



**Contracting authority:
Italian Agency for Development Cooperation AICS**

**Primary Health Care provision for vulnerable populations affected by
food insecurity and malnutrition**

NDICI AFRICA/2023/441-988

**Guidelines
for grant applicants**

Reference: Grant/02/HealthPro2

Deadline for submission of full application:

22 May 2026 at 17:00 GMT +3 (Addis Ababa, Ethiopia)

Notice

This is an open call for proposals, where all documents are submitted together (concept note and full application). In the first instance, only the concept notes will be evaluated. Thereafter, for the lead applicants who have been pre-selected, the full applications will be evaluated. After the evaluation of the full applications, an eligibility check will be performed for those which have been provisionally selected (including those placed on the reserve list). Eligibility will be checked on the basis of the supporting documents requested by the contracting authority and the signed 'declaration by the lead applicant' sent together with the full application.

All parts highlighted in blue are of utter importance and conducive to the submission of a fully compliant proposal.

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1. HealthPRO phase II - Primary Health Care provision for vulnerable populations affected by food insecurity and malnutrition in 3 targeted states, Sudan

a. Background

Modern Sudan has long been beset by conflict and instability since independence, with two lengthy north-south civil wars and a protracted war in the western region of Darfur.

The first significant eruption of violence occurred in 1955, when the southern regions, feeling marginalized, rebelled against the central government in Khartoum. This marked the onset of the First Sudanese Civil War, a conflict that persisted until 1972. The Addis Ababa Agreement brokered during this period and granted autonomy to the south, temporarily quelling hostilities.

This fragile peace though disintegrated in 1983 when the Sudanese government, under President Gaafar Nimeiry, annulled the autonomy of the south and imposed Islamic law (Sharia) nationwide. This seismic shift reignited hostilities, giving rise to the Second Sudanese Civil War, a devastating conflict that spanned over two decades. Within this period, the Sudan People's Liberation Army/Movement (SPLA/M), led by John Garang, emerged as a key player in the conflict, advocating for southern independence.

A new point in the conflict came in 2005 with the signing of the Comprehensive Peace Agreement (CPA) between the Sudanese government and the SPLA/M. The agreement granted the South a six-year period of autonomy, after which a referendum on independence would be conducted. This historic accord set the stage for the establishment of the semi-autonomous region of South Sudan.

In 2011, the people of South Sudan voted overwhelmingly for independence in a referendum, leading to the formal establishment of the Republic of South Sudan. While this marked the end of the Second Sudanese Civil War, it also gave rise to new challenges, including internal conflicts within South Sudan itself.

In the meantime, a new major conflict commenced in 2003, when the Sudan Liberation Movement (SLM) and the Justice and Equality Movement (JEM) rebel groups began fighting against the government of Sudan, which they accused of oppressing Darfur's non-Arab population. While the conflict did not stop, in July 2011 a peace building process started in Darfur with the signing of the Doha Document for Peace in Darfur, seemingly ushering a new era in the region. In September 2016, the Government of Sudan announced the end of the Darfur conflict and declared a unilateral ceasefire the following month.

In a situation of seemingly regained peace, the ouster of former President Omar al-Bashir in April 2019 and the declaration of the COVID Global Pandemic in March 2020, gave way to yet again another extremely turbulent period in the life and politics of the State, that persist today.

Following the uprising that led to al-Bashir's removal, the Sudanese military and a coalition of civic groups united under the Forces of Freedom and Change (FFC) established a transitional government to lead the country toward a democratic and civilian government. However, the transition suffered multiple setbacks, including political unrest, rising economic instability, and a military coup on 25 October 2021 that dismantled the civilian institutions and overturned parts of the previous power-sharing arrangement.

In December 2022, military and civilian political actors signed a framework agreement to relaunch the political process for Sudan's transition to a civilian government. The transition to a civilian government though was abruptly halted in the early hours of 15 April 2023, when fighting broke out between the Sudanese Armed Forces (SAF), commanded by Gen. Abdel Fattah al-Burhan, and the rapid Support Forces (RSF) led by Mohamed Hamdan Dagalo, in the south of Khartoum. Violence escalated quickly and spread out not only to Khartoum's sister cities, Omdurman and Bahri, but also to other parts of the country.

Two years after this new war erupted, Sudan remains trapped in one of the world's most severe humanitarian crises, with millions of lives at risk and essential services collapsing. Since the outbreak of conflict in mid-April 2023, the country has experienced the world's largest displacement crisis,

widespread infrastructure destruction, famine conditions in vast areas, and outbreaks of communicable diseases.

As of 29 July 2025, Sudan had an estimated 9,937,444 internally displaced persons (IDPs). This represents a decrease of 1,647,940 individuals compared to the peak IDP population reported in January 2025, which was estimated at 11.5 million. The decline in total IDPs is primarily due to increased return movements.

Return movements are increasing, particularly in central regions, with nearly 1.2 million people returning to the capital and surrounding states. However, these returns occur amid devastated infrastructure, limited access to basic services, and persistent protection risks.

Situation in the health sector

Sudan’s health sector is in a state of near-total collapse. After more than two years of brutal conflict, the country’s hospitals, clinics, and research institutions have been devastated. In many war-affected areas, almost all health facilities are either destroyed, abandoned, or too unsafe to operate. Even in relatively calmer states, nearly half of primary health centers are closed. By early 2025, only a small fraction of hospitals and clinics across the country remained functional, and the disease surveillance system had essentially ceased to exist.

Since 1 January 2025, Sudan has witnessed 43 attacks on health facilities. These incidents have resulted in at least 946 deaths and 166 injuries. Out of the total, 32 attacks directly targeted hospitals, clinics, or other health facilities, causing severe disruption to already fragile medical services. In 36 of these incidents, health workers were directly affected—killed, injured, or forced to flee—while in 21 cases, patients themselves became victims of the violence. The assaults have not been limited to treatment sites.

Medical warehouses and supply depots have also been struck, cutting off access to essential medicines, vaccines, and life-saving equipment. This has further deepened shortages across the country, crippling the ability of hospitals and humanitarian actors to deliver care.

In this situation diseases are spreading. As of August 23, 2025, there have been 101,963 suspected cholera cases and 2,515 related deaths, resulting in a national fatality rate (CFR - Case Fatality Rate) of 2.5%, surpassing emergency levels. Alarming, the CFR in refugee settlements has reached 4.6%, more than triple that in IDP sites (1.4%), indicating significant gaps in detection, treatment, and response. Community testing shows a high national positivity rate of 84%, with some states exceeding 90%.

Cholera has been reported in 115 localities, with high incidence rates reported in Kassala, Khartoum, Gedaref, River Nile, and White Nile states. While case numbers are declining in nine states, increases are noted in North Darfur, White Nile, South and West Kordofan, and East and South Darfur. Tawila in North Darfur continues to see rising cases, with WHO projecting around 2,418 new cases in the first week of August, though reporting delays create uncertainty. Significant reporting gaps exist across states, as illustrated in the table below.

Table 1: Status of Data Reporting Across States

Reporting Status by State -	N. of States	%
Active Reporting	13	72%
Partially Active Reporting	4	22%
No Reporting	1	6%

Additionally, dengue fever cases have doubled in recent weeks, with concerning trends in pertussis and diphtheria, while measles and malaria cases are declining. Here follows a summary table reporting the main figures regarding ongoing outbreaks since their insurgence in 2024 up to August 2025.

Table 2: outbreak update at August 2025

Outbreak	Cumulative cases	AR/100,000	Affected States	Cumulative deaths	CFR	Affected Localities
Cholera	101,963	250.8	18	2,515	2.50%	115

Dengue	6,053	31.48	6	9	0.10%	24
Measles	2,810	13.52	12	8	0.28%	44

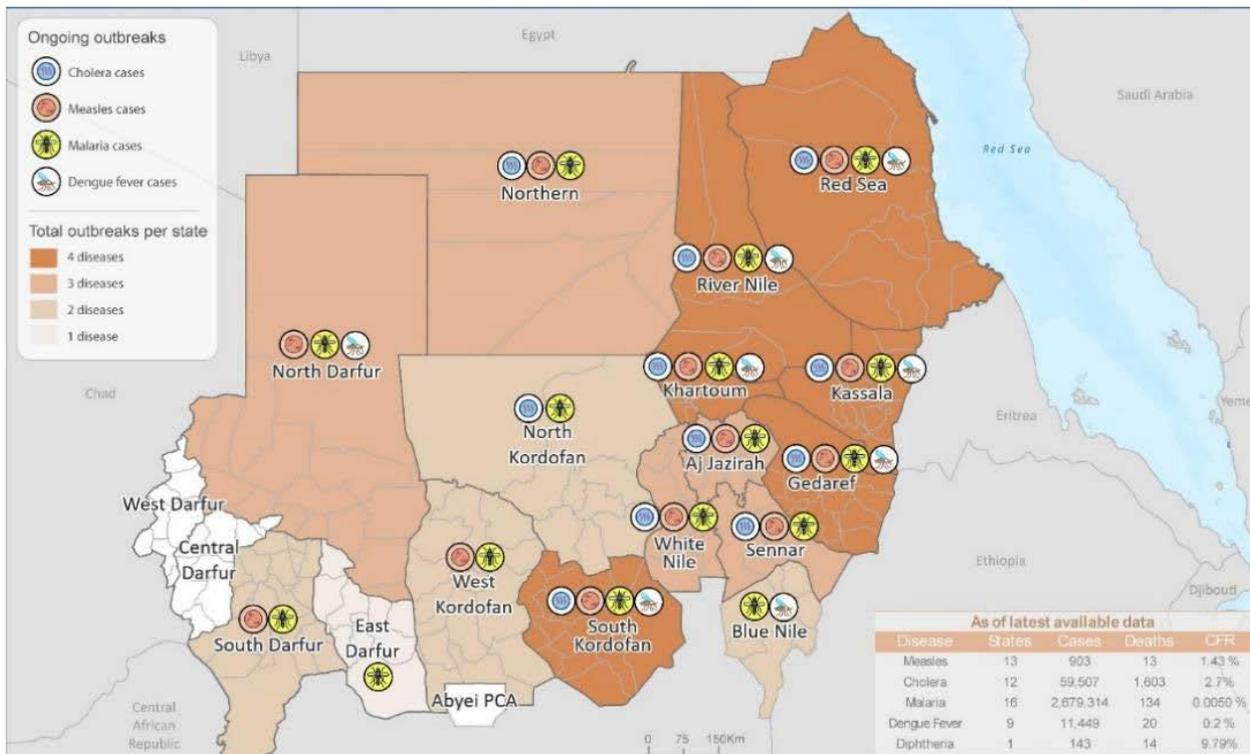


Figure 1: Disease outbreak reported across Sudan as of April 2025

Access to Health & Nutritional Services

Across states, health service delivery is marked by deep structural weaknesses. No state consistently meets the WHO/Sphere benchmark of one primary health care (PHC) facility per 10,000 people, with some localities falling far below the standard while others appear to exceed it. Yet it remains unclear whether higher facility density truly translates into better access or whether it comes at the expense of service quality and functionality. Reported coverage figures often mask reality: many PHCs are only partially functional or lack sufficient staff, medicines, or equipment, meaning effective access is far lower than headline ratios suggest. Urban hubs such as Port Sudan and Kosti show better coverage on paper but face overcrowding, stretching facilities beyond capacity and eroding service quality. Overall, health service coverage across states is highly uneven and fragile. Facility counts alone give a misleading picture, as real access depends just as much on whether those facilities are functional, adequately staffed, and resilient.

Health worker density and distribution

Even before the outbreak of the 2023 conflict, Sudan faced serious challenges in its health sector. The density of health workers, including doctors, nurses, and midwives, was significantly below the minimum threshold recommended by the World Health Organization (WHO). The WHO suggests at least 4.45 health professionals per 1,000 population to ensure adequate coverage of essential health services, while Sudan’s combined density hovered around 1.2 per 1,000. This shortage meant that large portions of the population had limited or no access to quality healthcare.

The problem was not uniform across the country. There was a stark urban–rural divide: most health professionals were concentrated in urban centers, particularly in Khartoum and a few central states, which house around 70% of the workforce. Meanwhile, rural and peripheral areas remain severely underserved. This inequitable distribution created significant barriers to accessing even basic services such as maternal care, vaccinations, and emergency treatment.

Adding to these challenges was a high rate of outmigration among health professionals. Many doctors and nurses sought employment abroad—particularly in Saudi Arabia, the Gulf countries, and the UK—in search of better pay, safer working conditions, and professional opportunities. This brain drain further weakened the already fragile health system, leaving local populations more vulnerable.

Since the onset of the war in 2023, these pre-existing weaknesses have been dramatically exacerbated. Active hostilities have destroyed hospitals and clinics, forced healthcare workers to flee or suspend operations, and disrupted supply chains for medicines and vaccines. As a result, child immunization rates have plummeted, some hospitals have closed entirely, and routine health services—including maternal and emergency care—have become virtually inaccessible in many areas. The war has transformed an already vulnerable system into a humanitarian crisis, with urgent needs for both health personnel and functional healthcare facilities across the country.

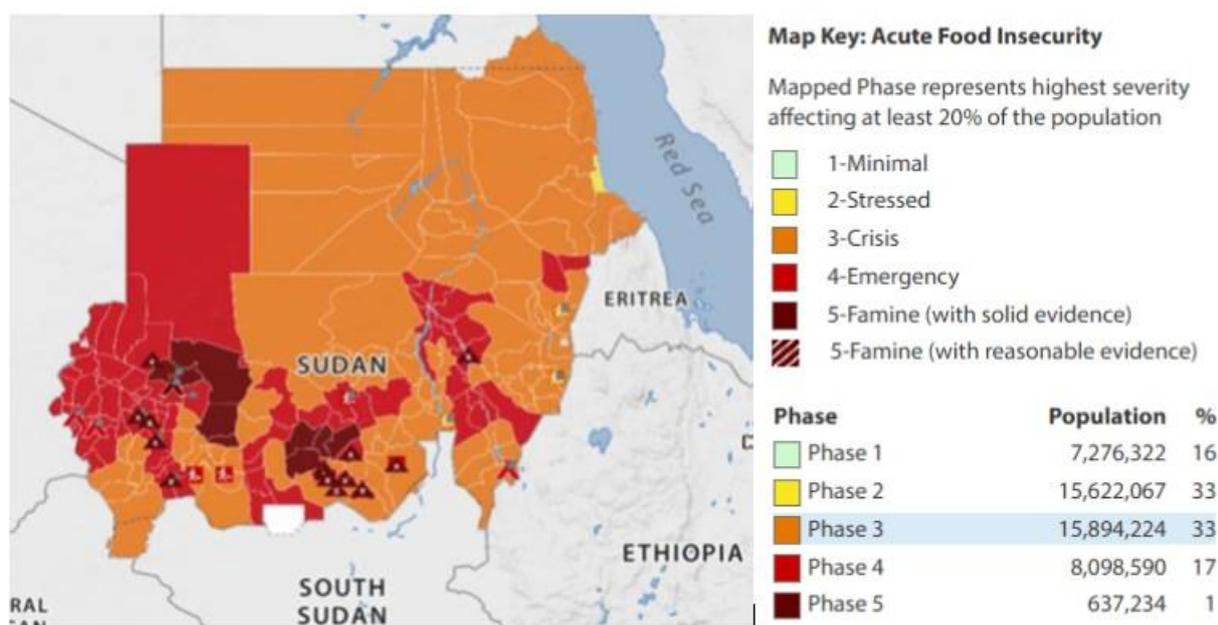
This uneven distribution not only reflects geographic and systemic inequities, but also highlights the strain on existing staff, who must serve large populations with limited resources and infrastructure.

Nutrition

Twenty-eight months into the conflict, Sudan is facing a rapidly worsening famine crisis. At least half of the population, around 24.6 million people, are experiencing acute food insecurity, with 15.9 million in Crisis (IPC Phase 3), 8.1 million in Emergency (IPC Phase 4), and more than 638,000 in outright Catastrophe (IPC Phase 5). The IPC Famine Review Committee has confirmed famine conditions in Zamzam camp in North Darfur since August 2024, which have since spread to Al Salam and Abu Shouk camps and the Western Nuba Mountains. Projections for December 2024 to May 2025 indicate famine will expand further in North Darfur, including Um Kadadah, Melit, El Fasher, At Tawisha, and Al Lait. Additional areas at risk include the Central Nuba Mountains and several conflict-affected localities across North and South Darfur, Al Jazirah, Khartoum, and East Darfur.

While above-average rainfall has supported farming in more secure areas, improving harvests compared to the lean season, these gains have not reached the most vulnerable. In high-conflict zones, ongoing violence has forced farmers to abandon fields, destroyed crops, and left displaced families—many sheltering in settlements or public buildings—unable to benefit from the harvest. Overall, the situation marks an unprecedented deepening and widening of Sudan’s food and nutrition crisis, driven by war, mass displacement, economic collapse, the breakdown of social services, and restricted humanitarian access.

Table 3: IPC Acute Food Insecurity Phase Classification



The IPC distinguishes five phases of acute food insecurity, which describe the progressive deterioration of conditions.

In **Phase 1 (None/Minimal)**, households are able to meet their basic food and non-food needs without resorting to unusual or harmful strategies.

In **Phase 2 (Stressed)**, families manage to maintain minimally adequate food consumption, but cannot afford other essential expenses – such as health, education, or shelter – except by relying on stress coping strategies like debt or reducing diet quality.

By **Phase 3 (Crisis)**, households experience clear food consumption gaps, often accompanied by elevated levels of acute malnutrition. Survival is possible only through selling productive assets or employing crisis coping strategies, such as reducing the number of meals or adults cutting back food intake to prioritize children.

Phase 4 (Emergency) is marked by severe food gaps that drive very high acute malnutrition and rising mortality. Families resort to extreme measures, including distress sales of remaining assets, consuming unsafe or wild foods, forced migration, or total dependence on assistance. Finally,

Phase 5 (Catastrophe/Famine) represents the most extreme conditions: households face complete food deprivation and have no coping options left. Starvation, death, critical malnutrition, and destitution are widespread. To classify an area as **Famine**, the IPC requires evidence of catastrophic levels of both acute malnutrition and mortality. **P3+** refers to the share of people in IPC Phase 3 (Crisis) or worse, meaning they face severe acute food insecurity and require urgent humanitarian assistance.

Rationale for Target Area Selection

In consideration of all elements described above, the project has decided to focus on 4 states only, identifying Red Sea, Gedaref, White Nile and Khartoum states as the most appropriate for HealthPro2 intervention

The process of selection has undergone several rounds, each of them analysing separate yet interrelated aspects:

Step 1_A first level analysis (in-house desk review) of all Sudan states took into consideration the following elements:

- (i) humanitarian and health needs (Annex 05);
- (ii) presence and operational capacity of international partners;
- (iii) accessibility and security conditions (Annex 06);

Through the consideration of these elements, a shortlist was established, making use of a systematic cross-check of humanitarian indicators, risk profiles, the presence of international partners, and the absence of overlaps with other ongoing AICS-funded initiatives.

The outcome of this analysis produced a shortlist of five States including Al Jazirah, White Nile, Gedaref, Sennar, and Red Sea.

Step 2_ As a second step, a dedicated security assessment was conducted, focused on the 5 states provisionally included in the shortlist of Step 1. The main outcomes of the “Security and Access Report” are outlined below (for complete report see Annex 02).

Aj Jazirah: Aj Jazirah remains one of the most dangerous and unstable regions of Sudan’s conflict. Frontlines are fluid, with RSF and SAF competing for control through parallel governance. Civilians face mass displacement (275,000 still displaced), disease outbreaks, and a near-collapse of the health system. Humanitarian actors are obstructed by checkpoints, extortion, and militia interference, while NGO facilities have been looted or occupied. Widespread atrocities, including massacres, sexual violence, and forced recruitment, mark the state as a high-risk operating environment.

Gedaref: while still under SAF control and spared direct battles, Gedaref is under growing pressure. Hosting over 1 million displaced persons, it is a logistical hub under extreme strain. Services are collapsing, with rising malnutrition and epidemics (cholera, dengue, measles). Access is constrained by seasonal flooding, militia checkpoints, and tribal gatekeepers who politicize aid. Tensions are rising due to RSF drone activity, criminal ambushes, and urban protests, making the environment increasingly volatile.

Red Sea: Port Sudan and Red Sea State, though spared ground combat, are now exposed to RSF drone strikes, including attacks on the airport and naval base. With over 300,000 IDPs, service systems are overwhelmed, and GBV, early marriage, and exploitation are rising in camps. Humanitarian access is

complicated by layered clearance systems, tribal patronage networks, and customs bottlenecks. Infrastructure fragility, flooding, and intercommunal tensions further jeopardize last-mile delivery and aid worker safety.

Sennar: although retaken by the SAF in March 2025, Sennar remains highly unstable. It hosts 185,000 IDPs, straining shelter, food, and water resources. Over 70% of hospitals are non-functional, schools are closed, and food insecurity is severe (IPC Phase 3+). Humanitarian access is obstructed by clearance requirements, extortion at checkpoints, and telecom blackouts. Rising ethnic tensions, militia infiltration, and attacks on convoys compound operational risks. The war economy and militia taxation dominate local markets.

White Nile: White Nile bears one of Sudan's heaviest burdens, with 650,000 IDPs and 400,000 South Sudanese refugees. The state is marked by protection crises, massacres, rampant GBV, and systemic infrastructure collapse (fewer than 30% of health facilities functional). Armed groups impose parallel permit regimes and extort aid operations along key corridors. Food insecurity is acute (IPC Phase 3+), agriculture has collapsed, and harmful coping strategies (child labour, early marriage) are widespread. Tensions between refugees, IDPs, and host communities are deepening.

Based on these findings, Aj Jazirah State was excluded from further consideration, while Gedaref, Red Sea, Sennar, and White Nile were retained for additional evaluation under the Needs Assessment.

Step 3_A baseline and need assessment was initiated, with the first task of further narrowing down the selection of states and starting the identification of suitable localities within the very states.

To identify which states should be prioritized for HP2 interventions, a new layered assessment was carried out, making use of scoring grid with indicators pertaining to several key domains. The domains were the following:

1. *Health Needs Severity:* measured through rates of acute malnutrition (GAM), population access to health and nutrition services, and the availability and distribution of health workers.
2. *Service Delivery Gaps:* assessed by the number of functional primary health care (PHC) facilities in target areas, considering both the essential services provided and the adequacy of health worker density.
3. *Population Pressure:* evaluated through the proportion of internally displaced persons (IDPs) and refugees relative to the host population.
4. *Security and Access Constraints:* analysed based on road quality and seasonal accessibility, the presence of militia checkpoints, and the frequency of ambushes or road attacks.
5. *Community Willingness and Participation:* considered the existence of community health committees or volunteers, as well as the degree of local engagement with humanitarian actors, including international NGOs.
6. *Operational Feasibility:* reviewed the overall condition of infrastructure and services that could support implementation.

Each domain was evaluated first and then scored to guide decision-making. In each state, three localities were evaluated using the criteria outlined above (with the exception of Red Sea, where only two were assessed). These evaluations were used to establish a ranking that highlights the relative priority of each locality. To ensure consistency and comparability across states, the scoring model presented in **Annex 04** was applied. In this model, a higher score indicates a greater likelihood of the locality being selected for inclusion in the HP2 interventions

Table 4: Multidimensional Assessment of Target Areas results

Domains	Gedaref						White Nile						Sennar Locality						Red Sea			
	Gedaref		Al-Rahad		Al-Fao		Ad Duwaim		Kosti		Tendalti		Sennar Locality		Sinja Locality		East Sennar Locality		Port Sudan Locality		Sawakin Locality	
Health Needs Severity – % Population with Access to Health & Nutritional Services	5	6	1	2	1	2	3	4	1	2	1	2	5	6	7	8	1	2	1	2	1	2
Health Needs Severity – Health worker density	9	10	5	6	5	6	9	10	7	8	7	8	9	10	9	10	3	4	9	10	9	10
Service Delivery Gaps – # of functional PHCs	9	10	7	8	5	6	7	8	7	8	5	6	7	8	9	10	1	2	5	6	5	6
Security and Access Constraints – Road quality and seasonal accessibility	5	6	3	4	3	4	5	6	5	6	3	4	5	6	5	6	3	4	5	6	5	6
Security and Access Constraints – Number/type of militia checkpoints	5	6	5	6	5	6	5	6	5	6	5	6	5	6	5	6	5	6	5	6	7	8
Security and Access Constraints – Frequency of criminal ambushes	7	8	7	8	7	8	7	8	7	8	7	8	7	8	7	8	7	8	7	8	7	8
Operational Feasibility – Condition of infrastructure and services	5	6	5	6	5	6	5	6	5	6	5	6	5	6	5	6	5	6	5	6	5	6
Total Score Range (min–max)	45	52	33	40	31	38	41	48	37	44	33	40	43	50	47	54	25	32	37	44	39	46
IDP's estimated Pressure	14%; Score 4: 50,000–99,999 IDPs or 11–20% of population						18%; Score 4: 50,000–99,999 IDPs or 11–20% of population						4%; Score 2: 1,000–9,999 IDPs or 2–5% of population						10%; Score 3: 10,000–49,999 IDPs or 6–10% of population			
Humanitarian Actors Presence	Strong presence						Moderate presence						Limited presence						Strong presence			

This structured approach ensured that the selection of intervention areas is evidence-based, balancing humanitarian needs with practical and operational realities. These results led to the inclusion of three states, in the next phase of the Needs Assessment, namely Gedaref, White Nile, and Red Sea, with the exclusion of Sennar State.

Table 5: final scores and ranking

State	Total Score Average (min–max)	IDPs	Humanitarian actors' presence	Final Score	Selected districts
Red Sea (included)	41.5	3	4	48.5	Swakin, Port Sudan
Gedaref (included)	39.8333	4	4	47.8	Gedaref, Al Rahad
White Nile (included)	40.5	4	3	47.5	Ad Duwaim, Kosti
Sennar (excluded)	41.8333	2	3	46.8	

Step 4 Finally the baseline and need assessment study was finalized on the selected states and localities to gather a better understanding of the situation on the ground, the study assessed also a total of 12 health facilities. The main outcomes of the study are the following (**for complete report see Annex 01**):

GEDAREF STATE

Gedaref faces severe demographic and displacement pressures, with high malnutrition rates and strained health infrastructure. While facilities exist in numbers, they lack depth, staffing, and supplies, making the system fragile and dependent on partners. PHC services are uneven, with evident gaps in emergencies, nutrition stabilization, and maternal care. Financial barriers, weak HIS, and limited rural coverage compound vulnerabilities. Despite a strong humanitarian presence, Gedaref remains a high-priority state for health and nutrition interventions.

1. Demographics and Population Pressure

- Total population: ≈3.85 million; children under five make up 18% (694,332), reflecting high fertility and youth dependency.
- High child shares in Al-Rahad (18.2%), Al-Fashaga (18%), and Eastern Galabat (16.7%) drive demand for maternal and child health services.
- Gedaref hosts ≈475,000 IDPs (95% displaced post-April 2023), equal to 14% of the state's population.
- Most IDPs live with host families (79%), straining housing, health, and food systems.

2. Food Security and Nutrition

- 29% (≈925,000 people) projected in Crisis (IPC 3+), including 61,000 in Emergency (IPC 4) by mid-2025.
- Child stunting: 46% (above national 38.2%); GAM: 15.4% (critical).
- Compared to Kassala, Gedaref has slightly less severe IPC levels but still high chronic malnutrition risk.

3. Health System Infrastructure

- 431 Health facilities: 43 hospitals, 93 PHC centers, 253 health units, 42 private.
- 96% functional, but quality compromised by:
 - 65% supply shortages, 61% staff shortages, 30% equipment gaps.
 - WASH deficits: 77% lack water, 89% sanitation, 88% hygiene.
 - Waste management failures: 96% unsafe disposal.
 - Power reliability issues (64%) weaken cold chain capacity.
- Heavy reliance on partners (97% facilities supported externally), creating fragility.

4. Service Availability & Gaps

- Emergency/Referral Care: Weak – only 26% ambulances functional, 49% lack triage, 80% lack emergency capacity.
- Child health: IMCI clinics in 61% of facilities, but CMAM (11%) and SAM stabilization (6%) are critically low.
- Communicable disease: Malaria/TB control insufficient, surveillance patchy.
- Maternal care: Family planning available, but emergency obstetric and GBV services nearly absent.
- NCDs & Mental health: Largely neglected.

5. PHC Infrastructure (Field Assessment)

- Sampled 4 PHCs (Gedaref & Al-Rahad): buildings intact, basic ANC/PNC, immunization, and labs available.
- Gaps:
 - Emergency/labor rooms only in 50–75%.
 - No advanced diagnostics (X-ray, ECG, ultrasound).
 - Stock-outs.
 - Ambulances present in only 25% of facilities.
 - Weak patient comfort (seating, privacy).

6. Human Resources

- Shortages in specialists, nutritionists, radiologists, and social workers.
- Workforce mainly midwives, nurses, CHWs, and lab staff.
- Retention problems: low/delayed pay, workload, isolation, and lack of career development (reported by 100% of cadres).
- Training gaps: nearly half had no refresher training in 2 years.

7. Service Access & Community Perceptions

- Financial barriers: 54% cited medicine costs; others noted transport and lab fees. Nearly all PHCs charge user fees (92.5% formal, 5.3% informal).
- Coping strategies: delaying care (32%), waiting until severe illness (30%), using traditional healers (24%), or selling assets (18%).
- Still, 40–55% reported no significant financial barriers.
- Community feedback: Concerns about long waiting times, drug shortages, poor water/sanitation, and weak trust in facility readiness.

8. Health Information Systems (HIS)

- Gaps: poor digitalization, weak accountability, lack of HIS focal persons.
- Only 45.7% of under-five children have proper growth monitoring records.
- Some consistency in reporting to local health departments, but little evidence of data being used for decision-making.

9. Locality Ranking and Vulnerability

- Gedaref scored high in vulnerability:
 - High GAM (15.4%) & stunting (46%).
 - Low health worker density: 0.82 per 1,000 in Gedaref locality vs. 2.1 in Al-Rahad.
 - Security constraints: SAF/RSF checkpoints, seasonal floods cutting off access.
- Strong humanitarian actor presence (>40 agencies in Gedaref town), but peripheral localities underserved.

10. Main Baseline Indicators (See Annex 01)

- 0% PHCs provided full-quality PHC package.
- Outpatient consultations: ≈9,450/month across selected PHCs.
- 55.3% of children screened for acute malnutrition.
- 90.3% of deliveries attended by skilled personnel (21% still at home).
- 82.5% immunization coverage (6–59 months).

Health Facilities selected for study purposes– Gedaref State

No.	Locality	Health Center	GPS Coordinates
1.	Gedaref	Abayo Shimal HC	14.008565,35.403141
2.		Hai Al-Nazir HC	14.033342,35.339091
3.	Al-Rahad	Al-Hawata HC	13.415029,34.624804
4.		Al-Hijrah (Wad Al-Shair) HC	13.4115173,34.63638

RED SEA STATE

Red Sea State has better service continuity and stability than Gedaref, with strong urban-based infrastructure in Port Sudan, but it suffers from unequal coverage, chronic drug shortages, and weak rural capacity. While cultural and gender barriers are minimal, systemic gaps—especially in emergency care, diagnostics, NCDs, and mental health—remain severe. Communities generally trust and value PHCs, but drug stockouts, wait times, and limited hours erode confidence. Red Sea is less insecure but highly vulnerable to seasonal access barriers and dependence on external partners.

1. Demographics & Context

- Population: ~1.5M spread across 9 localities. Port Sudan (487k) is the dominant urban hub and Sudan's de facto administrative capital since 2023.
- Children under five: ~18%, reflecting high fertility.
- Hosts IDPs displaced from conflict zones, though less concentrated than in Gedaref; displacement still strains services.
- Geography: Harsh, arid terrain with seasonal flooding (July–Sept) disrupting access.

2. Health System Infrastructure

- Facilities: mix of PHCs, hospitals, and private clinics, concentrated in Port Sudan; rural localities underserved.
- Functionality: Most facilities are operational but suffer drug stock-outs (60%), poor infrastructure (70%), and supply shortages (65%+).
- Utilities: Frequent power outages, unreliable water supply, weak waste management.
- Heavy reliance on NGO/UN support, especially in training and supply.

3. Human Resources

- Cadre imbalance: Shortages in specialists (OBGYN, paediatrics, surgery), midwives, and nutritionists; sometimes overstaffing in lab technicians.
- Training: 60% received refresher training in past 2 years, but coverage is uneven; NGOs provide nearly half of training.
- Retention: Challenged by low incentives, workload, and lack of career pathways.

4. Service Delivery & Access

- Core services: Nutrition (100%) and child health (100%) consistently available.
- Partial coverage: Family planning (67%), maternity care (67%), pharmacy (78%), health education (89%).
- Major gaps: Inpatient (11%), emergency/trauma (22%), HIV/TB (22%), chronic disease (22%), mental health (44%).
- Beneficiary flow: 25–35 patients/day; long waits in urban PHCs (up to 1 hr); shorter waits in rural ones.
- Fees: Port Sudan PHCs charge 4,600–5,000 SDG/visit; Swakin PHCs largely free.

5. Community Perspectives

- Barriers:
 - Drug shortages (43%) – main concern.
 - Long waits (27%), irregular hours/closures (26%).
 - Distance (15%) and cost (10%) less important.
 - Gender/cultural issues negligible (0% cited).
- Perceptions: 72% rated PHC services positively; cleanliness and staff behaviour scored highest, drug availability lowest.

6. Health Financing

- User fees: Mixed model – 76% report fees exist; 64% formal/posted, 14% informal, 19% free.
- Financial barriers:
 - 28% seek care only when very sick.
 - 26% resort to traditional healers/home remedies.
 - 7% sell assets or borrow for care.

7. Health Information Systems (HIS)

- Strengths: Port Sudan facilities use standard tools and digital reporting (DHIS2/Excel).
- Weaknesses: Swakin PHCs lack proper data entry, accountability, and data-use culture.
- Only 37.5% of HIS staff trained; poor internet/power limits reporting.

8. Disease Burden

- Top conditions: Malaria (100% facilities), hypertension (100%), diabetes (100%), diarrheal diseases (75%), ARI (50%).
- Other burdens: Maternal complications (63%), malnutrition (38%), TB (19%), trauma (19%).
- HIV prevalence is negligible (0%).

9. Security & Access

- 93% reported no insecurity disruptions.
- Seasonal flooding cuts access in July–Sept (29% cited).
- Community safety is generally high (85% always feel safe).

10. Baseline Indicators (See Annex 03)

- PHCs with full package: 25% (1/4 facilities).

- Children with proper growth monitoring: 56%.
- Outpatient consultations: ≈2,850/month (≈95/day).
- Skilled deliveries: 94% (15% still at home).
- Immunization (6–59 months): 72%.
- Children screened for malnutrition: 71%.
- Facilities functional during conflict: 97%.

Health Facilities selected for study purposes – Red Sea State

No.	Locality	Health Center	GPS Coordinates
1.	Swakin	Al-Mohandiseen HC	19.104660,37.332340
2.		Hai Al-Omda HC	18.662975 37.345075
3.	Port Sudan	Um Al-Qura HC	19.617850, 37.220220
4.		Daim Al-Noor HC (Al-Hijra HC)	19.617940,37.216820

WHITE NILE STATE

White Nile shows broad PHC coverage and strong community trust, but system fragility is masked by high facility “functionality” figures. In reality, WASH, waste management, power, and inpatient care are critically weak. While maternal and child health indicators are relatively strong (high skilled birth attendance, good immunization), sustainability is undermined by partner dependency, user fee barriers, and stockouts. HIS systems remain underdeveloped, limiting evidence-based planning. Seasonal floods and conflict-driven shortages exacerbate fragility. White Nile is moderately ranked in vulnerability, but high IDP pressure and systemic weaknesses make it a critical state for support.

1. Demographics & Context

- Population: ~920,000, concentrated in Ad Duwaim (492k) and Kosti (428k) localities.
- Children <5: ~17% of total population.
- Hosts large IDP influx (~26% acutely food insecure), adding pressure to already stretched services.

2. Health System Infrastructure

- 98% of facilities are partially functional, but vulnerabilities include:
 - 22 below capacity, 4 non-functional.
 - WASH gaps: 74% lack water, 93% lack sanitation, 93% lack hygiene.
 - Waste management failures: 85% no segregation, 84% no safe sharps disposal.
 - Power supply unreliable in 57%, though cold chain holds up (94%).
- Inpatient capacity is severely constrained: 44% ICU, 59% maternity, 37% general beds insufficient.
- 97% of facilities supported by partners, showing dependency.

3. Human Resources

- Staffing profile: midwives, nurses, CHWs, and lab staff dominate; shortage of specialists.
- Training coverage: 37.5–40% received HIS/M&E training; gaps in refresher courses and skills development.
- Staff face workload and retention problems, but community praised their professionalism and respectful treatment.

4. Service Delivery & Utilization

- Strengths:
 - All facilities provide labs, pharmacy, and referrals.
 - Chronic disease care (HTN, diabetes) in 88%.
 - Maternal & child health (ANC, FP, nutrition, PNC) available in 75%.
- Gaps:
 - Outpatient/general consultations & immunization in only 50%.

- Inpatient services: 12.5% availability.
- Absent services: HIV, TB, MHPSS, emergency trauma care.
- Patient flow:
 - 60–150 daily visits, 1,560–4,000/month.
 - Long waiting times (30–60 mins).
 - Fees 3,000–5,000 SDG per visit; some exemptions (e.g., Al-Goom).

5. Community Perceptions

- Positive: 83% satisfied/very satisfied; praised staff conduct, cleanliness, reliability.
- Negative: drug shortages, waiting times, lack of specialists.
- Cultural/gender barriers:
 - 100% of community respondents denied such barriers.
 - But health staff noted restrictions on women’s mobility without male permission.

6. Health Financing

- 100% PHCs charge user fees, formally posted.
- Barriers:
 - 44% cited transport costs.
 - 34% medicine costs.
 - 20% accommodation during referral.
- Impacts:
 - 49% delay care until illness severe.
 - 22% turn to traditional healers.
 - 21% sell assets or borrow.

7. Health Information Systems (HIS)

- Uneven functionality:
 - 3/4 facilities report regularly; 1 (Al-Goom) entirely disconnected.
 - No HIS focal persons in any facility.
- Training gap: only 25% of staff trained in HIS.
- Challenges:
 - 38% lack trained staff.
 - 50% poor internet/power.
 - 63% delays in receiving data.
- Limited evidence of data being used for decision-making.

8. Maternal & Child Health

- Child nutrition: 73% screened for malnutrition; only 52% had systematic growth monitoring.
- Immunization: 72% coverage; 20% faced vaccine stockouts.
- Skilled birth attendance: 94% (53% hospital, 15% home, 31% private).
- Referral system: reported in all PHCs, but weak functionality.

9. Security & Access

- Community safety: 100% report always feeling safe.
- Seasonal access: 17% report rainy season (Aug–Oct) floods block access.
- Facility disruption: 63% reported supply/staff shortages or service suspensions due to conflict.
- No armed checkpoints or attacks reported in past 12 months.

10. Baseline Indicators (See Annex 03)

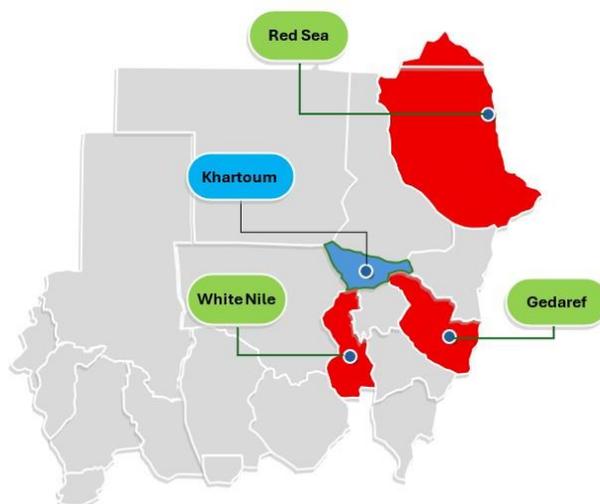
- PHCs with full package: 0%.
- Outpatient consultations: ≈9,460/month (~315/day).
- Skilled deliveries: 94% (15% home births).
- Children screened for malnutrition: 73%.
- Immunization (6–59m): 72%.
- Facilities consistently functional: 98%.

Health Facilities selected for study purposes – White Nile State

No.	Locality	Health Center	GPS Coordinates
1.	Kosti	Abubakr Satti HC	13.173941,32.658070
2.		Al-Goom HC	13.151924,32.648922

3.	Al-Duwaim	Al-Hai Al-Sabie HC	13.998318,32.312870
4.		Al-Hai Al-Ashir	14.013741,32.272461

Figure 2: geographical areas of intervention



General overview on food Insecurity and Health Vulnerabilities within Gedaref, Red Sea and White Nile States.

Health system fragility is compounded by acute food insecurity. Within HealthPRO 2 areas, the most severe conditions are concentrated in Ad-Duaim, Kosti, where up to 40% of the population falls within IPC Phases 3–4 - Crisis/Emergency – of the IPC Acute Food Insecurity Phase Classification (IPC scale) (A five-phase system (None/Minimal, Stressed, Crisis, Emergency, Catastrophe/Famine) used to assess food insecurity severity; P3+ refers to populations in Phase 3 or worse, facing severe acute food insecurity and needing urgent humanitarian assistance). These localities represent priority areas for urgent humanitarian interventions to avert deterioration in health and nutrition outcomes. Port Sudan and Sawakin, while relatively better off, still host tens of thousands of individuals in acute need, underscoring the systemic fragility even in nominally better-performing urban centers.

Table 6: IPC Acute Food Insecurity Phase Classification in 8 Localities

	Area Phase	Total # (pp)	Phase 1		Phase 2		Phase 3		Phase 4		Phase 5		P3+	
			#	%	#	%	#	%	#	%	#	%	#	%
Al Rahad	3	328,198	113,760	35%	132,388	40%	82,050	25%	0	0%	0	0%	82,050	25%
Gedaref	3	250,087	75,026	30%	100,035	40%	75,026	30%	0	0%	0	0%	75,026	30%
Ad Duwaim	3	771,891	153,269	20%	348,460	45%	231,568	30%	38,595	5%	0	0%	270,163	35%
Kosti	3	196,093	39,219	20%	78,437	40%	58,828	30%	19,609	10%	0	0%	78,437	40%
Port Sudan	2	551,726	247,168	45%	249,386	45%	55,173	10%	0	0%	0	0%	55,173	10%
Sawakin	2	100,025	50,013	50%	40,010	40%	10,003	10%	0	0%	0	0%	10,003	10%

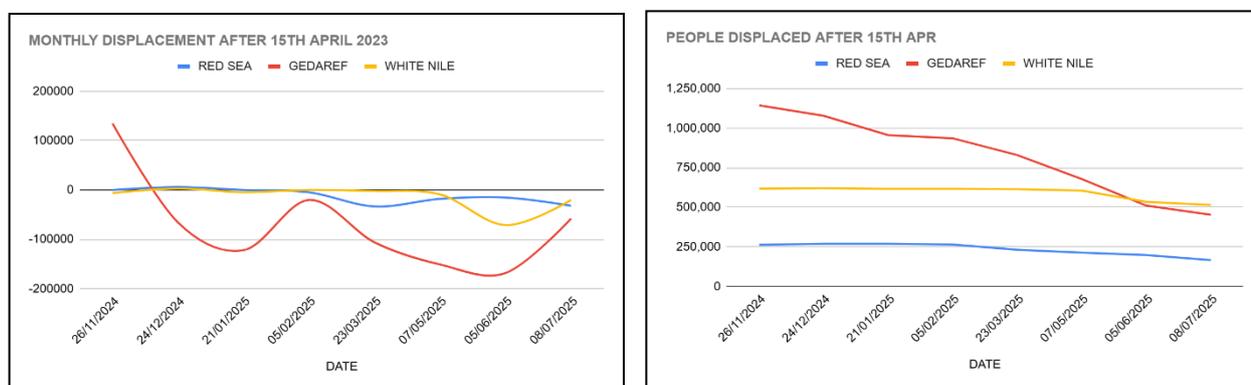
General overview on displacement as a System Stressor within Gedaref, Red Sea and White Nile States.

The presence of internally displaced persons (IDPs) further strains already overstretched services. White Nile bears the heaviest burden, with IDPs constituting 18% of the total population, significantly amplifying demand on health facilities. Gedaref also experiences high displacement, with 14% of residents identified as IDPs, overloading available services and staff. Even in Red Sea, where displacement affects 10% of the population, the additional demand is substantial. Overall, displacement represents a critical driver of health system stress, with White Nile the most acutely affected.

Table 7: Percentage of IDPs in State Population

	Population	N. IDPS	IDP Population (% of Total)
Gedaref State	3,160,180	453,146.00	14%
White Nile	2,884,594.00	514,597.00	18%
Red Sea	1,656,784.00	166,968.00	10%

Table 8: displacement trends in the 3 States



It is of note that, while the first assessment identified the 3 states of implementation as Gedaref, Red Sea and White Nile, the recent stabilisation of Khartoum state has made it viable for small interventions. As such Khartoum states and specifically Khartoum city has been added to the areas of implementation.

KHARTOUM STATE

After nearly three years of conflict, Khartoum has recently become accessible to humanitarian actors. Although the overall security situation has stabilized in recent weeks, the health system remains severely disrupted following prolonged hostilities, displacement of health workers, damage to infrastructure, and interruptions in supply chains.

The State Health Cluster Khartoum (SHCKTM) has resumed coordination meetings and begun consolidating priority needs. Health partners report significant operational and systemic gaps affecting the delivery of primary health care (PHC) services.

Disruption of Primary Health Care Services

The conflict has affected the functionality of health facilities across the state. Gaps include shortages of essential medicines, limited availability of controlled drugs (including mental health medicines), delays in procurement and importation, and unclear referral pathways. Expectations placed on PHC facilities in Khartoum often exceed standard PHC scope (e.g., diagnostic imaging), placing additional pressure on already weakened services.

The referral system remains weak, with some patients referred outside the state due to limited. At the same time, user fees in some facilities create tension with humanitarian principles of free-of-charge service provision.

Domain	Identified Gap	Operational Impact
Essential Medicines	WHO supply pipeline is currently limited in flexibility and coverage; last-mile transport funding reduced;	Increased risk of stock-outs at PHC level, interruption of treatment protocols, reliance on incomplete therapeutic regimens, and reduced continuity of care for acute and chronic conditions.
Controlled Drugs (incl. Mental Health Medicines)	Distribution of controlled medicines remains highly regulated and centralized through MoH mechanisms, with limited availability at PHC facilities.	Incomplete implementation of the WHO mhGAP package at primary health care level, resulting in limited identification, management and follow-up of mental health conditions, and interruptions in the continuity of MHPSS services due to staff shortages and restricted availability of psychotropic medicines.
PHC Scope and Service Expectations	Community and local authorities expect PHC facilities to provide services beyond the standard primary package (e.g., ultrasound, x-ray diagnostics).	Diversion of limited PHC resources, pressure on facility staff, mission creep, and potential inefficiencies in service delivery planning and budgeting.
Referral Pathways	Referral system between PHC and secondary/tertiary care is weak, poorly standardized, and sometimes results in out-of-state referrals due to limited in-state capacity.	Delayed access to specialized care, increased patient costs and transport barriers, loss to follow-up, and higher risk of adverse clinical outcomes.
Training and Capacity Building	Limited availability of certified facilitators for IMCI and iCCM; high logistical costs and coordination challenges for training deployment.	Inconsistent adherence to clinical protocols, reduced quality of paediatric case management, and variability in service standards across supported facilities.

Rising Burden of Communicable Diseases

Recent epidemiological updates highlight a sharp increase in malaria and dengue cases, particularly in areas experiencing population returns and infrastructure disruptions. In Epi Week 3, over 9,000 malaria cases were reported, predominantly in Karrari and Sharq Al-Neel localities, while dengue cases increased significantly in Khartoum locality. Other epidemic-prone diseases detected through EWARS include measles, pertussis and scabies.

Field reports indicate high proportions of severe malaria, especially among children, suggesting delayed care-seeking and insufficient preventive measures. Acute malnutrition cases have also been identified among children aged 1–5 years, further increasing vulnerability to infection and adverse outcomes.

Limited vector control measures, poor environmental health conditions and shortages of pediatric malaria supplies are placing additional strain on service delivery.

Epidemiological Situation – Key Reported Data Khartoum State			
Based on EWARS Epidemiological Report, Epi Week 3: 17–23 January 2026			
Indicator	Latest Reported Data (Khartoum State)	Geographic Notes	Key Implications
Malaria	>9,000 cases reported in Epi Week 3 (17–23 Jan 2026)	Predominantly Karrari and Sharq Al-Neel localities	Leading cause of morbidity; high burden on PHC facilities
Severe Malaria	270 severe cases reported in January 2026 (partner data, Mayo area sample)	Mayo neighbourhood, Khartoum locality	Indicates delayed care-seeking; high paediatric risk
Dengue	Increased from 344 cases (Epi Week 2) to 434 cases (Epi Week 3: 17–23 Jan 2026)	Khartoum locality identified as emerging focal area	Linked to returns, poor WASH and infrastructure disruption
Measles	25 cases reported in Epi Week 3 (17–23 Jan 2026)	Reported within Khartoum State through EWARS	Reflects immunization coverage gaps

Pertussis	14 cases reported in Epi Week 3 (17–23 Jan 2026)	Khartoum State	Indicative of routine EPI disruption
Scabies	32 cases reported in Epi Week 3 (17–23 Jan 2026)	Khartoum State	Suggests overcrowding and compromised living conditions
Acute Malnutrition	112 children identified in January 2026 (38 SAM cases)	Mayo area, Khartoum locality	Increased vulnerability among children 1–5 years

Immunization System Disruption

The Expanded Programme on Immunization (EPI) has been significantly affected by the conflict. All EPI premises across Khartoum State have been impacted, with the exception of Karrari locality. An increase in vaccine-preventable diseases has been reported, attributed to disruption of routine immunization services.

Vaccination campaigns for measles, diphtheria and polio are planned; however, gaps in partner engagement and health promotion activities have been noted during recent campaigns. Laboratory capacity constraints further complicated surveillance and response, with some samples transferred to other states for testing.

Indicator	Current Situation	Operational Implications
EPI Infrastructure	All EPI premises across Khartoum State have been affected by the conflict, with the exception of Karrari locality. Damage includes infrastructure disruption, equipment loss, and reduced functionality.	Reduced routine immunization coverage, interruption of outreach services, and weakened cold chain integrity, increasing the risk of vaccine-preventable disease outbreaks.
Vaccine-Preventable Diseases (VPDs)	Reported increase in measles, diphtheria and other VPDs following prolonged disruption of routine immunization services.	Elevated outbreak risk, particularly among children under five; need for catch-up vaccination and strengthened surveillance.
Laboratory Capacity	Diphtheria and AFP samples are transferred to River Nile State due to limited in-state laboratory capacity; measles testing remains partially functional.	Delays in confirmation of suspected cases, slower outbreak response, and weakened disease surveillance efficiency.

TB/HIV and Continuity of Chronic Care

Continuity of care for TB and HIV patients remains fragile. Approximately 17 facilities were reported functional at varying levels by end-December, with gradual restoration of GeneXpert services in selected localities. However, information gaps within hospitals and poor internal referral systems contribute to inefficiencies and misperceptions of stock availability.

Human Resources and Coordination Constraints

Health workforce availability remains uneven. Remapping staff following displacement and restoration of regular salary payments are identified priorities for 2026. Variations in incentive practices among actors have been highlighted, with a call for harmonization under existing Health Cluster frameworks.

Administrative and coordination challenges persist, including confusion regarding MoH technical agreements and registration requirements, and delays in reporting and procedural compliance. Strengthened alignment with State Ministry of Health structures and humanitarian coordination mechanisms is therefore critical.

Supply Chain Limitations

The health supply pipeline remains constrained. Reduced donor funding has affected last-mile transport capacity, and partners have been advised to budget essential supplies directly, as centralized pipelines cannot guarantee full coverage of needs. Importation delays and procurement bottlenecks further limit timely replenishment of stocks.

General overview on displacement as a System Stressor within Gedaref, Red Sea, White Nile and Khartoum States.

As of December 2025, Khartoum State hosted an estimated 330,956 internally displaced persons (IDPs) across seven localities, marking a three per cent increase compared to the previous month. The increase was primarily driven by displacement from North Darfur and the Kordofan region. While 64 per cent of IDPs were displaced within Khartoum State, others originated mainly from North Kordofan (14%), North Darfur (8%) and Aj Jazirah (5%). Most IDPs were concentrated in Karrari (34%), Um Bada (23%) and Um Durman (18%), largely due to relative stability. The vast majority resided in urban areas (92%), predominantly with host families (81%) or in rented accommodation (12%).

Following escalations in Al Fasher and the Kordofan region in late October 2025, more than 15,000 additional individuals were displaced to Khartoum.

At the same time, Khartoum recorded an estimated 1,458,103 returnees, representing a four per cent increase and accounting for 42 per cent of all returns nationwide. Most returnees (93%) returned from internal displacement, while seven per cent returned from abroad, mainly from Egypt. The majority resettled in urban neighborhoods and returned to their habitual residences. Improved security was cited as the primary reason for return (91%), although family reunification and depletion of resources in displacement areas also contributed.

Overall, Khartoum is experiencing simultaneous displacement inflows and large-scale returns, significantly increasing pressure on urban infrastructure, housing and essential services, including primary health care.

Population Movements – Khartoum State (December 2025)		
Indicator	Data	Key Notes / Implications
Internally Displaced Persons (IDPs)		
Total IDPs	330,956 individuals	+3% compared to previous month
Locations	1,017 locations across 7 localities	Statewide presence
Origin of IDPs	64% displaced within Khartoum; 14% North Kordofan; 8% North Darfur; 5% Aj Jazirah	Increase from North Kordofan linked to ongoing insecurity
Main Localities of Settlement	Karrari (34%); Um Bada (23%); Um Durman (18%)	Concentration in relatively stable areas
Urban vs Rural	92% urban; 8% rural	High pressure on urban services
Living Arrangements	81% with host families; 12% rented accommodation	Increased strain on host communities and housing market

Returnees		
Indicator	Data	Key Notes / Implications
Total Returnees	1,458,103 individuals	+4% increase; 42% of all returns nationwide
Origin of Return	93% from internal displacement; 7% from abroad	80% of external returns from Egypt
Return From (within Sudan)	32% from within Khartoum; 25% from River Nile; others from Northern, Red Sea, Aj Jazirah, Gedaref, Kassala, White Nile	Strong intra-state and regional mobility
Urban vs Rural	81% urban	Reinforces urban service pressure
Housing Situation	96% in habitual residence; 2% with hosts; 2% in collective centers	Limited but existing secondary vulnerability
Reasons for Return	91% improved security; 5% family reunification; 3% resource depletion	Security-driven but partly economically motivated

b. Objectives of the programme and priority issues

The **global objective** of this call for proposals is to improve the health conditions of vulnerable populations affected by extreme poverty, food insecurity and malnutrition in Sudan including IDPs, refugees and Host Communities

The **specific objective** of this call for proposals is to increase sustainable access to and demand for quality Primary Health Care (PHC), nutrition and Water, Sanitation and Hygiene (WASH) services in targeted States, including for host communities, Internally Displaced Persons (IDPs) and refugees. The priorities of this call for proposals (and associated activities) are:

Result 1: *Primary healthcare, nutrition and Water, Sanitation and Hygiene (WASH) services at Primary Health Care (PHC) centre and community level improved, including for IDPs, refugees and host communities, with particular reference to women and girls and people with disabilities (PwD).*

- 1.1. Strengthen Primary Health Care (PHC) infrastructure including Nutrition, Water, Sanitation and Hygiene (WASH) through the construction of communal latrines and ensuring access to safe drinking water.
- 1.2. Procurement of essential medical drugs and supplies for targeted PHC facilities.
- 1.3. Support public health disease surveillance including early warning and response capacity at PHC/local level.
- 1.4. Strengthen referral mechanisms between community, PHCs and rural hospitals (supported with critical services including quality Emergency Obstetric Care) EmOC.
- 1.5. Strengthen monitoring and follow ups.

Result 2: *Management capacity and accountability of local health systems strengthened.*

- 2.1 Strengthen capacity at State and Local levels.
- 2.2 Build or reinforce a local Health Information System.
- 2.3 Strengthen and formalize Community Health Committees, train them on public health and health management and social accountability approaches, and facilitate their engagement with the community, PHC and LHD.

Result 3: *Socio-cultural behavioural and gender barriers to health and nutrition are reduced.*

- 3.1 Assess awareness-raising and Social and Behavioural Change (SBC) needs related to PHC and nutrition.
- 3.2 Develop and implement awareness raising and behavioural change strategies, using standard key family practice integrated messaging.
- 3.3 Train key frontline staff and volunteers while support SBC Coordination and Advocacy at local and state levels.

c. Financial allocation provided by the contracting authority

The overall indicative amount made available under this call for proposals is **EUR 4.800.000,00**

The contracting authority reserves the right not to award all available funds.

Indicative allocation of funds by lot/geographical distribution:

This call for proposals is divided into 2 Lots according to the following indicative allocation of funds

LOT	TARGET		PRIORITY OF INTERVENTION	AVAILABLE AMOUNT
	Sates	Localities ¹	Clinics ²	
LOT A	Gedaref	Gedaref	Abayo Shimal HC	€ 4,000,000.00
			Hai Al-Nazir HC	
		Al Rahad	Al-Hawata HC	

¹ Localities of intervention can be changed (within the same state) if needs are demonstrated within the proposal. See paragraph 2.1.3 Eligible actions: actions for which an application may be made

² Clinics of intervention can be changed (within the same state) if needs are demonstrated within the proposal. See paragraph 2.1.3 Eligible actions: actions for which an application may be made

	White Nile	Ad Duwaim	Al-Hijrah (Wad Al-Shair) HC	
			Al-Hai Al-Sabie HC	
		Kosti	Al-Hai Al-Ashir	
			Abubakr Satti HC	
	Red Sea	Swakin	Al-Goom HC	
			Al-Mohandiseen HC	
		Port Sudan	Hai Al-Omda HC	
			Um Al-Qura HC	
			Daim Al-Noor HC (Al-Hijra HC)	
	LOT B	Khartoum	Khartoum	

Size of grants

Any grant requested under this call for proposals fall between the following minimum and maximum amount:

Lot A (Gedaref, White Nile and Red Sea)

- minimum amount: EUR 1.000.000,00
- maximum amount: EUR 4.000.000,00

Lot B (Khartoum)

- minimum amount: EUR 500.000,00
- maximum amount: EUR 800.000,00

The cost-based component(s) of any grant requested under this call for proposals must not exceed the maximum below percentage

- Maximum percentage: 90 % of the total eligible costs of the action (see also Section 2.1.4.).

The balance (i.e. the difference between the total cost of the action and the amount requested from the contracting authority) must be financed from sources other than the general budget of the Union or the European Development Fund³.

The grant may cover the entire eligible costs of the action if this is deemed essential to carry it out. If that is the case, the lead applicant must justify full financing in Section 2.1 of Part B of the grant application form. The validity of the justification provided will be examined during the evaluation procedure. The absence of any justification may lead to the rejection of the application.

2. Rules for this call for proposals

These guidelines set out the rules for the submission, selection and implementation of the actions financed under this call, in conformity with the practical guide (PRAG), which is applicable to the present call (available on the internet at this address

<https://wikis.ec.europa.eu/display/ExactExternalWiki/ePRAG>).⁴

2.1 Eligibility criteria

There are three sets of eligibility criteria relating to:

³ Where a grant is financed by the European Development Fund, any mention of European Union financing must be understood as referring to European Development Fund financing.

⁴ Note that a lead applicant (i.e. a coordinator) whose pillars have been positively assessed by the European Commission and who is awarded a grant will not sign the standard grant contract published with these guidelines, but a contribution agreement based on the contribution agreement template. All references in these guidelines and other documents related to this call to the standard grant contract shall in this case be understood as referring to the relevant provisions of the contribution agreement template.

- (i) the actors (2.1.1.):
 - (ii) the ‘**lead applicant**’, i.e. the entity submitting the application form.
 - a. if any, its **co-applicant(s) (where it is not specified otherwise the lead applicant and its co-applicant(s) are hereinafter jointly referred as ‘applicant(s)’)**;
 - b. and, if any, **affiliated entity(ies)** to the lead applicant and/or to a co-applicant(s);
- (iii) the actions (2.1.3.):
 - a. actions for which a grant may be awarded.
- (iv) the eligible costs or results/conditions (2.1.4.):
 - a. where the grant takes the form of reimbursement of costs (totally or partially): the eligible costs, the types of cost that may be taken into account in setting the amount of the grant.
 - b. where the grant takes the form of financing not linked to costs (totally or partially): the eligibility conditions for the results/conditions.

2.1.1. Eligibility of applicants (i.e. lead applicant and co-applicant(s)) (applicable to both LOT A and B)

Lead applicant (acting individually, with no co applicant nor affiliated entity)

In order to be eligible for a grant, the lead applicant must:

- be a legal person **and**
- be non-profit-making **and**
- be a specific type of organization such as non-governmental organization⁵, public sector operator, local authority, international (inter-governmental) organization as defined by Article 159(1) of the EU Financial Regulation⁶ **and**
- be effectively established in⁷ countries eligible under NDCI – Global Europe funded programmes (see PRAG Annex a2a1 for the list of eligible countries), **and**
- be directly responsible for the preparation and management of the action with the co-applicant(s) and affiliated entity(ies), not acting as an intermediary **and**
- not being in any of the situations listed in Section 2.4. of the practical guide **and**
- be registered and active in the PADOR (Potential Applicant Data On-Line Registration, EU on-line database of legal entities) **and**
- be registered and authorized to implement activities in Sudan **and**
- be registered and/or authorized to implement activities in the states included in the respective proposals (Gedaref and/or Red Sea and/or White Nile States and/or **Khartoum state**⁸) **and**

⁵ For the avoidance of doubt, non-governmental organisation means a voluntary, independent from government, non-profit organisation, which is not a political party or a trade union (Article 2(48) FR).

⁶ International organizations are international public-sector organizations set up by intergovernmental agreements as well as specialized agencies set up by them; the International Committee of the Red Cross (ICRC) and the International Federation of National Red Cross and Red Crescent Societies are also recognized as international organizations. While the European Commission may assimilate other non-profit organizations to international organizations, this is not relevant for this call for proposals. Thus, a non-profit organization assimilated by the European Commission under Article 159(3) is not regarded as an international organization under this call for proposals.

⁷ To be determined on the basis of the organization’s statutes, which should demonstrate that it has been established by an instrument governed by the national law of the country concerned and that **its head office is located in an eligible country**. In this respect, any legal entity whose statutes have been established in another country cannot be considered an eligible local organization, even if the statutes are registered locally or a ‘Memorandum of Understanding’ has been concluded.

- have worked in the states included in the respective proposals (Gedaref and/or Red Sea and/or White Nile States and/or **Khartoum state**⁹) at least in the previous 1 year **and**
- have worked in Sudan at least in the previous 2 year **and**
- be specifically active in the field of health **and**
- have managed programmes funded by AICS and/or the EU in the past 2 years

Lead applicant (acting with co applicants and/or affiliated entities)

In order to be eligible for a grant, the lead applicant must:

- be a legal person **and**
- be non-profit-making **and**
- be a specific type of organization such as non-governmental organization¹⁰, public sector operator, local authority, international (inter-governmental) organization as defined by Article 159(1) of the EU Financial Regulation¹¹ **and**
- be effectively established in¹² countries eligible under NDCI – Global Europe funded programmes (see PRAG Annex a2a1 for the list of eligible countries), **and**
- be directly responsible for the preparation and management of the action with the co-applicant(s) and affiliated entity(ies), not acting as an intermediary **and**
- not being in any of the situations listed in Section 2.4. of the practical guide **and**
- be registered and active in the PADOR (Potential Applicant Data On-Line Registration, EU on-line database of legal entities) **and**
- be registered and authorized to implement activities in Sudan **and**
- have worked in Sudan at least in the previous 2 year **and**
- be specifically active in the field of health **and**
- have managed programmes funded by AICS and/or the EU in the past 2 years

The lead applicant may act individually or with co-applicant. Partnering with national organizations is not mandatory but highly recommended.

If awarded the grant contract, the lead applicant will become the beneficiary identified as the coordinator in Annex G (special conditions). The coordinator is the sole interlocutor of the contracting authority. It represents and acts on behalf of any other co-beneficiary (if any) and coordinates the design and implementation of the action.

Co-applicants

Co-applicants participate in designing and implementing the action, and the costs they incur are eligible in the same way as those incurred by the lead applicant.

⁸ **Activities in Khartoum must be demonstrated before 2022**

⁹ **Activities in Khartoum must be demonstrated before 2022**

¹⁰ For the avoidance of doubt, non-governmental organisation means a voluntary, independent from government, non-profit organisation, which is not a political party or a trade union (Article 2(48) FR).

¹¹ International organizations are international public-sector organizations set up by intergovernmental agreements as well as specialized agencies set up by them; the International Committee of the Red Cross (ICRC) and the International Federation of National Red Cross and Red Crescent Societies are also recognized as international organizations. While the European Commission may assimilate other non-profit organizations to international organizations, this is not relevant for this call for proposals. Thus, a non-profit organization assimilated by the European Commission under Article 159(3) is not regarded as an international organization under this call for proposals.

¹² To be determined on the basis of the organization's statutes, which should demonstrate that it has been established by an instrument governed by the national law of the country concerned and that **its head office is located in an eligible country**. In this respect, any legal entity whose statutes have been established in another country cannot be considered an eligible local organization, even if the statutes are registered locally or a 'Memorandum of Understanding' has been concluded.

Co-applicants must satisfy the following eligibility criteria:

- be a legal person **and**
- be non-profit-making **and**
- be a specific type of organization such as non-governmental organization¹³, public sector operator, local authority, international (inter-governmental) organization as defined by Article 159(1) of the EU Financial Regulation¹⁴ **and**
- be effectively established in¹⁵ countries eligible under NDCI – Global Europe funded programmes (see PRAG Annex a2a1 for the list of eligible countries), **and**
- be directly responsible for the preparation and management of the action with the co-applicant(s) and affiliated entity(ies), not acting as an intermediary **and**
- not being in any of the situations listed in Section 2.4. of the practical guide **and**
- be registered and active in the PADOR is mandatory. In exceptional cases where PADOR registration is technically impossible for a local partner, the Contracting Authority may accept the 'Offline PADOR registration form (Annex F) **and**
- be registered and/or authorized to implement activities in the states included in the respective proposals (Gedaref and/or Red Sea and/or White Nile States and/or Khartoum state) **and**
- have worked in the states included in the respective proposals (Gedaref and/or Red Sea and/or White Nile States and/or Khartoum state) at least in the previous 1 year **and**
- be specifically active in the field of health **and**
- have managed programmes funded by AICS and/or the EU in the past 1 year is highly recommended but not mandatory.

Co-applicants must sign the mandate in Part B Section 4 of the grant application form.

If awarded the grant contract, the co-applicant(s) (if any) will become beneficiary(ies) in the action (together with the coordinator).

Affiliated entities

The lead applicant and its co-applicant(s) may act with affiliated entity(ies).

Only the following entities may be considered as affiliated entities to the lead applicant and/or to co-applicant(s):

Only entities having a structural link with the applicants (i.e. the lead applicant or a co-applicant), in particular a legal or capital link.

This structural link encompasses mainly two notions:

- (i) Control, as defined in Directive 2013/34/EU on the annual financial statements, consolidated financial statements and related reports of certain types of undertakings:
Entities affiliated to an applicant may hence be:

¹³ For the avoidance of doubt, non-governmental organisation means a voluntary, independent from government, non-profit organisation, which is not a political party or a trade union (Article 2(48) FR).

¹⁴ International organizations are international public-sector organizations set up by intergovernmental agreements as well as specialized agencies set up by them; the International Committee of the Red Cross (ICRC) and the International Federation of National Red Cross and Red Crescent Societies are also recognized as international organizations. While the European Commission may assimilate other non-profit organizations to international organizations, this is not relevant for this call for proposals. Thus, a non-profit organization assimilated by the European Commission under Article 159(3) is not regarded as an international organization under this call for proposals.

¹⁵ To be determined on the basis of the organization's statutes, which should demonstrate that it has been established by an instrument governed by the national law of the country concerned and that **its head office is located in an eligible country**. In this respect, any legal entity whose statutes have been established in another country cannot be considered an eligible local organization, even if the statutes are registered locally or a 'Memorandum of Understanding' has been concluded.

- Entities directly or indirectly controlled by the applicant (daughter companies or first-tier subsidiaries). They may also be entities controlled by an entity controlled by the applicant (granddaughter companies or second-tier subsidiaries) and the same applies to further tiers of control;
- Entities directly or indirectly controlling the applicant (parent companies). Likewise, they may be entities controlling an entity controlling the applicant;
- Entities under the same direct or indirect control as the applicant (sister companies).

(ii) Membership, i.e. the applicant is legally defined as a e.g. network, federation, association in which the proposed affiliated entities also participate, or the applicant participates in the same entity (e.g. network, federation, association...) as the proposed affiliated entities.

The structural link shall, as a general rule, be neither limited to the action nor established for the sole purpose of its implementation. This means that the link would exist independently of the award of the grant; it should exist before the call for proposals and remain valid after the end of the action.

By way of exception, an entity may be considered as affiliated to an applicant even if it has a structural link specifically established for the sole purpose of the implementation of the action in the case of so-called 'sole applicants' or 'sole beneficiaries'. A sole applicant or a sole beneficiary is a legal entity formed by several entities (a group of entities) which together comply with the criteria for being awarded the grant. For example, an association is formed by its members.

What is not an affiliated entity?

The following are not considered entities affiliated to an applicant:

- Entities that have entered into a (procurement) contract or subcontract with an applicant, act as concessionaires or delegates for public services for an applicant,
- Entities that receive financial support from the applicant,
- Entities that cooperate on a regular basis with an applicant on the basis of a memorandum of understanding or share some assets,
- Entities that have signed a consortium agreement under the grant contract (unless this consortium agreement leads to the creation of a 'sole applicant' as described above).

How to verify the existence of the required link with an applicant?

The affiliation resulting from control may in particular be proved on the basis of the consolidated accounts of the group of entities the applicant and its proposed affiliates belong to.

The affiliation resulting from membership may in particular be proved on the basis of the statutes or equivalent act establishing the entity (network, federation, association) which the applicant constitutes or in which the applicant participates.

If the applicants are awarded a grant contract, their affiliated entity(ies) will not become beneficiary(ies) of the action and signatory(ies) of the grant contract. However, they will participate in the design and in the implementation of the action and the costs they incur (including those incurred for implementation contracts and financial support to third parties and subcontractors) may be accepted as eligible costs, provided they comply with all the relevant rules already applicable to the beneficiary(ies) under the grant contract.

Affiliated entity(ies) must satisfy the same eligibility criteria as the lead applicant if they do not possess an implementing role or must satisfy the same eligibility criteria as the co-applicant(s) if they have an implementing role. They must sign the affiliated entity(ies) statement in Part B Section 5 of the grant application form.

2.1.2. Associates, contractors, recipients of financial support

The following entities are not applicants nor affiliated entities and do not have to sign the ‘mandate for co-applicant(s)’ or ‘affiliated entities’ statement:

- **Associates**

Other organizations or individuals may be involved in the action. Such associates play a real role in the action but may not receive funding from the grant, with the exception of per diem or travel costs. Associates do not have to meet the eligibility criteria referred to in Section 2.1.1. Associates must be mentioned in Part B Section 6 — ‘Associates participating in the action’ — of the grant application form.

- **Contractors**

The beneficiaries and their affiliated entities are permitted to award contracts (subcontracting or implementation contracts). Beneficiaries, affiliated entity(ies), recipients of financial support or associates cannot be also contractors in the project. Contractors are subject to the procurement rules set out in Annex IV to the standard grant contract.

Each actor should only participate in a single role in an action. This is to avoid any potential conflicts of interest and ensure clear allocation of rights and obligations as well as certainty on cost eligibility.

2.1.3. Eligible actions: actions for which an application may be made

Definition

An action is composed of a set of activities.

Duration

The initial planned duration of an action may not exceed 18 months.

Sectors or themes

1. Universal coverage of basic and/or essential health package
2. Emergency obstetric and newborn care
3. Referral among the primary and secondary health services
4. Gender-sensitive and gender-responsive
5. GBV prevention and management
6. Sexual and Reproductive Health Rights (SRHR)
7. Nutrition

Location

Actions must take place in all the following areas:

TARGET		PRIORITY OF INTERVENTION
Sates	Localities	Clinics
Gedaref	Gedaref	Abayo Shimal HC
		Hai Al-Nazir HC
	Al Rahad	Al-Hawata HC
		Al-Hijrah (Wad Al-Shair) HC
White Nile	Ad Duwaim	Al-Hai Al-Sabie HC
		Al-Hai Al-Ashir
	Kosti	Abubakr Satti HC
		Al-Goom HC
Red Sea	Swakin	Al-Mohandiseen HC
		Hai Al-Omda HC
	Port Sudan	Um Al-Qura HC
		Daim Al-Noor HC (Al-Hijra HC)
Khartoum	Khartoum	

The localities identified and selected for the baseline and need assessment should be prioritized for implementation. **Alternative localities will be considered only if detailed and thoroughly explained reasons are included in the submitted application. The explanation will have to include a new scoring, modeled based on the one included in the baseline and need assessment and will have to demonstrate that the alternative localities have a higher score for implementation. Finally, should the new localities be selected for implementation, a new baseline of the very same localities will have to be included in the proposal, using the same model indicators and tools of the study already produced. The proposal not containing a clear and identifiable targeting or containing a targeting different that the one proposed by these Guidelines, lacking the required justifications and additional info, will be rejected.**

The primary health facilities involved in interventions should be those serving host communities, Internally Displaced Persons (IDPs), and refugees within Gedaref, White Nile, Red Sea States included in the baseline and need assessment. It is essential to prioritize facilities that cater to vulnerable populations, including women, children, and individuals at risk of exclusion, ensuring that services are accessible, equitable, and delivered in accordance with the principles of inclusivity and non-discrimination. **Alternative health facilities will be considered only if detailed and thoroughly explained reasons are included in the submitted application. Should the new health facilities be selected for implementation, a new baseline of the very same facilities will have to be included in the proposal, using the same model indicators and tools of the study already produced. The proposal not containing a clear and identifiable targeting or containing a targeting different that the one proposed by these Guidelines, lacking the required justifications and additional info, will be rejected**

It is of note that Khartoum had not been originally included in the need assessment and baseline conducted by AICS, so forth implementation areas and clinics selected will be at applicants discretion. A justification of the selection of those areas will have to be included in the proposal, along with a rapid need assessment and a baseline.

Types of action

All proposed actions should contribute to sustainable improvements in access to and demand for quality Primary Health Care (PHC), nutrition, and Water, Sanitation and Hygiene (WASH) services in the targeted States, addressing the needs of host communities, Internally Displaced Persons (IDPs), and refugees and must fall within the project logic mentioned at paragraph 1.2 *Objectives of the Programme and Priorities*

Interventions must deliver measurable short- and long-term impact, using SMART, beneficiary-focused, and results-oriented indicators. Proposals should outline a coherent set of activities with clearly defined operational objectives, target groups, tangible outcomes, and a limited implementation timeframe.

Actions must be:

- Sustainable, scalable, and replicable.
- Inclusive and participatory, aligned with the principles of “*leave no one behind*” and “*do no harm*”.
- Responsive to the specific needs of the identified target groups.
- Supported by robust Monitoring & Evaluation and Risk Management mechanisms.
- Designed with careful consideration of potential risks and challenges within target communities.

The following types of action are ineligible:

- **actions concerned only or mainly with individual sponsorships for participation in workshops, seminars, conferences and congresses.**
- actions concerned only or mainly with individual scholarships for studies or training courses.
- actions and measures that may result in violation of human rights in partner countries or causing significant adverse effects on the environment or the climate¹⁶;

¹⁶ Article 29 NDICI.

Types of activity applicable to LOT A

The activities and related Results must be chosen from among those listed below:

Result 1: *Primary healthcare, nutrition and Water, Sanitation and Hygiene (WASH) services at Primary Health Care (PHC) center and community level improved, including for IDPs, refugees and host communities, with particular reference to women and girls and people with disabilities (PwD).*

- 1.1 Strengthen Primary Health Care (PHC) infrastructure including Nutrition, Water, Sanitation and Hygiene (WASH) through the construction of communal latrines and ensuring access to safe drinking water.
- 1.2 Procurement of essential medical drugs and supplies for targeted PHC facilities.
- 1.3 Support public health disease surveillance including early warning and response capacity at PHC/local level.
- 1.4 Strengthen referral mechanisms between community, PHCs and rural hospitals (supported with critical services including quality Emergency Obstetric Care) EmOC.
- 1.5 Strengthen monitoring and follow ups.

Result 2: *Management capacity and accountability of local health systems strengthened.*

- 2.1 Strengthen capacity at State and Local levels.
- 2.2 Build or reinforce a local Health Information System.
- 2.3 Strengthen and formalize Community Health Committees, train them on public health and health management and social accountability approaches, and facilitate their engagement with the community, PHC and LHD.

Result 3: *Socio-cultural behavioural and gender barriers to health and nutrition are reduced.*

- 3.1 Assess awareness-raising and Social and Behavioural Change (SBC) needs related to PHC and nutrition.
- 3.2 Develop and implement awareness raising and behavioural change strategies, using standard key family practice integrated messaging.
- 3.3 Train key frontline staff and volunteers while support SBC Coordination and Advocacy at locality and state levels.

One or more result and related activities can be included in the proposal.

For the accompanying monitoring system, see Annex 03. All indicators pertaining to the chosen results must be taken from the mentioned Annex; additional indicators can be added as long as those contained in Annex 03 are included.

Types of activity applicable to LOT B

The activities and related Results must be chosen from among those listed below:

Result 1: *Primary healthcare, nutrition and Water, Sanitation and Hygiene (WASH) services at Primary Health Care (PHC) center and community level improved, including for IDPs, refugees and host communities, with particular reference to women and girls and people with disabilities (PwD).*

- 1.1 Strengthen Primary Health Care (PHC) infrastructure including Nutrition, Water, Sanitation and Hygiene (WASH) through the construction of communal latrines and ensuring access to safe drinking water.
- 1.2 Procurement of essential medical drugs and supplies for targeted PHC facilities.
- 1.3 Support public health disease surveillance including early warning and response capacity at PHC/local level.
- 1.4 Strengthen referral mechanisms between community, PHCs and rural hospitals (supported with critical services including quality Emergency Obstetric Care) EmOC.
- 1.5 Strengthen monitoring and follow ups.

Result 2: *Management capacity and accountability of local health systems strengthened.*

- 2.1 Strengthen capacity at State and Local levels.
- 2.2 Build or reinforce a local Health Information System.

2.3 Strengthen and formalize Community Health Committees, train them on public health and health management and social accountability approaches, and facilitate their engagement with the community, PHC and LHD

One or more results and related activities can be included in the proposal.

For the accompanying monitoring system, see Annex 03. All indicators pertaining to the chosen results must be taken from the mentioned Annex; additional indicators can be added as long as those contained in Annex 03 are included.

Financial support to third parties¹⁷

Applicants may propose financial support to third parties in order to help achieving the objectives of the action.

The maximum amount of financial support per third party is EUR 60.000 except where achieving the objectives of the actions would otherwise be impossible or overly difficult, in which case this threshold can be exceeded.

In compliance with the present guidelines and notably of any conditions or restrictions in this Section, the lead applicant should define mandatorily in Section 2.1.1 of the grant application form:

- (i) the overall objectives, the specific objective(s) and the outputs¹⁸ (i.e. the results) to be achieved with the financial support
- (ii) the different types of activities eligible for financial support, on the basis of a fixed list
- (iii) the types of persons or categories of persons which may receive financial support
- (iv) the criteria for selecting these entities and giving the financial support
- (v) the criteria for determining the exact amount of financial support for each third entity, and
- (vi) the maximum amount which may be given.

In all events, the mandatory conditions set above for giving financial support (points (i) to (vi)) have to be strictly defined in the grant contract as to avoid any exercise of discretion.

Recipients of financial support cannot be designated in the lists of EU restrictive measures.

Visibility

The applicants must take all necessary steps to ensure the visibility of the European Union and of the contracting Authority (AICS) as the funder or co-founder of the action, through the correct and prominent display of the EU emblem and relevant funding statement. Unless the European Commission and AICS agree otherwise, actions that are wholly or partially funded by the European Union and AICS must ensure the visibility of EU and AICS financing by displaying the EU and AICS emblem in accordance with the guidelines set out in the Operational guidelines for recipients of EU funding, published by the European Commission.

All measures and activities relating to visibility and, if applicable, communication, must comply with the latest Communication and Visibility Requirements for EU-funded external action, laid down and published by the European Commission ([Communication and Visibility Requirements for EU External Actions | International Partnerships \(europa.eu\)](#)).

Derogation from contractual visibility obligations is permitted in exceptional situations, which may be required in the framework of this action due to security issues for the staff and beneficiaries, local political sensitivities, when this is in the interest of the beneficiary or the contracting authority. In such cases, visibility tools, products, and channels to be used in promoting a given action will be determined on a case-by-case basis, in consultation and agreement with the EU prior to limiting EU visibility. Requests for derogation from contractual visibility obligations should be included in Annex A.2 – Full application form and negotiated as part of the Special Conditions of the contract.

Number of applications and grants per applicants / affiliated entities

¹⁷ These third parties are neither affiliated entity(ies) nor associates nor contractors.

¹⁸ As per OECD DAC definition, the term ‘results’ includes ‘impact’ (overall objective), ‘outcome(s)’ (specific objective(s) and ‘output(s)’.

- The lead applicant may submit a maximum of 2 project proposal under this call for proposal, 1 per LOT
- The lead applicant may be awarded a maximum of 2 grants under this call for proposal, 1 per LOT.
- The lead applicant may not be a co-applicant or an affiliated entity in another application.
- A co-applicant/affiliated entity may be the co-applicant or affiliated entity in a maximum of 2 project proposal under this call for proposal, 1 per LOT
- A co-applicant/affiliated entity may be awarded a maximum of 2 project proposals under this call for proposal, 1 per LOT.

Form of the grant

The grants awarded under this call for proposals take the following form:

Reimbursement of eligible costs that may be based on the following form as per Section 2.1.4:

- (i) actual costs incurred by the beneficiary(ies) and affiliated entity(ies);

2.1.4. Eligibility of costs and eligibility of results/conditions

Reimbursement of costs¹⁹

Where the grant takes the form of reimbursement of costs (entirely or partially), only ‘eligible costs’ can be covered by a grant. The categories of costs that are eligible and non-eligible are indicated below. The budget is both a cost estimate and an overall ceiling for ‘eligible costs’.

Eligible direct costs

To be eligible under this call for proposals, costs must comply with the provisions of Article 14 of the general conditions to the standard grant contract (see Annex G of the guidelines).

The applicants (and where applicable their affiliated entities) agree that the expenditure verification(s) referred to in Article 2.8 of the general conditions to the standard grant contract (see Annex G of the guidelines) will be carried out by external body authorized by contracting authority.

Recommendations to award a grant are always subject to the condition that the checks preceding the signing of the grant contract do not reveal problems requiring changes to the budget (such as arithmetical errors, inaccuracies, and in case of reimbursement of costs, unrealistic costs and ineligible costs). The checks may give rise to requests for clarification and may lead the contracting authority to impose modifications or reductions to address such mistakes or inaccuracies. It is not possible to increase the grant or the percentage of EU co-financing as a result of these corrections. It is therefore in the applicants' interest to provide a **realistic and cost-effective budget**.

Contingency reserve

The budget may include a contingency reserve not exceeding 5% of the estimated direct eligible costs (in case of actions comprising also financing not linked to costs, to be calculated on the cost-based component). It can only be used with the **prior written authorization** of the contracting authority.

Eligible indirect costs

The indirect costs incurred in carrying out the action may be eligible for flat rate funding, but the total must not exceed 7% of the estimated total eligible direct costs (except volunteer costs and project office costs) (in case of actions comprising also financing not linked to costs, to be calculated on the cost-based component). Indirect costs are eligible provided that they do not include costs assigned to another budget heading in the standard grant contract. The lead applicant may be asked to justify the percentage requested before the grant contract is signed. However, once the flat rate has been fixed in the special conditions of the grant contract, no supporting documents need to be provided.

If any of the applicants or affiliated entity(ies) is in receipt of an operating grant financed by the EU, it may not claim indirect costs on its incurred costs within the proposed budget for the action.

Contributions in kind

Contributions in kind mean the provision of goods or services to beneficiaries or affiliated entities free of charge by a third party. As contributions in kind do not involve any expenditure for beneficiaries or affiliated entities, they are not eligible costs (except for personnel costs for the work carried out by volunteers under an action or an operating grant if so authorized).

Contributions in kind may not be treated as co-financing. However, if the description of the action as proposed includes contributions in kind, the contributions have to be made

Ineligible costs

Costs that do not comply with the conditions laid down in the contract are not eligible. The following costs are not eligible:

- debts and debt service charges (interest);
- provisions for losses or potential future liabilities;
- costs declared by the beneficiary(ies) and financed by another action or work programme receiving a European Union (including through EDF) grant;
- purchases of land or buildings, except where necessary for the direct implementation of the action, in which case ownership must be transferred in accordance with Article 7.5 of the general conditions of the standard grant contract, at the latest at the end of the action;
- currency exchange losses;
- in kind contributions (except for volunteers' work);
- bonuses included in costs of staff;
- negative interest charged by banks or other financial institutions;
- credit to third parties;
- salary costs of the personnel of national administrations

2.1.5. Ethics and values

Absence of conflict of interest

The applicant must not be affected by any conflict of interest and must have no equivalent relation in that respect with other applicants or parties involved in the actions. Any attempt by an applicant to obtain confidential information, enter into unlawful agreements with competitors or influence the evaluation committee or the contracting authority during the process of examining, clarifying, evaluating and comparing applications will lead to the rejection of its application and may result in exclusion decisions for other award procedures and/or financial penalties according to the Financial Regulation in force.

Respect of environmental legislation and core labour standards

Applicants who are awarded a grant must comply with the environmental legislation including multilateral environmental agreements, and with the core labour standards as applicable and as defined in the relevant International Labour Organization conventions (such as the conventions on freedom of association and collective bargaining; elimination of forced and compulsory labour; abolition of child labour).

Respect of EU values

Applicants who are awarded a grant must commit to and ensure the respect of basic EU values, such as respect for human dignity, freedom, democracy, equality, the rule of law and human rights, including the rights of minorities.

Zero tolerance for sexual exploitation, abuse and harassment

The European Commission applies a policy of 'zero tolerance' in relation to all wrongful conduct which has an impact on the professional credibility of the applicant.

Physical abuse or punishment, or threats of physical abuse, sexual abuse or exploitation, harassment and verbal abuse, as well as other forms of intimidation shall be prohibited.

Applicants (and affiliated entities) other than (i) natural persons, (ii) pillar-assessed entities and (iii) governments and other public bodies, whose application has been provisionally selected or placed in a reserve list shall assess their internal policy against sexual exploitation, abuse and harassment (SEA-H) through a self-evaluation questionnaire (Annex L). For grants of EUR 60 000 or less no self-evaluation is required. Such self-evaluation questionnaire is not part of the evaluation of the full application by the contracting authority but is an administrative requirement. See Section 2.5.6 of the PRAG.

Anti-corruption and anti-bribery

The applicant shall comply with all applicable laws, regulations and codes relating to anti-bribery and anti-corruption. The contracting authority reserves the right to suspend or cancel project financing if corrupt practices of any kind are discovered at any stage of the award process or during the execution of a contract and if the contracting authority fails to take all appropriate measures to remedy the situation. For the purposes of this provision, 'corrupt practices' are the offer of a bribe, gift, gratuity or commission to any person as an inducement or reward for performing or refraining from any act relating to the award of a contract or execution of a contract already concluded with the contracting authority.

Unusual commercial expenses

Applications will be rejected or contracts terminated if it emerges that the award or execution of a contract has given rise to unusual commercial expenses. Such unusual commercial expenses are commissions not mentioned in the main contract or not stemming from a properly concluded contract referring to the main contract, commissions not paid in return for any actual and legitimate service, commissions remitted to a tax haven, commissions paid to a payee who is not clearly identified or commissions paid to a company which has every appearance of being a front company.

Grant beneficiaries found to have paid unusual commercial expenses on projects funded by the European Union are liable, depending on the seriousness of the facts observed, to have their contracts terminated or to be excluded from receiving EU/EDF funds.

Breach of obligations, irregularities or fraud

The contracting authority reserves the right to suspend or cancel the procedure, where the award procedure proves to have been subject to breach of obligations, irregularities or fraud. If breach of obligations, irregularities or fraud are discovered after the award of the contract, the contracting authority may refrain from concluding the contract.

2.2 How to apply and the procedures to follow

Open call for proposals

2.2.1 Application forms

Applications must be submitted in accordance with the instructions on the concept note and the full applications in the grant application form annexed to these guidelines (Annex A). Lead applicants should then keep strictly to the format of the grant application form and fill in the paragraphs and pages in order.

Applicants must apply in English.

Please complete the full application form carefully and as clearly as possible so that it can be assessed properly.

WARNING

The title of your proposal will become, if selected, the subject matter of the grant contract that will be signed with your organisation.

On the [Europa website](#), the field 'Public subject', using the title of the selected proposal, is used for publication in the Financial Transparency System (FTS) of all EU grants. This field, being intended for the general public, should provide general and clear information on the purpose of the expenditure.

We therefore recommend to define the subject matter of your proposal along the following indications.

An appropriate subject:

- refers to the content of the project or its objective;
- does not repeat information available in other fields such as the recipient's name, the programme, the year;
- is preferably written in English;
- may contain acronyms if relevant for the citizens;
- may contain the reference to the project or programme.

Any error or major discrepancy related to the points listed in the instructions on the concept note or any major inconsistency in the application (e.g. if the amounts in the budget worksheets are inconsistent) may lead to the rejection of the application.

Clarifications will only be requested when the information provided is unclear and thus prevents the contracting authority from conducting an objective assessment.

Please note that only the grant application form and the published annexes which have to be filled in (budget, logical framework) will be evaluated. It is therefore of utmost importance that these documents contain ALL the relevant information concerning the action.

Please note that incomplete applications may be rejected. Lead applicants are advised to verify that their application is complete using the checklist (Section 7 of Part B of the grant application form).

With the application the lead applicant also has to submit completed PADOR registration form (Annex F) for the lead applicant, each co-applicants (if any) and each affiliated entities (if any).

In addition, the following documents should be submitted together with the PADOR registration form and the application form:

1. **The statutes or articles of association of the lead applicant, (if any) of each co-applicant and (if any) of each affiliated entity.** Where the contracting authority has recognised the lead applicant's, or the co-applicant(s)'s, or their affiliated entity(ies)'s eligibility for another call for proposals under the same budget line within 2 years before the deadline for receipt of applications, it shall submit instead, a copy of the document proving their eligibility in a former call (e.g. a copy of the special conditions of a grant contract received during the reference period), unless a change in legal status has occurred in the meantime. This obligation does not apply to international organisations which have been subject of a pillar assessment.
2. **A completed identification form (see Annex D).**
3. **The declaration on honour (Annex H to these guidelines)** signed by the lead applicant as well as all co-applicants and affiliated entities certifying that they are not in one of the exclusion situations (see Section 2.4.2 of the practical guide) where the amount of the grant exceeds EUR 15 000.
4. In addition, for the purpose of the evaluation of the financial capacity, the following documents should be submitted²⁰:

²⁰ No supporting documents will be requested for applications for a grant not exceeding EUR 60 000, or the following categories of lead applicants: (i) natural persons in receipt of education support (ii) natural persons most in need, such as unemployed and refugees, and in receipt of direct support (iii) public bodies, including Member State organisations (iv) international organisations.

- a. For action grants exceeding EUR 750 000 and for operating grants above EUR 100 000, the lead applicant must provide an audit report produced by an approved external auditor where it is available, and always in cases where a statutory audit is required by EU or national law. That report shall certify the lead applicant accounts for up to the last three available financial years.

The external audit report is not required from the co-applicant(s) or affiliated entities (if any).

- b. A copy of the lead applicant's profit and loss account and the balance sheet for up to the three last financial years for which the accounts were closed. A copy of the latest account is neither required from the co-applicant(s) (if any) nor from affiliated entity(ies) (if any).

These documents must be supplied in the form of originals, photocopies or scanned versions (i.e. showing legible stamps, signatures and dates) of the said originals. The declaration on honour on exclusion criteria shall be submitted in original. For the other documents, originals shall be kept on file for controls in accordance with the record keeping obligations laid down in Section 2.5.5. of the practical guide.

Where such documents are not in one of the official languages of the European Union, a translation into English of the relevant parts of these documents proving the lead applicant's and, where applicable, co-applicants' and affiliated entity(ies)' eligibility, must be attached for the purpose of analysing the application.

Where these documents are in an official language of the European Union other than the language of the call for proposals, a translation into the language of the call for proposals of the relevant parts of these documents proving the lead applicant's and, where applicable, co-applicants' and affiliated entity(ies)' eligibility, must be attached for the purpose of analysing the application.

Where these documents are in an official language of the European Union other than the language(s) of the call for proposals, it is strongly recommended, in order to facilitate the evaluation, to provide a translation of the relevant parts of the documents, proving the lead applicant's and, where applicable, co-applicants' and affiliated entity(ies)' eligibility, into the language of the call for proposals.

If the abovementioned supporting documents are not provided by the deadline for the submission of the application form, the application may be rejected.

No additional annexes should be sent.

2.2.2 Where and how to send applications

Applications must be submitted exclusively by electronic mail (email).

The complete application form (Part A: Concept Note and Part B: Full Application Form), PADOR registration form, budget and logical framework must be provided in PDF format, duly signed. The application file must be transmitted as a single document (i.e. the application must not be split into several different files). Hand-written applications will not be accepted.

Subject line of the email:

“applicant's name /Grant/01/HealthPro2 /Primary Health Care provision for vulnerable populations affected by food insecurity and malnutrition”.

Submission procedure:

- The complete application must be sent ONLY AND ESCLUSIVELY to the following email address: procurement.addisabeba@aics.gov.it. For security purposes, the file must be password-protected or encrypted,
- The password/encryption key must be sent in a separate email, ONLY AND ESCLUSIVELY to the following officially designated recipient: samia.shehab@aics.gov.it

Applications must be received before the deadline specified in the Guidelines for Applicants. Late applications will not be accepted.

Applications sent by any other means (fax, courier, or hand delivery, or to other addresses) will be rejected.

Incomplete applications may also be rejected. Applicants are advised to verify that their application is complete using the checklist (Section 7 of Part B of the Application Form).

2.2.3 Deadline for submission of applications

The application/full proposal must be sent before the date for submission, and it is the acknowledgment of receipt given at the time of the delivery of the application/full proposal which will serve as proof.

The deadline for the submission of applications is **22/05/2026, 5 p.m GMT+3 (Addis Ababa time)**

Any application submitted after the deadline will be rejected.

2.2.4 Further information about applications

The first information session on this call for proposals will be held on 26/02/2026 at 10.00 am East Africa Time (EAT) - GMT+3. A Teams link will be shared along with the invitation email.

The second information session on this call for proposals will be held on 27/02/2026 at 11.00 am East Africa Time (EAT) - GMT+3. A Teams link will be shared along with the invitation email.

Questions may be sent by e-mail no later than 13/03/2026 to the below address(es), indicating clearly the reference of the call for proposals:

E-mail address:

- procurement.addisabeba@aics.gov.it

The contracting authority has no obligation to provide clarifications to questions received after this date.

Replies will be given no later than 18/03/2026.

To ensure equal treatment of applicants, the contracting authority cannot give a prior opinion on the eligibility of lead applicants, co-applicants, affiliated entity(ies), an action or specific activities.

Questions that may be relevant to other applicants, together with the answers, will be published on the website where the call was published: https://trasparenzaaddisabeba.aics.gov.it/pagina952_bandi.html as the need arises.

It is therefore advisable to consult the above-mentioned website regularly in order to be informed of the questions and answers published.

Please note that the contracting authority may decide to cancel the call for proposals procedure at any stage according to the conditions set out in Section 6.5.9 of the practical guide.

2.3 Evaluation and selection of applications

Applications will be examined and evaluated by the contracting authority with the possible assistance of external assessors. All applications will be assessed according to the following steps and criteria.

If the examination of the application reveals that the proposed action does not meet the eligibility criteria stated in Section 2.1, the application will be rejected on this sole basis.

2.3.1 STEP 1: OPENING & ADMINISTRATIVE CHECKS AND CONCEPT NOTE EVALUATION

During the opening and administrative check the following will be assessed:

- **If the deadline has been met. Otherwise, the application will be automatically rejected.**
- **If the application satisfies all the criteria specified in the checklist in Section 7 of Part B of the grant application form. This includes also an assessment of the eligibility of the action. If any of the requested information is missing or is incorrect, the application may be rejected on that sole basis and the application will not be evaluated further.**

The concept notes that pass this check will be evaluated on the relevance and design of the proposed action.

The concept notes will receive an overall score out of 50 using the breakdown in the evaluation grid below. The evaluation will also check on compliance with the instructions on how to complete the concept note, which can be found in Part A of the grant application form.

The evaluation criteria are divided into headings and subheadings. Each subheading will be given a score between 1 and 5 as follows: 1 = very poor; 2 = poor; 3 = adequate; 4 = good; 5 = very good.

	Scores*	
1. Relevance of the action	Sub-score	20
1.1 Consistency with the objectives of the call: How relevant is the proposal to the objectives and priorities of the call for proposals and to the specific themes/sectors/areas or any other specific requirement stated in the guidelines for applicants? Are the expected results of the action aligned with the priorities defined in the guidelines for applicants (Section 1.2)?	5	
1.2 Relevance to the country/region/sector needs: How relevant is the proposal to the particular needs and constraints of the target country(ies), region(s) and/or relevant sectors (including synergy with other development initiatives and avoidance of duplication)?	5	
1.3 Target groups and final beneficiaries: How clearly defined and strategically chosen are the target groups and final beneficiaries? Have their needs (as rights holders and/or duty bearers) and constraints been clearly defined? Does the proposal address them appropriately?	5	
1.4 Added value elements: Does the proposal contain particular added-value elements (e.g. innovation, best practices)? <i>[and the other additional elements indicated under 1.2. of the guidelines for applicants]</i>	5	
2. Design of the action	Sub-score	30
2.1 Intervention logic. Does the proposal indicate the expected results (outputs/outcomes/impacts) to be achieved by the action? Does the design of the proposed action identify explicitly the necessary sequence to achieve the desired objectives beginning with inputs, moving through activities and outputs, and culminating in outcomes and impacts?	5x2**	
2. Context analysis. Does the design of the action include a robust analysis of the needs to be addressed, including the capacities of the relevant stakeholders? Are those also embedded adequately in the intervention logic?	5	
2.3 Risks and assumptions. Is the design based on clear assumptions (the necessary and positive conditions that allow for a successful cause-and-effect relationship between different levels of results)? Does it take into account also risks (the factors that might hinder the achievement of results)?	5	
2.4 Indicative Activities. Is the indicative list of activities linked to and consistent with the expected outputs?	5	
2.5 Cross-cutting issues: To which extent does the proposal integrate relevant cross-cutting elements such as environmental/climate change issues, promotion of gender equality and equal opportunities, needs of disabled people, rights of minorities and rights of indigenous peoples, youth, combating HIV/AIDS (if there is a strong prevalence in the target country/region)?	5	
TOTAL SCORE		50

* Note: A score of 5 (very good) will only be allocated if the proposal specifically addresses all the required priorities as indicated in Section 1.2 (objectives of the programme) of these guidelines

**this score is multiplied by 2 because of its importance

Once all concept notes have been assessed, a list will be drawn up with the proposed actions ranked according to their total score.

Firstly, only the concept notes with a score of at least 30 will be considered for pre-selection.

Secondly, the number of concept notes will be reduced, taking account of the ranking, to the number of concept notes whose total aggregate amount of requested contributions is equal to at least 200% of the available budget for this call for proposals. The amount of requested contributions of each concept note will be based on the indicative financial envelopes for each lot, where relevant.

After the evaluation of concept notes, the contracting authority will send letters to all lead applicants, indicating whether their application was submitted by the deadline, informing them of the reference number they have been allocated, whether the concept note was evaluated and the results of that evaluation.

The evaluation committee will then proceed with the lead applicants whose proposals have been pre-selected

2.3.2 STEP 2: EVALUATION OF THE FULL APPLICATION

If the applications pass the opening and administrative checks along the instructions of the Step 1: they will be further evaluated on their quality, including the proposed budget and capacity of the applicants and affiliated entity(ies). They will be evaluated using the evaluation criteria in the evaluation grid below. There are two types of evaluation criteria: selection and award criteria

The selection criteria help to evaluate the applicant(s)'s and affiliated entity(ies)'s operational capacity and the lead applicant's financial capacity and are used to verify that they:

- have stable and sufficient sources of finance to maintain their activity throughout the proposed action and, where appropriate, to participate in its funding (this only applies to lead applicants);
- have the management capacity, professional competencies and qualifications required to successfully complete the proposed action. This applies to applicants and any affiliated entity(ies).

The award criteria help to evaluate the quality of the applications in relation to the objectives and priorities set forth in the guidelines, and to award grants to projects which maximise the overall effectiveness of the call for proposals. They help to select applications which the contracting authority can be confident will comply with its objectives and priorities. They cover the relevance of the action, its consistency with the objectives of the call for proposals, quality, expected impact, sustainability and cost-effectiveness.

Scoring:

The evaluation grid is divided into Sections and subsections. Each subsection will be given a score between 1 and 5 as follows: 1 = very poor; 2 = poor; 3 = adequate; 4 = good; 5 = very good.

Evaluation grid

Section	Maximum Score
1. Financial and operational capacity	20
1.1 Do the applicants and, if applicable, their affiliated entity(ies) have sufficient in-house experience of project management?	5
1.2 Do the applicants and, if applicable, their affiliated entity(ies) have sufficient in-house technical expertise? (especially knowledge of the issues to be addressed)	5
1.3 Do the applicants and, if applicable, their affiliated entity(ies) have sufficient in-house management capacity? (Including staff, equipment and ability to handle the budget for the action)?	5
1.4 Does the lead applicant have stable and sufficient sources of finance?	5

2. Relevance	20
<i>Score transferred from the Concept Note evaluation</i>	
3. Design of the action	15
3.1 Intervention logic: Does the proposal indicate the expected results (outputs/outcomes/impacts) to be achieved by the action? Does the design of the proposed action identify explicitly the necessary sequence to achieve the desired objectives beginning with inputs, moving through activities and outputs, and culminating in outcomes and impacts? Is the indicative list of activities linked to and consistent with the expected outputs?	5
3.2 Logical Framework Matrix: Is the logical framework provided in Annex C complete? Does each result (output, outcome, impact) include an adequate number of indicators that are sufficient in scope to measure its achievement? Is each indicator RACER (Relevant, Accepted, Credible, Easy to monitor, Robust)? Does each indicator have a baseline value (with year), target value (with year), and a credible source of data? If baselines and targets are not available, this is to be justified and a study (or other relevant tools) to be foreseen and budgeted in the proposal? In the case of use of FNLC, are the FNLC results and indicators clearly marked?	5
3.3 Context analysis. Does the design of the action include a robust analysis of the needs to be addressed, including the capacities of the relevant stakeholders? Are those also embedded adequately in the intervention logic?	5
4. Implementation approach	15
4.1 Action plan: Is the action plan for implementing the action clear and feasible? Are types of activities clearly clustered by output in the Activities Matrix? Is the timeline realistic?	5
4.2 Monitoring, reporting and evaluation: Does the proposal include an effective and efficient monitoring and reporting system? Is the system in place adequate to update the values of the indicators included in the Logical Framework Matrix - thus informing regularly on progress towards the achievement of impact, outcomes and outputs? Is there an evaluation planned and budgeted (previous, during or/and at the end of the implementation)? If relevant, is the role of third-party assessor included?	5
4.3 Project management (technical): Do the co-applicant(s) and (if applicable) their affiliated entities have the necessary technical skills to attain the objectives of the action? Are the co-applicant(s)'s and affiliated entity(ies)'s adequately involved in the implementation (e.g. advocacy, research, capacity building, outreach related activities)?	5
5. Sustainability of the action	15
5.1 Long-lasting benefits: Is the action likely to ensure long-lasting and transformative benefits to the target groups and the final beneficiaries?	5
5.2 Multiplier effects: Is the action likely to have multiplier effects, including scope for replication, extension, cross-fertilization of experience and knowledge sharing?	5
5.3 Sustainability How likely the effects are to last after the intervention ends? <ul style="list-style-type: none"> - Financial sustainability: which financial resources are available to fund the continuation of the services provided by the intervention? How long are they likely to be available and from which sources?) - Institutional sustainability: which institutional arrangements allow for maintaining the benefits achieved? Is there any measure in place to ensure local ownership? - Policy level sustainability (if applicable): is there any expected policy related effect from the action, e.g. improved legislation, codes of conduct, methods 	5

- Environmental sustainability (if applicable): will the action have a negative/positive environmental impact?	
- Risk analysis and mitigation measures: will the action be accompanied by a good risk analysis (including physical, environmental, political, economic and social risks) and relevant mitigation measures?	
6. Budget and efficiency of the action	15
6.1 Budget: Are the activities appropriately reflected in the budget? In the case of entire or partly use of financing not linked to costs, are the results and performance indicators adequately reflected in the budget?	/ 5
6.2 Efficiency: Is the relation between the estimated amounts as per budget and the expected results adequate??	/ 10
Maximum total score	100

If the total score for Section 1 (financial and operational capacity) is less than 12 points, the application will be rejected. If the score for at least one of the subsections under Section 1 is 1, the application will also be rejected.

If the lead applicant applies without co-applicants or affiliated entities the score for point 4.3 shall be 5 unless the involvement of co-applicants or affiliated entities is mandatory according to these guidelines for applicants.

Provisional selection

After the evaluation, a table will be drawn up listing the applications ranked according to their score. The highest scoring applications will be provisionally selected until the available budget for this call for proposals is reached. In addition, a reserve list will be drawn up following the same criteria. This list will be used if more funds become available during the validity period of the reserve list. The contracting authority informs those lead applicants provisionally selected and those placed on the reserve list, that they will be subject to the final eligibility check.

2.3.3 STEP 3: VERIFICATION OF ELIGIBILITY OF THE APPLICANTS AND AFFILIATED ENTITY(IES) AND OTHER SUPPORTING DOCUMENTS

The eligibility verification will be performed on the basis of the supporting documents requested by the contracting authority see Section 2.2. It will by default only be performed for the applications that have been provisionally selected (including those placed on the reserve list) according to their score and within the available budget for this call for proposals. In this case:

- The declaration by the lead applicant (Section 8 of Part B of the grant application form) and declaration of honour on selection and exclusion criteria will be cross-checked with the supporting documents provided by the lead applicant. Any missing supporting document or any incoherence between the declaration by the lead applicant and the supporting documents may lead to the rejection of the application on that sole basis.
- The eligibility of applicants and the affiliated entity(ies) will be verified according to the criteria set out in Section 2.1.1, including exclusion criteria.

Any rejected application will be replaced by the next best placed application on the reserve list that falls within the available budget for this call for proposals.

In the eventuality that the evaluation committee is not satisfied with the strength, solidity, and guarantee offered by the structural link between one of the applicants and its affiliated entity, it can require the submission of the missing documents allowing for its conversion into co-applicant. If all the missing documents for co-applicants are submitted, and provided all necessary eligibility criteria are fulfilled, the above-mentioned entity becomes a co-applicant for all purposes. The lead applicant has to submit the application form revised accordingly.

2.4 Award Decision

After verifying the supporting documents (step 3), the evaluation committee will make a final recommendation to the contracting authority, which will decide on the award of grants.

The contracting authority may decide not to award any grants and cancel the call for proposals without having the applicants any right to compensation.

The award decision shall indicate the successful applicants, the names of the applicants rejected, and a reserve list (if any).

2.5 Notification of the Contracting Authority's decision

The lead applicants will be informed in writing of the contracting authority's decision concerning their application. Please note that the lead applicant is the intermediary for all communications between applicants and the contracting authority during the procedure.

In case of rejection, they will be informed about the reasons for the negative decision. For the avoidance of doubt, please note that for applications rejected for reasons such as non-compliance with the admissibility requirements (for example, if the application was sent after the deadline), with the eligibility (the entity or person is not part of the predefined eligible population of entities or persons), the selection (the entity does not have financial capacity or professional or operational capacity) and the award criteria (the proposal does not comply with the predefined requirements such as quality, cost/efficiency), no prior adversarial procedure is required.

Applicants placed on the reserve list will also be informed. The applicable terms to the reserve list are laid down in Section 6.5. of the practical guide.

The successful applicants shall also be informed, and will be requested to provide some information and documents, including (for grants exceeding EUR 60 000) the self-evaluation questionnaire on SEA-H. The lead applicant as well as all co-applicants and affiliated entities other than (i) natural persons (ii) pillar-assessed entities and (iii) governments and other public bodies shall fill in the self-evaluation questionnaire assessing the organization's internal policy and procedures against sexual exploitation, abuse and harassment (SEA-H) (Annex L) (see Section 6.2.10 of the practical guide).

Successful applicants will also be informed if the first instalment of pre-financing is subject to the validation of a financial guarantee by the contracting authority. In this case, the applicant will be requested to send the guarantee in time to proceed to the payment of the first instalment in accordance with the payment provisions of the grant contract.

An applicant believing that it has been harmed by an error or irregularity during the award process may lodge a complaint. See Section 2.12 of the practical guide.

2.6 Signature of the grant contract

Following the decision to award a grant, the beneficiary(ies) will be offered a contract based on the standard grant contract (see Annex G of these guidelines). By signing the application form (Annex A of these guidelines), the applicants agree, if awarded a grant, to accept the contractual conditions of the standard grant contract. Where the coordinator is an organization, whose pillars have been positively assessed, it will sign a contribution agreement based on the contribution agreement template. In this case, references to provisions of the standard grant contract and its annexes shall not apply. References in these guidelines to the grant contract shall be understood as references to the relevant provisions of the contribution agreement.

The budget proposed for the action by the successful applicants at the call for proposals stage must be corrected to remove any obvious arithmetical errors or ineligible costs prior to signing the contract. The description of the action is corrected accordingly if need be.

The contracting authority may decide that other clarifications or minor corrections may be made to the description of the action or to the budget in so far as they do not call into question the grant award decision, do not conflict with equal treatment of applicants, and:

- relate to matters clearly identified by the evaluation committee; or
- aim at taking into consideration changes that have occurred since the date of receipt of the proposal.

These amendments cannot lead to an increase in either the amount of the grant or the percentage of the

European Union contribution as set in the guidelines of the call for proposals. In this respect, records of the contacts with the applicants must be kept on the file.

In no case the conditions announced in the guidelines can be altered at this stage. Apart from the above-mentioned clarifications and/or corrections, any other alteration of the initial proposal or deviation from the award conditions laid down in the guidelines is strictly prohibited.

Any other alteration to the successful applicant's proposal, or negotiation of it, is prohibited.

2.7 Indicative timetable

	DATE	TIME
1. Information meeting 1	26/02/2026	10 am GMT +3 (Addis Ababa, Ethiopia)
2. Information meeting 2	27/02/2026	11 am GMT +3 (Addis Ababa, Ethiopia)
3. Deadline for requesting any clarifications from the contracting authority	13/03/2026	-
4. Last date on which clarifications are issued by the contracting authority	18/03/2026	-
5. Deadline for submission of applications	22/05/2026	17:00 GMT +3 (Addis Ababa, Ethiopia)
6. Information to lead applicants on opening, administrative checks and concept note evaluation (Step 1)	26/05/2026	-
7. Information to lead applicants on full application evaluation (Step 2)	29/05/2026	
8. Notification of the contracting authority decision	29/05/2026	-
7. Contract signature	01/06/2026	-

All times are in the time zone of the country of the contracting authority.

This indicative timetable refers to provisional dates (except for dates 2, 3, and 4) and may be updated by the contracting authority during the procedure. In such cases, the updated timetable will be published on the web site where the call was published: https://trasparenzaaddisabeba.aics.gov.it/pagina952_bandi.html

2.8 Early detection and exclusion system

Applicants and, if they are legal entities, persons who have powers of representation, decision-making or control over them, natural or legal person that assumes unlimited liability for the debts, natural or legal person who is essential for the award or for the implementation of the legal commitment, beneficial owner or any affiliate of the applicant, are informed that, should they be in one of the situations of early detection or exclusion, their personal details (name, given name if natural person, address, legal form) may be registered in the early detection and exclusion system, and communicated to the persons and entities concerned in relation to the award or the execution of a grant contract.

For more information, you may consult the privacy statement available on http://ec.europa.eu/budget/explained/management/protecting/protect_en.cfm

3. List of annexes

DOCUMENTS TO BE COMPLETED

Annex A	Grant application form (Word format)
A.1	Concept note
A.2	Full application form
Annex B	Budget (Excel format)
Annex C	Logical framework (Excel format)
Annex D	Identification form
Annex F	PADOR registration form
Annex H	Declaration on Honour on exclusion criteria
Annex L	Self-evaluation questionnaire on SEA-H

DOCUMENTS FOR INFORMATION²¹

Annex G	Standard grant contract
Annex II	General conditions
Annex IV	Procurement rules for beneficiaries
Annex V	Standard request for payment
Annex VI	Model narrative and financial report
Annex VII-A	Model report of factual findings and terms of reference for an expenditure verification of an EU financed grant contract for external action
Annex VIII	Model financial guarantee
Annex IX	Standard template for transfer of ownership of assets
Annex I	Daily allowance rates (per diem), available at the following address: https://international-partnerships.ec.europa.eu/funding/guidelines/managing-project/diem-rates_en
Annex J	Information on the tax regime

TECHNICAL ANNEXES

Annex 01	Need Assessment Report
Annex 02	Security assessment report
Annex 03	Project Logframe, Baseline Assessment of Health PRO phase II
Annex 04	Scoring model for locality ranking
Annex 05	Sudan - Humanitarian Needs and Response Plan Executive Summary
Annex 06	Sudan Risk Analysis OCHA

USEFUL LINKS

PRAG	https://wikis.ec.europa.eu/display/ExactExternalWiki/ePRAG
Project Cycle Management Guidelines	https://ec.europa.eu/international-partnerships/funding/managing-project_en
The implementation of grant contracts, A Users' Guide	https://wikis.ec.europa.eu/pages/viewpage.action?pageId=48169235
Financial Toolkit ²²	https://ec.europa.eu/international-partnerships/financial-management-toolkit_en
Early Detection and Exclusion System (EDES)	https://commission.europa.eu/strategy-and-policy/eu-budget/how-it-works/annual-lifecycle/implementation/anti-fraud-measures/edes_en#data-protection

²¹ These documents should also be published by the contracting authority.

²² Please note that the toolkit is not part of the grant contract and has no legal value. It merely provides general guidance and may in some details differ from the signed grant contract. In order to ensure compliance with their contractual obligations, beneficiaries should not exclusively rely on the toolkit but always consult their individual contract documents.