skills and knowledge for the production of SSB and other construction trades, will increase their opportunities for employment.

Table 3: Risk Analysis

Description	Date Identified	Type	Impact & Probability	Countermeasures / Mitigation/ response	Responsible Agency
Degradation of the security situation in Darfur	At the design stage of the project (May2014)	Security	Medium	Coordination & information sharing with UN Department of Safety & Security (UNDSS) and UN security field personnel. Recruitment of qualified, national staff from target sites Active engagement of local authorities and communities	UN Habitat, UNFPA, UNICEF, WHO
Political instability and consequent weakening of government institutions leading to a (temporary) halt of implementation		Political	Medium	Monitoring/observing the political situation and changing the implementation plans as and when necessary to avoid delays.	WHO, UNFPA, UN Habitat, UNICEF
Delays and difficulties on getting visas, travel permit to project sites		Sec and political	Medium	Hire competent local staff who do not need travel permit; Strengthen the communication with state HAC; Request facilitation from federal level.	WHO, UNICEF UNFPA, UN Habitat
Communities, authorities and other stakeholders may have radically different understanding of the main project objectives	To be monitored and recorded at the initial stage	Cultural	Low	Clear understanding and agreement with relevant authorities of the goals, targets, deadlines and mode of implementation from the initial phases. Work closely with state MPUD and MoH and community leaders from the initial stage.	WHO, UNFPA, UN Habitat, UNICEF
Increased rehabilitation and construction works across the sectors results on prices surge for construction materials, transport and qualified workers	At the design stage	Economic	Medium	Wide advertisements for contracts and staffing Capacity building and institutional training activities for local communities included into project design to increase the pool of skilled workers Reserve/contingency funds built up in the budgets	
Adverse impact on environment		Environ-mental	Low	The results of different studies and lesson learned from the implementation of other infrastructure project included into project design Adherence to the WHO standards for environmental and communities' protection against biological hazards.	

Lack of motivation is one of the main causes for the high turnover and lack of skilled workers in public health facilities. The prioritisation of health facilities took into account the MOH commitment to support all necessary staff positions during the next years through the inclusion into the MOH human resources plan so at least the salaries can be paid. The inclusion of the targeted health facilities into the revolving stock scheme has been agreed with the MOH as sustainable mechanism for ensuring staff incentives. Based on the evaluation results of the pilot project for National Health Insurance, further system-wide interventions will be jointly designed with MOH for the expansion of the system

Formation of new health professional will increase the pool of qualified health staff in each State with a long lasting impact on the health system.

5. Results Framework

5.1 Planned activities and related results

See Table 4: Results Framework below.

5.2 Activities narrative

The proposed activities aim to ensure the functional rehabilitation and upgrading of the targeted health facilities to ensure that the newly upgraded building will be used for the delivery of a standard quality medical services package. The project targets health facilities that serve large rural communities, and health facilities in selected rural sites to bring services closer to them. In the five capital cities, only critical services (general and obstetrical surgery) that are in a dire condition and that are essential for ensuring critical referral services for the project targeted communities have been planned at this stage.

5.2.1 Functional rehabilitation and upgrading of targeted health facilities

This will be implemented by UNFPA, WHO, UNICEF and in partnership with MOH (state and federal level).

- The activities will enable the delivery of an integrated package of primary health care services in all targeted health facilities to include; diagnosis and treatment of most common diseases, reproductive health care (antenatal, postnatal, delivery, family planning), child health care (EPI, IMCI, nutrition), stabilisation of emergency cases, health promotion, surveillance and alert investigation, referral, and integration into MOH vertical programs for control of malaria, tuberculosis, HIV/AIDS, guinea worm, and polio.
- Provision of medical equipment and furbishing to fill in the identified gaps and enable the provision of quality health services.. The order for international quotations and procurement will be placed – by WHO, UNICEF and UNFPA - in the first quarter of project of implementation period so they will be received in the country during the third and fourth quarter. The distribution will be done gradually, as soon as the infrastructure rehabilitation is accomplished and sustainable electricity and water supply established. The donated equipment will be recorded into the health facilities and MOH inventory and records. To address one of the major challenges encountered for equipment maintenance, spare parts will also be procured and distributed for major types of equipment.

Table 4: Results Framework

JP/ Project Title	Commence Upgrading and Rehabilitation the Existing Health Facilities in 5 States of Darfur
DDS Pillar	II. Reconstruction
DDS outcome	Facilities offering complete packages of health and nutrition services of acceptable quality, with particular attention to Return Locations (Urban and Rural)
Relevant DDS Pillar Priority: 4. Increased access & utilisation of comprehensive health and nutrition services, privileging vulnerable and disadvantaged population groups 6. Successful social and economic reintegration of returnees (including special groups)	

JP/ Project Outputs	UN Organisation	Other Implementing partner(s)	Performance Indicators	Baseline	Target	Means of Verification
JP Output 1: By the end of the first month the designs and documentation for infrastructural and functional rehabilitation of targeted health facilities are finalised and endorsed by the relevant authorities.	UN-Habitat, UNFPA, WHO, UNICEF	SMOH	# designs for each targeted HFs endorsed by MOH and DRA	0 0	30 1	Meeting reports and endorsed/signed documents
JP Output 2: By 2017, 30 health facilities (20 rural and referral and 10 in return sites) are rehabilitated and/or upgraded in 5 Darfur states to enhance the quality of health services, and increase population coverage	UN-Habitat	SMOH, private sector (contractors/ suppliers)	# of facilities rehabilitated and/or upgraded according with agreed standards	12 constructed	42 (20 under 4.5 and 10 under 6.7.2. sub-objective of FaST projects)	Field monitoring reports, and assessment/ survey reports Hand over documents

Cont'd

Table 4: ***(Cont'd)***

JP/ Project Outputs *(Cont'd)*	UN Organisation	Other Implementing partner(s)	Performance Indicators	Baseline	Target	Means of Verification
JP Output 3: By 2017, the range and quality of services provided by the 30 targeted health facilities are as per MOH standards, through availability of adequate human resources skills combination and number.	UNFPA, UNICEF, WHO	SMOH, FMOH, Academy of Allied Medical Sciences, and NGOs	# of new health staff (different categories) developed through institutional training #/% of female staff # of staff (different categories) participated in refresher trainings (35% female) # (and percentage) of rehabilitated HFs having the right mixture of skilled staff as per MOH standards	0 0 0 0	360 35% 820 30 (100%)	Enrolment documents Graduation certificates and employment documents Regular field monitoring report, training reports and news letter
JP Output 4: By 2017 health services are improved in the selected health facilities through procurement and delivery of medical equipment and medical supplies.	WHO, UNICEF, UNFPA	SMOH	# of targeted HF having functional equipment according to the MOH standards # and % of targeted rural hospitals providing comprehensive EmOC services	0 0	30 10	Regular field monitoring report, and assessment/ survey report

5.2.2 Health staff and skills availability:

Ensure adequate number, and right skill combination of qualified staff for each targeted health facility to enable the delivery of a service package according to their classification (WHO, UNICEF, and UNFPA). ***This will include:***

- Defining the micro-plan for human resources development for each staff category together with MOH (state and federal) .
- Ensuring, together with state and federal MOH the positions are mapped in state Human Resources plans.
- Identifying the candidates (male and female), preferably from within the catchment population of each health facility aiming also to cover the local pastoral communities.
- Enrolment of the students (male and female) for institutional training by the Allied Medical Studies Academies (EL Fasher, Nyala and Geneina) as EPI focal points, nurses, laboratory, radiology technicians, CHWs, and midwives, including community midwives for nomad communities living in the catchment areas of the targeted sites.
- Conducting refresher trainings targeting all staff categories (male and female) and levels on; IMCI, alert investigation and initial response, trauma and mass casualty, infection prevention in hospital setting, health information system and use of the health data, and Emergency Obstetric care
- Training of relevant staff from SMOH on medical equipment maintenance.
- Support visits by Obstetrics/ Gynaecology consultants to rural hospitals to identify gaps and provide technical and practical support to general practitioners on EmONC. One visit to each hospital every six months, for four days duration.

The formation of new health staff from within communities when the gap can't be filled through new recruitment has been agreed with SMOH as a sustainable solution to address the present existing challenges. As the institutional training can take up to 16 month (for community midwives), UNFPA, UNICEF, and WHO will be initiated early during the implementation so as at the end of the project all necessary positions are filled.

A joint (MOH, DRA, UNFPA, UNICEF, and WHO) review and revision of the way the funds raised through revolving stock scheme are used for staff incentive payments to evaluate the impact and address challenges will be conducted and recommendations used for advocacy and fund raising for a system-wide intervention.

5.2.3 Structural rehabilitation and upgrading, implemented by UN-Habitat

To reach output 1 "The health facilities are assessed comprehensively in the 5 states of Darfur to determine the detailed plans for rehabilitation/upgrading works", UN-Habitat will hire qualified technical staff (engineers and architects) who will first conduct a comprehensive detailed assessment & evaluation of the rehabilitation and functional upgrading needs, including the solar system needs, through field-visits in the 20 health facilities selected during the joint rapid assessment. WHO and MOH will provide technical inputs for ensuring optimal patient, material, and waste circuits within health facilities is promoted through infrastructural adaptations thus enhancing prevention of nosocomial infections and protection of the environment

After this assessment, to reach output 2 "Rehabilitation, upgrading and expansion of 20 health facilities are carried out to enhance the quality and range of health services and increase population coverage" UN-Habitat will prepare the health facilities design drawings and bill of quantities, identify contractors through open bidding and undertake procurement for SSB manual/hydraform machines and solar panels. The rehabilitation and upgrading works in the construction sites will start. In the meantime on-the-job trainings of unemployed youth on production and application of SSB and other construction trades (carpentry, steel fixing, and plumbing) will be carried out. The rehabilitation and upgrading works will be monitored throughout the project by UN-Habitat senior Project Manager/coordinator in El-Fashir and the state Committee for Project Implementation.

Upon completion of rehabilitation, functional upgrading and extension of provided services of the selected health facilities, UN habitat will coordinate with WHO, the States Ministries of Health and DRA for the hand-over of the completed sites, in accordance with the United Nations rules and regulations; an opening ceremony will also be arranged to increase the visibility of the joint programme and of the donor and to ensure the ownership of the achieved results by the States ministries and DRA.

5.3 Monitoring and supervision

A regular monitoring schedule for field sites will be decided at state level by teams to include MOH, UNFPA, UN Habitat, UNICEF, and WHO. The results will be shared during the monthly meetings of the State Project Coordination Committee and Khartoum Task Force, and synergic actions for addressing the challenges recommended.

Feedback and recommendations will be provided to the field and each organisation country team.

6. Management and Coordination Arrangements

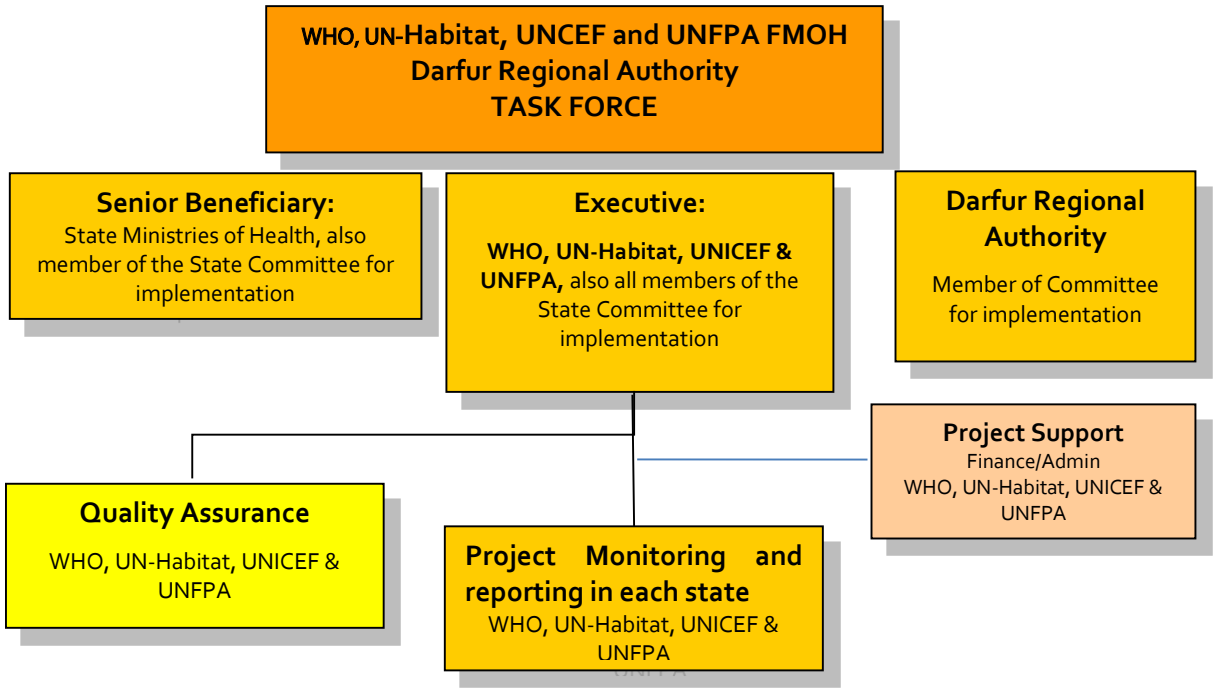
This project will be jointly implemented by the World Health Organisation (WHO), the United Nations Human Settlements Programme (UN-Habitat) and the United Nations Population Fund (UNFPA) in partnership with the competent authorities, namely: the Darfur Regional Authority, the five Darfur State Ministries of Health (SMOHs), the Federal Ministry of Health, and the 5 States Ministries of Planning and Urban Development (SMPUDs).

At national level a **Project Task force** will be established including senior management level from all stakeholders. The Task Force will be responsible for making strategic and managerial decisions for the project and provide guidance and technical support whenever needed with regard to the project components and activities. It will play a critical role in the project monitoring and evaluations by quality assuring these processes and products, and using evaluations for performance improvement, accountability and learning. The Task force will ensure that required resources are committed and efficiently used, arbitrate on any conflicts within the project that could not be solved at state level, and negotiate solutions to any problems with external bodies. It will facilitate the negotiations and access to governmental bodies as required. In addition, the Task force will approve the appointment and responsibilities and the detailed work-plan. Based on the approved Annual Work Plan, the Project Task Force can also consider and approve its revision and any essential deviations from the original plans. The Task Force will meet every three months.

At each state level, a **Committee for Project Implementation** will be established to include the representatives (senior level) from Beneficiary (State Ministry of Health), Executive agencies (UN Habitat, UNFPA, UNICEF, and WHO), and the Darfur Regional Authority. The committee will be in charge of defining the detailed plans, monitor implementation, identify gaps and recommend corrective measures, facilitate negotiations at state levels, resolve conflicts etc.

The main responsibility for quality insurance, monitoring of progress, reporting, and financial and administrative management will be with the implementing agencies (UN Habitat, UNFPA, UNICEF, and WHO). Technical expertise will be provided by each agency in its specific areas of expertise. The coordination with other sectors and projects will be ensured through regular meetings with leading agencies.

6.1. Proposed Project Management structure:



Each agency will establish its own management and implementation structures integrated and making use of their already existing capacities and systems

Activities related to WHO will be implemented through its sub-offices in the five States of Darfur with backstopping from the team in Khartoum. A project coordinator will be placed in El Fashir for closer coordination and monitoring of the progress. The WHO project manager based in Khartoum together with the technical staff will provide support for the state project coordinators and their teams. All financial and administrative operations (including procurement) will be conducted as per WHO guidelines and standard operation procedures.

UNFPA has a field presence in 4 states which are all staffed with qualified medical doctors/RH program officers, GBV officers, and admin/finance staff. These teams are in charge for the implementation, follow up and monitoring of project activities jointly with WHO and UN HABITAT and the state.

UNICEF will implement the activities related to child health (health facility and community) and nutrition services with the support of the existing health and nutrition specialists in its field offices in five Darfur states.

The rehabilitation works will be done by UN-Habitat through its sub-offices in Darfur states. UN Habitat will place a senior Project Manager/coordinator in El-Fashir and qualified engineers and construction technicians in the five States of Darfur, backstopped by the national and international staff in Khartoum, as well as the Regional Office for Arab states in Cairo.

7. Funds allocation and Cash Flow Management

Funds allocation for the joint program will be done in line with the UNDF Terms of Reference and Rules of Procedure approved by the UNDF Steering Committee. This section should refer to, and quote from these documents as appropriate.

UN Habitat, WHO, UNICEF, and UNFPA will be separately responsible for their areas of intervention and work and will receive funds separately. UN-Habitat, WHO, UNICEF, and UNFPA will maintain close coordination and dialogue with United Nations development and humanitarian actors in Sudan (UNDP, ,

WHO, UNHCR, OCHA, etc.) to ensure synergies with their planned activities in Darfur and strengthen information sharing at the different stages of the project.

Maintaining transparency all along project implementation by the project management team is an effective approach to prevent and address any possible tensions or conflicts.

Utilisation of funds allocated to each agency will be administered according with its own rules, regulations, directives and procedures. Cash transfers to contracting to others companies, NGOs etc. will also be done under the rules of procedures of each agency.

The disbursement of funds is planned in three instalments based on the individual agencies financial projections for different phases of the project: 1st instalment at the contract approval, the 2nd one after six months, and the last one after one year. The instalments will be subject to the submission of progress and financial (not certified) reports. (See attached Annex 1, Cash Flow planning includes the information for WHO, UN Habitat, UNICEF, and UNFPA)

8. Monitoring, Evaluation and Reporting

8.1 Joint monitoring framework

The partners will develop a monitoring framework during the first six months of the project in order to monitor the activities and their impact throughout the period. Monitoring will be facilitated by the all partners, but very closely with national and state government, and with the continuous support required by the civil society of the selected area or related NGOs. When possible, monitoring responsibilities will be incorporated in agreement with partners.

Reporting on activities conducted with stakeholders will be produced in collaboration and/ or reviewed by stakeholders whenever possible. Every three months, the lead agency in close partnership with all partners will update the project progress, outputs and activities against the agreed targets and work-plan. Each implementing agency will set resources and staff for monitoring and reporting.

Table 5: Joint Programme Monitoring Framework (JPMF)

Expected Results (Outcomes & outputs)	Indicators (with baselines & indicative timeframe)	Means of verification	Collection methods	Responsible Agency
Output 1: By the beginning of the project, the design and technical documentation of selected health facilities in Darfur states are defined and endorsed by the relevant authorities	***Indicators:*** # of assessments ***Base line:*** 0 ***Target:*** 1 End of the first month of project period	Regular field reports assessment/ survey report, and detailed implementation plans	Direct supervision by field staff	UN-Habitat, MOH, DRA, WHO, UNICEF, and UNFPA
Output 2: **By 2017, thirty health facilities are rehabilitated and/or upgraded in 5 Darfur states to enhance the quality of health services, and increase population coverage**	***Indicators:*** # of facilities ***Baseline:*** 12 (constructed) ***Target:*** 42 June 2017	Regular field supervision and monitoring reports analysed against agreed benchmarks	Direct supervision by field staff who have day-to-day follow-up in construction sites	UN-Habitat, MOH, DRA

Cont'd

Table 5: (Cont'd)

Expected Results (Outcomes & outputs) (Cont'd)	Indicators (with baselines & indicative timeframe)	Means of verification	Collection methods	Responsible Agency
Output 3: **By 2017, the range and quality of services provided by the 30 targeted health facilities are up to the standards through availability of adequate human resources skills combination and number**.	***Indicators:*** # of new health staff developed through institutional training Baseline: 0 Target: 360 June 2017 #/% of female trained ***Baseline;*** 0 ***Target;*** 35% June 2017 # of staff (different categories) participated in refresher trainings (35% female) ***Baseline:*** 0 ***Target;*** 820 June2017 # of HFs having the right mixture of skilled staff as per MOH standards ***Baseline:*** 0; ***Target*** 30 June 2016	Regular field supervision and monitoring reports, Enrolment documents and graduation certificates	Direct supervision by field staff, who have day-to-day follow-up in the sites. Meetings with teaching institutes	WHO, UNFPA, UNICEF, MOH, DRA, Darfur Academy for allied Medical Sciences
Output 4: **By 2017 health services are improved in the selected health facilities through procurement and delivery of medical equipment.**	***Indicators:*** # of HF having functional equipment according to the MOH standards and facility categorisation ***Baseline;*** 0; ***Target;*** 30 Nov 2016 # and % of targeted rural hospitals providing comprehensive EmOC services ***Baseline*** 0; ***Target*** 10 June 2017	Regular field supervision and monitoring reports Donation certificates MOH update inventory lists	Direct joint supervision by field staff who have day-to-day follow-up in the sites	WHO, UNICEF, UNFPA, MOH and DRA

8.2 Annual/Regular reviews:

Annual Reviews will be conducted jointly by all stakeholders within the framework of Project Task Force and states 'Committees for Project Implementation and an external consultant (hired by WHO), based on terms of reference that will be agreed with the donor. The annual reviews conducted by the individual implementing agencies on respective project components will constitute the basis of the overall project review that will outline the strength and weaknesses of joint programing and implementation, progress towards achievement of set targets, use of available resources, and linkages and synergies with other sectors 'interventions. The aim is to have sufficient accurate information on the implementation progress and challenges that will guide further project implementation, review accordingly the plans, and address identified risks and bottlenecks.

The results of the annual reviews will be disseminated to all stakeholders, and form a part of the DDS annual review; this will allow sharing experiences, learning from other agencies experiences , plan for joint actions to outcome challenges and seek opportunities for mutual support.

The project will be coordinated by the UN-Habitat Sudan Country Office with the support of the Regional Office for Arab States (ROAS). Reporting will be done to the Government of Sudan, the donor and UN-Habitat. This includes the dissemination of assessment reports, financial reports, evaluation reports and progress reports based on the stipulated requirements of the Government of Sudan, the donor and UN-Habitat.

8.3 Evaluation:

As stated in the work plan; WHO, UN-Habitat, UNICEF, and UNFPA will prepare the TOR for the evaluation process ensuring that they are gender sensitive, and revise the main indicators at the early stage of the implementation. The project evaluation will be initiated in the final six months of the project, noting that it will build upon the project's monitoring plan. The evaluation at the end of the project will be carried out by an internal or external evaluator. It is expected that the final project evaluation report will be adopted not later than three months after the completion of project activities.

UN Habitat, WHO and UNICEF will undertake internal mid-term evaluation of their project components in accordance with agencies' internal Evaluation Policy and with the support and guidance of their regional Evaluation Units. The engagement of external evaluators will be considered based on advice from the Evaluation Unit. The action will require consultations with Sudanese national and state authorities and local stakeholders.

The results of the mid-term review will be used to adjust the project approach towards achieving the expected accomplishments of the project. Moreover, it will make recommendations on the goals and terms of reference for the final evaluation, considering also the requirements of the donor and the advice by the Evaluation Unit.

8.4 Reporting

UN-Habitat, UNICEF, and UNFPA will prepare narrative and financial reports every six month. WHO will consolidate then in one narrative progress report and submit it to the UNDF secretariat regular reports; the narrative will include the progress made towards achievements of targets. The interim financial statement certified by organisations' Finance Officers, in line with article 38 of the UNDF Terms of Reference;

Each participating UN organisation will provide the Administrative Agent with the following statements and reports prepared in accordance with their own accounting and reporting procedures:

i) Consolidated Interim narrative progress reports to be provided every six months
ii) Individual interim financial statements (uncertified) on funds utilisation to be provided every six months
iii) Final consolidated narrative report to be provided no later than four months after the project end date

Certified final financial statements and reports for each organisation to be provided separately by each implementing agency no later than six months after the end date of the project.

8.5 Visibility

Recognition of donor contribution towards the wellbeing of deprived, war affected communities in Greater Darfur would be ensured by the implementing agencies throughout the project implementation. Acknowledgment of Qatar Government funding of the intervention will be included in all official correspondence and documentation with state and federal authorities /government. Boards and signs in all rehabilitation sites specifying the source of funding along with the names and logos of implementing partners will be installed during the work and on the buildings after the completion.

Ceremonies for the handing over of the rehabilitated clinics and graduation of new health staff from the Allied Medical sciences Academies with participation of high rank officials and the representative of Qatari Embassy will be organised and local and national media invited to ensure high visibility of Qatar Government contribution.

9. Work plans and budgets

Duration of the JP/Project: 18 months

Table 6: Work plan of: "Commence Upgrading and Rehabilitating of the Existing Health Facilities in 5 States of Darfur"

Specific Objectives of the Fund: Increased access to health care facilities									
Expected products & Key activities	Calendar (by activity)						Geographic area	Responsible Participating Organisation	Planned budget (by product/ activity) US$
	Q1	Q2	Q3	Q4	Q1	Q2			
Output 1: The designs and documentation for infrastructural and functional rehabilitation of targeted health facilities are finalised and endorsed by the relevant authorities									
1.1. Deploy qualified technical staff (engineers and architects) and directly responsible for the project implementation at field level	X	X	X	X	X	X		UN-Habitat	720,000
1.3. Finalise the design drawings and all necessary documentation for rehabilitation/construction of targeted health facilities.	X							UN-Habitat	30,000
1.2. Carry out field visits to each of the 30 facilities and undertake a comprehensive assessment of the actual needs of rehabilitation, extension and upgrading, provision of solar system according to construction and health standards	X	X	X	X	X	X	All targeted sites	UN-Habitat, WHO, UNFPA, MOH, DRA	UN Habitat 60,000 WHO 8,000
1.5 Preparation (list and international bidding) of the international and national procurement of equipment, medical supplies and medicines with detailed specifications taking into account country specific challenges.	X						Khartoum	WHO, UNFPA, UNICEF	0
Output 2: Rehabilitation, upgrading and expansion of 30 health facilities are carried out to enhance the health services and increase coverage									
2.1. Select qualified contractors and undertake procurement for rehabilitation/reconstruction	X	X					El-Fashir, Nyala, El-Geneina, Ed-Da'ein and Zalingei	UN-Habitat	0
2.2. Procurement of SSB manual/hydraform machines	X	X							190,000
2.3. Rehabilitation and upgrading work	X	X	X	X	X	X	All targeted sites		4,470,080

Cont'd

Table 6: ***(Cont'd)***

Expected products & Key activities	Calendar (by activity)						Geographic area	Responsible Participating Organisation	Planned budget (by product/ activity) US$
	Q1	Q2	Q3	Q4	Q1	Q2			
Output 2: Rehabilitation, upgrading and expansion of 30 health facilities are carried out to enhance the health services and increase coverage ***(Cont'd)***									
2.4. Procurement and installation of solar panels	X	X	X	X	X	X	Khartoum and all targeted sites	UN-Habitat	300,000
2.5. Monitor/Supervise the rehabilitation/upgrading of health facilities		X	X	X	X		All targeted sites		0
2.6. Trainings of unemployed youth on production and application of SSB and other construction trades (carpentry, steel fixing, plumbing)		X	X	X	X		El-Fashir, Nyala, El-Geneina, Ed-Da'ein and Zalingei	UN-Habitat	150 000
2.7.Handover of completed facilities and evaluation			X	X	X	X			0
Output 3: Capacity building activities are carried out for the health/medical staff serving in the selected facilities									
3.1. Deploy project staff at field level directly responsible for the implementation of project activities technical support	X							WHO UNFPA	WHO 480,000 UNFPA 190,000 UNICEF 75,090
3.2. Support the enrolment and schooling for institutional training for EPI/nutrition focal points, nurses, laboratory and radiology assistants, anaesthesiologist technicians, CHW, and community midwives.		X	X	X	X	X	El-Fashir, Nyala, El-Geneina, Ed-Dein and Zalingei	WHO, UNFPA, Academy for Allied medical sciences MOH	WHO 945,957 UNFPA 174,500
3.3. On the job training of available staff on: IMCI, , alert investigation, Infection prevention measures at health facility level, surveillance and the use of data and planning; EmNOC, medical equipment maintenance	X	X	X	X	X	X		UNFPA, WHO, MOH, UNFPA	WHO 410,200 UNFPA 397,000 UNICEF 181,042

Cont'd

Table 6: ***(Cont'd)***

Expected products & Key activities	Calendar (by activity)						Geographic area	Responsible Participating Organisation	Planned budget (by product/ activity) US$
	Q1	Q2	Q3	Q4	Q1	Q2			
Output 4: Health/medical services are improved in the selected health facilities through procurement and delivery of medical supplies, equipment and drugs									
4.1. Initiate international procurement of equipment and medicines		X					Khartoum	WHO, UNFPA UNICEF	
4.2. Receive and handing over/distribution of the medical equipment and medicines coordinated with the infrastructure component				X	X	X	All targeted sites	WHO, MOH, UNFPA	WHO 2,200,000 UNFPA 482,441 UNICEF 240,000
M & E – Evaluation									
Field monitoring and reporting	X	X	X	X	X	X	All targeted sites	UN-Habitat, UNFPA, WHO, MOH, DRA	UN-Habitat 60,000 WHO 70,000 UNFPA 57,000 UNICEF 10,690
Evaluation of implementation progress, challenges and revisions		X		X				UN-Habitat, UNFPA, WHO, FMOH, DRA, SMOH	UN-Habitat 20,000 WHO 48,000 UNFPA 28,000 UNICEF 5,000
Conduct official conference (high level government and Qatar Embassy) to establish baseline and midterm and final evaluation of impact, lesson learned and further interventions	X		X			X	Khartoum and all targeted sites	UN-Habitat, UNFPA, WHO, MOH, DRA	UN-Habitat 26,000 WHO 42,000 UNFPA 24,000 UNICEF 5,000
Total of the 1st Participating Organisation – UN-Habitat (without the 7% indirect cost & without 1% Administrative agency cost)									6,026,080
Total of the 2nd Participating Organisation – WHO(without the 7% indirect cost & without 1% Administrative agency cost)									4,204,157
Total of the 3rd Participating Organisation –(UNFPA without 7% indirect costs &without 1% Administrative agency cost)									1,352,941
Total of the 4th Participating Organisation –(UNICEF without 7% indirect costs & without 1% Administrative agency cost)									516,822
Total Direct project costs									12,100,000
Total planned budget including 7% indirect program support costs for implementing agencies									12,947,000
Total planned budget (including 7% indirect support cost implementing agencies & 1% Administrative Agency cost)									**13,068,000**

Table 7: Budget by Participating UN Organisation, using UNDG Budget Categories

UN FUND FOR DARFUR JOINT PROGRAMME BUDGET* (US$)					
CATEGORIES	UN-Habitat	UNFPA	UNICEF	WHO	Total
1. Staff and other personnel costs	720,000	190,000	75,090	480,000	1,465,090
2. Supplies, Commodities, Materials	52,000	420,441	220,000	2,140,000	2,832,441
3. Equipment, Vehicles and Furniture including Depreciation	200,000	0	0	41,219	241,219
4. Contractual Services	4,862,820	151,500	0	886,938	5,901,258
5. Travel	31,260	57,000	18,390	40,000	146,650
6. Transfers and Grants to Counterparts	0	374,000	181,042	220,000	775,042
7. General Operating and Other Direct Costs	160,000	160,000	22,300	396,000	738,300
Sub-Total Project Costs	6,026,080	1,352,941	516,822	4,204,157	12,100,000
Indirect Support Costs for Implementing agency 7%	421,826	94,706	36,178	294,290	847,000
TOTAL with 7% ISC	6,447,906	1,447,647	553,000	4,498,447	12,947,000
Administrative Agency 1%	60,261	13,529	5,168	42,042	121,000
Grand Total cost with 7% + 1%	**6,508,167**	**1,461,176**	**558,168**	**4,540,489**	**13,068,000**

Table 8: Budget allocation and sources

PJ Code	Pillar Obj	Joint Projects proposal	DDS Provision	DDS Budget US$	JP Budget (plus 8% PSC) US$
P2E	II.4.5	**4.5.** Commence upgrading and rehabilitating the existing health facilities; Target; 15 rural and 5 essential referral services in 5 states of Darfur	**4.5.** Commence upgrading and rehabilitating the existing health facilities (Targeting 4/state in year one)	10,000,000	10,800,000
	II.4.1	N.B.: These critical assessments have already been completed by FMOH, with WB and WHO support (reports attached	**4.1. Critical assessments:** **4.1.1.** Number and status of existing and required health facilities by State, especially in Return areas: A review of pharmaceutical supply arrangements **4.1.2.**Feasability study of expanding access to health care through the subsidised enrolment in NHE	500,000	Request moving the allocated amount to the Pillar II Objective 6; sub-objective 6.7.2 for the Rehabilitation and upgrading of health facilities infrastructure
P2G	II 6.7.	**6.7.** Upgrading/ rehabilitation/ construction of 10 health facilities in selected return sites using the "hub for service" approach - the population living in 23 return sited will have improved access to essential health care.	**6.7.2.** Basic services are provided in return sites: health facilities rehabilitated/constructed	1,600,000 (6.7. first year allocation is USD 5,000,000 for 3 sectors)	2,268,000 (2,100,000 +8%) (2,100,000 includes USD 1,600,000 from 6.7.1 year 1 allocation) + USD 500,000 reallocated from Pillar II 4.1 already conducted activities)