South Sudan
2013 CHF Standard Allocation Project Proposal

for CHF funding against Consolidated Appeal 2013

For further CHF information please visit http://unocha.org/south-sudan/financing/common-humanitarian-fund
or contact the CHF Technical Secretariat chfsouthsudan@un.org

This project proposal shall be submitted by cluster partners in two stages to the Cluster Coordinators and Co-coordinators for each project against which CHF funds are sought. In the first stage, before cluster defenses, applying partners fill sections I and II. The project proposal should explain and justify the activities for which CHF funding is requested and is intended to supplement information already available in the CAP Project Sheets. The proposals will be used by the cluster Peer Review Team in prioritizing and selecting projects for CHF funding during CHF Standard Allocation round. Partners should also fill and submit to cluster coordinator/ co-coordinator the CHF Project Summary (Annex 1). In the second stage projects recommended for funding by the CHF Advisory Board must complete Section III of this application and revised/update sections I and II if needed.

SECTION I:

CAP Cluster	**Health**

CHF Cluster Priorities for 2013 First Round Standard Allocation

This section should be filled by the cluster Coordinators/Co-coordinators before sending to cluster partners. It should provide a brief articulation of Cluster priority activities and geographic priorities that the cluster will recommend for funding from the CHF in line with the cluster objectives highlighted in the CAP 2013.

Cluster Priority Activities for this CHF Round

- Maintain the existing safety net by providing basic health packages and emergency referral services
- Strengthen emergency preparedness including surgical interventions
- Respond to health related emergencies including controlling the spread of communicable diseases

(see chf 2013 R1 health cluster priorities description document for more details on specific supported activities)

Cluster Geographic Priorities for this CHF Round

All states. Grossly underserved counties in the equatorial states (Western, Eastern and Central Equatorial)

Project details

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

Requesting Organization

Christian Mission Aid (CMA)

Project CAP Code

SSD-13/H/55436/6088

CAP Project Title *(please write exact name as in the CAP)*

Provision of essential gender-sensitive high-impact health services, emergency referral and health system strengthening assistance in underserved Fangak, Nyirol & Pigi Counties in Jonglei and Longechuk County in Upper Nile, South Sudan.

Project Location(s) (list State, and County (or counties) where CHF activities will be implemented. If the project is covering more than one State please indicate percentage per State)

State	%	County
Jonglei	57%	Fangak
Upper Nile	43%	Longechuk

Total Project Budget requested in the in South Sudan CAP	**US$2,720,272**
Total funding secured for the CAP project *(to date)*	**US$1,148,953**

Funding requested from CHF for this project proposal	**US$250,000**

Are some activities in this project proposal co-funded?

Yes ☑ No ☐ *(if yes, list the item and indicate the amount under column i of the budget sheet)*

EPI Supplies & Pharmaceuticals, Personnel, Staff Travel, Vehicle Operations, Office Equipment & Communications

Direct Beneficiaries *(Ensure the table below indicates both the total number of beneficiaries targeted in the CAP project and number of targeted beneficiaries scaled appropriately to CHF request)*

	Number of direct beneficiaries targeted in CHF Project	Number of direct beneficiaries targeted in the CAP
Women:	18,190	51,600
Girls (<15) years:	10,410	29,500
Men:	12,490	35,300
Boys <15 years:	10,410	29,500

Indirect Beneficiaries

10,4000

Catchment Population (if applicable)

320,000

Total:	51,500	145,900

Implementing Partner/s (Indicate partner/s who will be sub-contracted if applicable and corresponding sub-grant amounts)
None

CHF Project Duration (12 months max., earliest starting date will be Allocation approval date)
Indicate number of months: 6 months (April – September 2013)

Contact details Organization's Country Office	
Organization's Address	ECS Church Compound Hai Jerusalem Opposite Juba Teaching Hospital Juba.
Project Focal Person *Name, Email, telephone*	Dr. Robert V. Abalu med@cmaid.or.ke +211 955 001 757 +88 216 679 00
Country Director *Name, Email, telephone*	Esau Riaroh sud@cmaid.or.ke + 211 954 166 375
Finance Officer *Name, Email, telephone*	Simeon Njiru prog@cmaid.or.ke +211 955 835 293 +88 216 679 00 557

Contact details Organization's HQ	
Organization's Address	Christian Mission Aid (CMA Kugeria Maisonnettes, House No. 13, Ralph Bunche Road PO Box 57351-00200 Nairobi, Kenya
Desk officer *Name, Email, telephone*	Debra Kitchel ken@cmaid.or.ke 254-20-272-1872
Finance Officer	Koki Kyalo finance@cmaid.or.ke +211 977 155 507

SECTION II

A. Humanitarian Context Analysis

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

Data from CMA's PHCCs in Fangak & Longechuk Counties show high levels of outpatient treatments, caused by:

- Returnees & IDPs continue to migrate/settle in Juaibor, Keew and Mathiang in order to access health facilities;
- The number of kala-azar patients has been sustained at high levels;
- Heavy rains & flooding has resulted in a high malaria burden, and damage health facilities;
- Food prices remain high causing malnutrition related illnesses.

CMA's data shows a new threat of measles may be emerging. A survey conducted for WFP showed that measles was the cause of sickness of 34% of children <2 years in Jonglei and 12% in UNS (*South Sudan Food Security Monitoring, Round 8, October 2012, pg 7*). Dry season enables the spread of measles.

Returnees increased in 2012. SSRRC records show IDP and returnee populations now exceed 50% in Keew and Juaibor, and 80% in Mathiang. According to OCHA's data (*Weekly Humanitarian Bulletin 06 January 2013*), there has been a huge influx of returnees (45,787) into UNS. Most have flocked to Renk, but many are finding their way to key market centers including Mathiang & Dajo to take advantage of health facilities. UNS has also been the recipient of the majority of refugees from Blue Nile. Jonglei has received more than 12,000 returnees. New arrivals of returnees & refugees are expected to pick up in dry season (*OCHA Humanitarian Bulletin South Sudan, September 2012*).

Kala-azar is endemic in project areas and without treatment, 95% of kala-azar patients die (*Kala-azar Epidemiology and Control, Southern Sudan EID Journal, Vol. 14, April 2008)*. By the end of September 2012, the number of new infections had declined by about 25%. In 2012, 3,039 patients were treated. Kala-azar is expected to remain a persistent problem in 2013.

OCHA Humanitarian Bulletin South Sudan (September 2012), reported severe flooding in Jonglei & UNS. Prices of sorghum remain 93% to 122% higher than the five year average (*South Sudan Food Security Monitoring, Round 8, October 2012, pg 5*). Reduced yields due to flooding in 2012 is one of the drivers of sustained high sorghum prices (*FEWSNet, South Sudan Food Security Outlook, November 2012*). Further, in the targeted counties, FEWSNet data shows the food security outcome at the household level is at the Stressed level. Food insecurity is manifest in poor nutrition and malnutrition associated diseases especially among vulnerable populations (young children, pregnant and lactating women, IDPs and returnees). High food prices have increased the number of poor households, which prevents these populations from accessing health services.

Jonglei and UNS experienced serious negative impacts as a result of conflict (*South Sudan: Humanitarian Snapshot December 2012 – OCHA*). UNS is enduring the brunt of refugees from the Blue Nile conflict. Jonglei endures the brunt of inter-communal conflict. This national context of insecurity causes localized tensions to flare into conflict that prevents delivery of, and access to health services, especially for women and children in both Fangak and Longechuk counties. Flood damaged health facilities cannot properly deliver the level of services now being demanded.

B. Grant Request Justification

Briefly describe (in no more than 500 words) the reasons for requesting CHF funding at this time. Explain how CHF funding will help address critical humanitarian gaps in your cluster. Explain the value added by your organization (e.g. geographical presence). Indicate if any other steps have been taken to secure alternative funding.

To maintain the safety net of basic health and emergency referral services given the humanitarian context of Jonglei & UNS, four factors justify CHF's funding of this project:

- INGO operated facilities have been handed over to MOH, and with reduced MOH budgets due to low revenues from oil exports, service gaps including eruption in drug supplies are inevitable;
- Kala-azar, high volume of consultations, and the measles threat combine to sustain a high burden on facilities that out-strips human resources and medical supplies;
- Flooding in 2012 has reduced crop yields lending to malnutrition associated diseases, and damaged health facility structures;
- Localized conflict has created new IDPs and curtailed access to health services, and there is sustained need to conduct outreaches to deliver services equally to conflicting groups, and especially women and children.

Transition to RRHP shows significant reduction in funding for CMA's facilities previous funded by OFDA plus CHF assistance. RRHP assistance will be 60% of OFDA assistance. INGOs have handed over facilities to MOH for RRHP assistance, but experienced international personnel have not been retained. Without sustained funding from CHF, the high volume of consultations coupled with kala-azar and measles threat, health services demands will certainly overwhelm RRHP/MOH capacity, and eruptions in drug supplies are likely. Without CHF funding to sustain a core

[1] To the extent possible reference needs assessment findings and include key data such as mortality and morbidity rates and nutritional status, and how the data differs among specific groups and/or geographic regions. Refer situation/data/indicators to national and/or global standards.

team of international personnel, with experience in management of kala-azar, measles and high volume of patients, many lives will be lost. Further, MOH has very limited capacity to retain experienced national personnel previously employed by INGOs. Without CHF funding, experienced national personnel formerly with INGOs will be lost, further eroding health sector capacity.

Complicating these issues, the humanitarian context continues to illustrate significant negative impacts from flooding, insecurity and conflict. Health facility structures need to be refurbished first to maintain functionality, and second to withstand the next rain season. Continuing insecurity means more IDPs and returnees migrate toward functional health facilities, significantly adding to service demand stresses. Access to basic services, especially immunizations for children and reproductive health/ANCs for women is severely curtailed by localized conflict. Without CHF funding, repairs to flood damaged facilities will not be possible resulting in reduced capacity to deliver life-saving health and referral services. Without CHF funding, health outreach services that give access to vulnerable individuals will be lost resulting in the inevitable loss of lives.

CMA's critical value added is its long experience working in the health sector. Through CHF12 Round 2 funding, CMA recruited additional female health professionals and conducted gender-sensitivity training modeled on ADAPT & ACT C framework as means to achieve better gender balance in the health teams and to better deliver health services in a gender sensitive approach. Further, CMA is the contracted agent to implement RRHP in both Fangak and Longechuk. CMA is best positioned to coordinate the use of scares resources toward maintaining the safety net of BPHS services. With health teams in four locations, CMA has the capacity assign skilled personnel to the location of health emergencies to deliver quality services and save many lives.

C. Project Description (For CHF Component only)

i) Contribution to Cluster Objectives

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

Since RRHP/MOH is only capable of providing financial assistance for core health services with an emphasis on health system strengthening, CHF funding will be critical for maintaining the critical life-saving health services in 4 PHCCs and 8 PHCUs namely Juaibor PHCC Fangak (served by Kuernyang and Mandeng PHCUs); Keew PHCC Fangak (served by Thokchak, Kuerpon & Paguir PHCUs); Dajo PHCC Longechuk (served by Wilitka PHCU) and Mathiang PHCC Longechuk (served by Jangok & Wudier PHCUs). CHF funding will be focused on maintaining the safety net of the basic health package and referral services in these underserved areas, and fill funding gaps as CMA transitions into the RRHP/MOH programming, and in this transition period as INGOs handover facilities to MOH. CHF funding will be directed into areas where access to health services have been limited due to conflict and/or lack of (or collapse of) health facility structures, and toward activities that reach the most vulnerable groups, especially children, pregnant and lactating women, IDPs and returnees, and any other at risk populations. The critical health priority activities assisted with CHF funding will be maintaining efforts to manage kala-azar, and coping with the emerging threats of malnutrition related illnesses and measles that afflict these target groups.

CHF funding will also be used fill any gaps as the result of eruption in the MOH drug supply chain, and toward the repair of health facilities damaged by the floods to ensure that facilities are adequate for the delivery of life-saving health services through the dry season and next rainy season. CHF funding will be essential to help CMA retain the female health personnel recruited with CHF's Round 2 funding in 2012. CHF funding will enable CMA to maintain a gender balanced professional cadre of health workers at the PHCC level. These personnel will be essential for the provision of the life-saving health services and health education outreaches that address sexual and reproductive rights of women and girls in a gender-sensitive way, especially to serve the needs of women in reproductive health services and issues related to addressing GBV and women's empowerment. CHF funding will enable CMA to retain 2 qualified nurse/midwife persons for each of the 4 PHCCs.

ii) Project Objective

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

The overall objective of the project is to maintain the provision of life-saving health interventions focused on the most vulnerable populations of children, women, IDPs & returnees in underserved Fangak and Longechuk counties during the April to September period of health sector transition in donor funding and changing implementing agencies.

The specific objectives are:

1. To maintain the existing safety net of basic health packages and emergency referral services;
2. To strengthen capacity and preparedness to respond to emergencies caused by inclimate weather, conflict, insecurity and drug stock-outs, etc.;
3. To respond to health related emergencies including kala-azar, the threat of measles, and the potential for malnutrition related conditions, etc.

iii) Proposed Activities

List the main activities to be implemented with CHF funding. As much as possible link activities to the exact location of the operation and the

corresponding number of direct beneficiaries (broken down by age and gender to the extent possible).

Activities & total budgets ($1,398,953) have been planned for the April – September period of 2013. Contributions from CHF-Canada ($353,000) and RRHP/MOH ($795,953) for the period have been confirmed. The funding gap anticipated for April – September period is $250,000. This $250,000 is the fund requested from CHF Round 1 funding.

The activities for CHF funding are listed below and detailed indicators have been provided in section C(v) below.
1. Provide basic packages of life-saving health services including IMCI, EPI, ANC/reproductive health services and the inpatient and outpatient treatment of common communicable diseases:
1.1 provide gender-balanced qualified personnel to deliver life-saving services from properly equipped outpatient facilities, inpatient & maternity wards & adequately supplied laboratories & pharmacies at 4 PHCCs & 8 PHCUs, and at 4 additional PHCCs to retain critical skilled personnel that would otherwise be lost in transition from INGO to MOH:

- Fangak, Manajang-Juaibor PHCC: 11 professional + 28 CHW/EPI & 4 CHWs at 2 PHCUs and Paguir-Keew PHCC: 9 professional + 26 CHW/EPI & 6 CHW at 3 PHCUs;
- Longechuk, Mathiang PHCC: 6 professional + 15 CHW/EPI & 4 CHWs at 2 PHCUs and Dajo PHCC: 7 professional + 14 CHW/EPI & 2 CHWs at 1 PHCU;

1.2 for <5 children, implement growth monitoring, promote breast-feeding, micronutrient supplements & nutrition action for severely malnourished children, and implement IMCI with EPI & promotion of LLITNs, vaccination for measles & teach mothers on prevention & home treatment of childhood diseases (malaria, diarrhea, ARI, measles) & recognition of when to seek PHCC services;
1.3 provide ANC/reproductive health services, & through community outreaches, sensitize men & women on reproductive health issues, ANC & safe motherhood emphasizing LLITNs, infant delivery with professionally trained birth attendants.

2. Repair and maintain health facility structures and provide essential equipment to ensure capacity to deliver gender sensitive life-saving BPHS, and procure & pre-position essential drugs, medical supplies, ANC/reproductive health and EPI supplies to PHCCs & PHCUs to mitigate impacts of drug stock-outs:
2.1 provide materials & skilled construction workers (6 positions part-time supported with CHF funds) and conduct major repairs of health facilities to secure capacity to deliver life-saving health and referral services;
2.2 maintain/replace equipment necessary to deliver life-saving health and referral services, including EPI services from PHCCs, PHCUs and through outreaches;
2.3 maintain/replace equipment necessary for adequate maternity services and deliver ANC/reproductive health services from PHCCs, PHCUs and through health service outreaches;
2.4 manage procurement of medicines to mitigate stock-outs (CHF funds to provide for drug delivery eruption of 3 months duration), and procure medical supplies & EPI vaccines & related supplies through MOH channels & other suppliers (in case of stock-outs), in collaboration with the CHDs & collaborating NGOs.

3. Provide life-saving emergency health services specifically kala-azar and measles treatments, and monitoring of rates of malnutrition among children <5 years, CHF to fund 2 positions in each of 4 PHCCs to manage kala-azar/measles outbreaks:
3.1 conduct IDSR with weekly reports submitted with specifics on monitoring caseloads for kala-azar, measles and malnutrition;
3.2 diagnose & provide inpatient treatment services for kala-azar;
3.3 diagnose & treat measles, and provide inpatient services as required;
3.4 report and respond to cases of childhood malnutrition, including nutrition education for parents/guardians of malnourished children.

iv). Cross Cutting Issues

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

Gender: CMA's gender analysis shows women have low status, low education and limited access to household resources that would enable them to access reproductive health, MCH & ANC programs. As such there is low uptake of ANC services and most infant deliveries occur at home. Those who do come to CMA facilities have delivery complications. Men have not been educated to permit women to access home health promoters & health clinics for safe delivery by a trained birth attendant. In addition, distance, insecurity and the harsh climate are deterrents for pregnant women to seek health and assistance from trained birth attendants at health clinics. Similarly, women lack resources to ensure their children can access EPI services. Knowledge about the disease prevention value of EPI is still low. Clearly, education on MCH, ANC, EPI & hygiene needs to be increased. CMA will ensure women participate equally in the services provided through this project by conducting outreaches to deliver health services and health education that reach women and men in their communities and homes. Through these mechanisms, CMA will engage both men and women in awareness sessions on GBV, sexual and reproductive rights of women and girls, and on the specific health needs of pregnant women. These interventions will be intended to curb GBV, and encourage men to support women to access MCH & ANC services, and enable mothers to regularly access EPI services for their children. CMA will ensure that women participate in decision making by fostering their inclusion in leadership positions in Boma/Village health committees and Payam Health Departments. Consultations targeting community leaders will reach both women and men and include issues on rights of women and girls, and promote basic and appropriate services that support well-being and quality of life of women.

Environment: CMA will ensure that health technical staff is trained on proper disposal of used materials emphasizing biohazard prevention. CMA will also ensure that incinerators are functioning at all PHCCs and PHCUs. It is CMA's policy to burn all bio-hazard materials in metal drums and then to deeply bury all burned refuse in a pit that is condoned off with a barbed wire.

HIV/AIDS: CMA will conduct HIV/AIDS awareness in affected communities, specifically:

- Training and sensitizing health workers on HIV/AIDS & prevention methods;
- The project will deliver HIV/AIDS awareness messages through the health education and community outreach activities;
- CMA will make available the medications for treatment of opportunistic infections associated with HIV/AIDS as diagnosed.

v) Expected Result/s

Briefly describe (in no more than 300 words) the results you expect to achieve at the end of the CHF grant period.

Outcome: Reduced morbidity & mortality among vulnerable populations in underserved Fangak & Longechuk counties.

Output 1. The safety net of basic packages of health and referral services will be delivered from 4 PHCCs and 8 PHCUs. These life-saving services will reach a total of 51,500 individuals (women – 18,190, girls – 10,410, men – 12,490, boys – 10,410). The total of <5 consultations will be 11,210 individual (girls 5,605, boys 5,605). Measles vaccinations for <5 children will reach 600 girls and 600 boys. Further, IMCI package & micronutrient supplements and nutrition action for <5 children will reach 2,400 (1,200 female, 1,200 male), 1,200 will receive LLITNs, 1,200 will receive DPT3, and 1,200 severely malnourished children will be assisted.

Skilled birth attendants will deliver at least 300 births, and 600 pregnant women will attend 2+ ANC clinics & receive IPT2 second dose. 1,550 men & 1,550 women will be sensitized on sexual and reproductive rights and related health issues.

Output 2. The 4 PHCCs and 8 PHCUs will be strengthened through repairs and equipment, essential drugs, reproductive health & EPI supplies to secure capacity to maintain life-saving BPHS, emergency and referral service. Inpatient and maternity wards, laboratories and pharmacies at PHCCs will be equipped to maintain life-saving BPHS services and receive referral from PHCUs. The program will secure medical kits with drugs and supplies at the rate of 1 kit / month / PHCC.

Output 3. The health facilities will effectively respond to health emergencies. Kala-azar and measles outbreaks and childhood malnutrition will be monitored through weekly IDSR reports. An anticipated 1,200 kala-azar patients will be treated, 1,200 <5 children (600 girls, 600 boys) will be treated for measles and 2,400 <5 malnourished children will be identified (1,200 girls, 1,200 boys).

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

SOI (X)	#	Output Indicators (Ensure the output indicators are consistent with the output indicators that will be used in the results framework section III of this project proposal).	Target (indicate numbers or percentages) (Targets should be disaggregated by age and sex as per the standard output indicators list and add-up to the number of direct beneficiaries identified page 1)
(X)	1.	Total direct beneficiaries of women, girls <15 years, men & boys <15 years	total of 51,500 individuals (women – 18,190, girls – 10,410, men – 12,490, boys – 10,410)
(X)	2.	Number of consultations of 5 years and older	total of 40,290 individual consultations (female - 22,990, male - 17,300)
(X)	3.	Number of <5 consultations	total of 11,210 individual consultations (girls 5,605, boys 5,605)
(X)	4.	Number of measles vaccinations given to <5 in emergency or returnee situation	total of 1,200 individual vaccinations (girls 600, boys 600)
	5.	Number of <5 children reached with IMCI package & micronutrient supplements and nutrition action	Total consultations of <5 children 2,400 (1,200 female, 1,200 male) - 1,200 receive LLITNs, 1,200 receive DPT3, 1,200 severely malnourished children assisted
(X)	6.	Number of births attended by skilled birth attendants	300 births attended by trained attendants
(X)	7.	Number of antenatal clients receiving IPT2 second dose	600 pregnant women attend 2+ ANC clinics & receive IPT2 second dose
	8.	Number of men & women reached and gender sensitized with reproductive health education	1,550 men & 1,550 women are sensitized on sexual and reproductive rights and related health issues
(X)	9.	Number of health facilities providing components of	4 PHCCs & 8 PHCUs in 2 counties

		BPHS	
	10.	Number of health facilities repaired to maintain life-saving BPHS service delivery	4 PHCCs and 8 PHCUs
	11.	Number of health facilities with inpatient, laboratories and pharmacies adequately equipped to maintain life-saving BPHS service delivery	4 PHCCs
	12.	Number of health facilities with maternity wards adequately equipped to provide safe delivery environment for pregnant women	3 maternity wards
	13.	Medical kits with drugs, equipment & consumables delivered on time	24 kits delivered to 4 PHCCs (1 kit / month / PHCC)
	14.	IDSR reports completed weekly	2 disease outbreaks reported (measles, kala-azar) & 2,400 malnourished children identified and reported
	15.	Number of patients receiving emergency diagnostic and treatment services for kala-azar	1,200 kala-azar patients treated
	16.	Number of children receiving emergency diagnosis and treatment for measles	1,200 <5 children (600 girls, 600 boys)
	17.	Number of <5 consultation and assessed to be malnourished	2,400 <5 malnourished children identified (1,200 girls, 1,200 boys)
(X)	18.	Total indirect beneficiaries	10,400 individuals

vi) Implementation Mechanism

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

CMA has delivered programs in South Sudan since 1993, and over this period, CMA has experienced many health emergencies similar to the present situation. As the contracted agent to implement RRHP in both Longechuk and Fangak counties, CMA will implement this project in full collaboration with CHDs, and with the participation of local community-based groups. No other NGOs or contractors will be involved in the delivery of this project.

CMA's structure for delivering the life-saving emergency services detailed in this proposal will be headed by a Medical Manager, a South Sudanese national who is a qualified MD with a Master's Degree in Public Health. This person will hold the responsibility for overseeing the teams of the 4 PHCC clusters, and lead in liaison and collaboration with CHDs and the other PHCCs assisted to retain critical skilled health professionals through this period of transitioning from INGOs to MOH. In addition, the Medical Manager will be responsible for managing any new and emerging health emergencies (in terms of personnel, facilities, pre-positioning of essential pharmaceuticals, managing the expected MOH pharmaceutical supply eruption etc.), kala-azar services and the new threat of measles. The Medical Manager will control the locations where personnel are assigned in order to ensure sufficient personnel are located where most needed and ensure that they are provided with the requisite life-saving drugs, medical supplies, equipment etc.

Each PHCC team will be comprised of senior personnel including a field coordinator (a health professional to lead the medical team), a clinical officer, nurses/midwives and medical nurses. This team of skilled personnel will supervise the laboratory technicians, pharmacy technicians, CHWs, EPI workers and logistical and support personnel of the PHCC & PHCUs. The clinical officer and medical nurse positions are filled by South Sudanese nationals, while the field coordinator and nurse/midwife positions are filled by international personnel. All pharmacy technicians, CHWs, EPI workers and logistical and support personnel of the PHCC & PHCUs are national personnel.

Each PHCC team will divide the work of the PHCC into that of outpatient & inpatient, MCH/ANC, laboratory, pharmacy, EPI, and the health service outreaches, gender awareness and health education activities. Two laboratory technologist (one per county) share the responsibility of training the South Sudanese laboratory technicians and ensure these personnel are capable of running the laboratory. Each PHCU team will be comprised of 2 CHWs and support personnel. These personnel will work under the supervision and report to the field coordinator located at the PHCC.

A Logistics Coordinator will be responsible for procuring and delivering all supplies necessary to maintain program operation, and to sustain the ongoing health services. The Logistics Coordinator will be assisted by 6 Logistics Assistants/Skilled Construction Workers to ensure that required building materials and supplies are procured and delivered to the sites where required in order to complete the repairs and maintenance of health facilities that are needed to deliver the BPHS, but were extensively damaged in the floods of 2012.

This project will provide life-saving health services as part of the MOH BPHS. As the contracted agent of the RRHP, CMA is required to coordinate and work in close collaboration with the CHDs in the delivery of health services. In addition to the links with CHDs, CMA has established mechanisms at the state levels to liaise with MOH. Through CMA's management and logistical personnel located in Juba, CMA will remain in close contact with state and national levels of the MOH.

CMA is experienced working in the health sector in collaboration with MOH and to operate in respect of the protocols, policies, strategies and practices directed by government. The features that are important for coordination with MOH will be:

- Ensuring that the services of the project reach the populations most vulnerable in the current emergency, and to implement outreach/mobile services to special at-risk populations reluctant to access health services because of insecurity or other reasons;
- Ensuring this project is delivering services in complement to MOH and other state and national level health services providers, and to make focused effort to reach populations not otherwise served;
- Ensuring the pharmaceuticals are pre-positioned to ensure stock is available throughout the emergency, and in case of an eruption in MOH supply chain;
- Ensuring that pharmaceuticals used in treating patients are either sourced through the MOH or approved by MOH and that MOH approved treatment protocols are followed, and to monitor drug supplies and anticipate the expected eruption in drug supplies in order to be prepared to act in a timely manner and secure drugs supplies for the PHCCs covered in this program.

At the national level, CMA will coordinate with other health service stakeholders ensuring an adequate exchange of knowledge and information on present and emerging health emergencies with peer organizations and networking bodies specifically, the NGO Health Forum, UN agencies (UNICEF, WFP, UNOCHA, UNDP) and donor agencies (CHF, MDTF, IMA/World Bank and USAID/OFDA) through meetings, sitting on committees and sharing of annual reports and lessons learned. Similarly, the project will endeavor to link the described basic services with emergency preparedness and response through effective utilization of IDSR reporting and EWARN.

Under RRHP, CMA will be required to work in full collaboration with CHDs and the County Commissioners and links with other agencies to facilitate delivery of emergency food, mass EPI services and medical relief assistance to cope with the current and any new health emergencies. At the payam level, CMA's orientation in coordination will be on mobilizing the local stakeholders to take increasing responsibility for health emergency services ensuring BPHS meet priority needs of local and IDP/returnee populations, vulnerable women and children. At all times, CMA will be monitoring and reporting disease outbreaks, and growth monitoring to assess malnutrition rates. At the PHCC level, monthly meetings with key stakeholders will be the means of undertaking this coordination. CMA will ensure the participation of the benefiting populations through the BHCs at the PHCU level, and through the PHDs at the PHCC level. Churches, women's groups, CBOs, and other NGOs help immensely in information dissemination and feedback.

vii) Monitoring and Reporting Plan

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

1. Explain how will you measure whether a) Activities have been conducted, b) Results have been achieved, c) Cross-cutting issues have been addressed, and d) Project objectives have been met
2. Indicate what monitoring tools and technics will be used
3. Describe how you will analyze and report on the project achievements
4. Ensure key monitoring and reporting activities are included in the project workplan (Section III)[2].

1. Overview of Monitoring Plans

CMA's program monitoring effort will be aimed at:

- Improving project effectiveness in the context of the present and new health emergencies, and the effectiveness of specific activities & methods;
- Ensuring best quality of health/medical practices are implemented even in the emergency situation and ensure uniformity and compliance with MOH and donor guidelines;
- Assessing the transition from INGOs to MOH service delivery to identify and fill gaps as required;
- Regularly assessing health emergency situations, especially as related to kala-azar, measles, malnutrition and the security context in relation to changes in the IDP and returnee populations and rivalries between tribes, clans and competing and conflicting communities, which have the potential to pose security threats and interrupt project implementation.

By applying a results based orientation, CMA will apply a robust and rigorous approach to monitoring project progress. At the project level, the expected outcome results with indicators have been defined. The targeted output results have also been defined. This information will be summarized in a log frame. Project reports will provide assessment of planned versus actual progress toward achieving expected outcome and output results using the indicators identified in section C(v) above.

2. Data Collection for Monitoring

OCHA's regular data on returnees and the census completed in 2008 have been used for establishing overall population figures for the areas served. To monitor this project, CMA will conduct annual community and household surveys for outcome results data as well as draw data from the ongoing project.

[2] CHF minimum narrative reporting requirements will include the submission of a final narrative report and where applicable a narrative mid-term report. Narrative reports will include a progress on the project achievements using the outputs indicators listed in this project proposal.

To monitor output achievement, each PHCU and PHCC will collect the data on each outpatient & inpatient treatment; kala-azar and measles treatments, growth monitoring of <5 children; the mothers and children served in the MCH & ANC; the number of children reached with EPI; the number of participants in community outreaches, HIV/AIDS and hygiene education activities along with topics presented in health education campaigns; and the number of patients treated for non-communicable disease conditions, and other data as required. Data from each PHCU will be added to data from the PHCCs on a monthly basis.

To monitor the outcome of health services and outreach education, an M&E Specialist attached to this project will maintain monitoring systems at each PHCC. These monitoring systems will gather data on changes in health seeking behavior and practice, and change in disease prevalence and the morbidity and mortality. The M&E Specialist will work under the direction of the Medical Manager and in collaboration with the Field Coordinators leading each PHCC. CHWs and EPI workers selected from the cadre of South Sudanese personnel of each PHCC will implementing health surveys and community-based data gathering under the direction of the M&E Specialist.

3. Data Analysis and Application

For output monitoring, the primary data gathered from the outpatient/inpatient services will be analyzed at the PHCC level. Any unusual trends in disease incidence, outbreak or malnutrition will be further verified and investigated to determine root cause. This analysis will improve or change the content of the medical aspects of the project, and for addressing any outbreaks of diseases, including kala-azar, measles and malnutrition. Monthly reports of the unusual trends will be submitted to CMA's Sudan program management team and to UNICEF, the CHDs and MOH. These reports will be compiled into quarterly reports for submission to USAID/OFDA and used internally for ongoing planning.

In relation to outcome monitoring, the M&E Specialist will lead the analysis of the data gathered through community surveys. This officer will prepare the analysis for reporting purposes, and he will work with the Medical Manager to feed conclusions and recommendations back to the PHCC Field Coordinators. Results of this analysis will be used by CMA for review of strategies and approaches to primary health care services in these remote areas. It will be reported in the annual end-of-project report and also made available to CHF/UNDP, UNICEF, the CHDs and MOH.

CMA will monitor changes in local conditions that may affect the implementation of health activities (movement of IDPs/returnees, prevalence of kala-azar infection, measles infections, changes in climate and security, the potential for conflict between communities etc.) in order to plan appropriate and timely responses to any emerging health emergencies. If an unusual trend or crisis is detected, CMA is well placed to inform the GOSS and UN/NGO coordination mechanisms and other agencies, so that complementary, consistent and coordinated responses can be carried out. CMA will continue to use UNICEF and MOH formats and the Health Information System (HIS) for reporting health sector data. This system serves both as an internal monitoring tool as well as reporting into the MOH and UN/NGO systems and allows CMA to share and compare health data with other partners and NGOs.

4. Responsibilities for Reporting

At the output level, the PHCC Field Coordinators will be responsible for data collection, analysis and reporting, including health emergency and crisis analysis. With assistance from the Medical Manager, the Field Coordinators will analyze this data, interpret the results and prepare monthly reports for submission to CMA's South Sudan Director. The Medical Program Manager will compile monthly reports into quarter reports. In consultation with the field teams, and analyze these reports comparing actual with planned results. When results appear unsatisfactory, the Medical Manager will ensure that measures are taken to improve performance. The PHCC Field Coordinator will also be responsible for the pharmaceutical records of his/her PHCC cluster with assistance from the field and Juba-based Logisticians. The Medical Program Manager will submit quarterly reports to the Sudan Director for completion and presentation to donors. At the outcome level, the M&E Specialist will work with the Medical Manager and Field Coordinators to gather, analyze and report data on the community-level effects of the program. This team will compile an annual report from the data gathered ensuring that it is applied both in future PHC planning and also that it is fed back to the PHCC level for application in the ongoing delivery of services.

5. Monitoring Program Expenses Versus Progress in Output Achievement

Field Coordinators will compile monthly financial reports for submission to the Medical Manager and South Sudan Director. CMA's Accountant will complete the quarterly financial reports for the South Sudan Director who will complete and submit the reports to donors. These reports will be reviewed by the offices of CMA's Director and Director of Administration. CMA's South Sudan Director will be responsible for analyzing program costs versus achievements and monitoring the rate of expenditure of the program. This analysis will be conducted in consultation with CMA's Director of Administration, and if progress of output achievement appears to be lagging behind expenditures, mitigation measures will be determined by these senior managers. The progress review will be done quarterly, or as required.

E. Total funding secured for the CAP project

Please add details of secured funds from other sources for the project in the CAP.

Source/donor and date (month, year)	**Amount** (USD)
CHF – Canada for the period April – September 2013	$353,000
RRHP/MOH for the period April – September 2013	$795,953

F. Budget Guideline

Each CHF project proposal must include a budget which details the costs to be funded by CHF. The budget should reflect activities described in the project narrative, and include sufficient detail to provide a transparent overview of how CHF funds will be spent. Budget lines should be itemized including quantity and unit prices of items to be procured whenever possible.
Use the annexed excel sheet to fill the budget ensuring it strictly adheres to CHF budget guidelines hereafter. These guidelines provide guidance on budget category description (section i), type of budgetary information required (section ii) and guidance on Direct and Indirect costs (section iii)

Note i) Description of Budget Categories

1. RELIEF ITEMS and TRANSPORTATION	NOTES
• Direct operational input including the procurement of consumable supplies for project implementation (e.g. drugs, food, NFIs, seeds, tools, etc.); and related costs of transportation and handling.	• Breakdown by line item and indicate unit/ quantity/ cost per unit • Provide itemized description for those without quantity/cost per unit • If relief items are received from pipeline or other sources please list the items and indicate the amount under column i "Other funding to this project including in kind". • Cost for supplies should be presented separately from cost of transport in the budget sheet.
2. PERSONNEL	
• Organization staff costs and entitlements involved in the implementation of the project (programme and support staff)	• Provide detailed description of Responsibility/title, post location, quantity and the percentage of full time equivalent (FTE) dedicated to the CHF project • Indicate the percentage dedicated to the CHF project. • Do not include consultancies with firms or agreements with implementing partners (which go under Category 5 Contracts)
3. STAFF TRAVEL	
• Costs incurred for the travel of staff members	• Provide detailed description of staff members (title, post location) • Provide breakdown of all costs (frequency, amount and number of staff)
4. TRAINING WORKSHOPS/SEMINARS/CAMPAIGNS	
• Only training directly related to implementation of the project to be included (counterparts and staff members)	• Describe type of training, number of participants, location, duration, unit cost • Provide breakdown of costs incurred during each of the training
5. CONTRACTS	
• Specialized services provided to the project by an outside contractor including groups, firms, companies, and NGOs (e.g. printing press, consultancy firms, construction companies)	• Depending on type of contract and services provided- the budget line should be itemized • Give itemized breakdown of pass-through funding for each Implementing Partner
7. VEHICLE OPERATING AND MAINTENANCE COSTS	
• This budget line includes the purchase/rental of vehicles directly serving the implementation of the project	• Rental of vehicles and maintenance could be a paid on a monthly basis (Lump Sum) or $/kilometer • Provide breakdown by item/activity, location, quantity, unit cost
8. OFFICE EQUIPMENT AND COMMUNICATION	
• Procurement of non-consumables (telecom equipment, IT equipment, office supplies, etc.) • Office rent and fuel for the generators, utilities (telephone, water, electricity etc)can be included in this budget line	• Provide breakdown by item/activity, location, quantity, unit cost • Other office supplies that cannot be itemized can be indicated as lump sum (LS)
9. OTHER ADMINISTRATIVE COSTS	
• Other costs related to the project not covered by the above such as bank transfer charges, courier charges,. etc	• Provide itemized description of costs if not possible to breakdown by unit/quantity/cost per unit
OVERHEAD/PROGRAMME SUPPORT COSTS (PSC)	
• To cover PSC at HQ/regional and country level.	• PSC not to exceed 7% **of subtotal** project costs
AUDIT Costs	
• NGOs are required to budget at least 1% of total project cost for audit, UNDP/TS will contract external audit	
11. GRAND TOTAL COSTS	
• The total of project costs	• The Sum of subtotal project costs, PSC and Audit.

Note ii) type of budgetary information required

(a) Items Description: Provide a brief description of items required to implement the project.
(b) Location: The place where the cost is incurred. This column is key to determine the Direct and Indirect nature of the budget line in column c.
(c) Cost Type (I or D): Indicate if a budget line is D (direct) or I (indirect). See Notes iii) below for guidance on how to determine the cost type.
(d) Unit of measurement: indicate the unit used to measure the budget line. e.g months, tonnage, pieces etc
(e) Percentage/full-time-equivalent (FTE): indicate the percentage or FTE that CHF will cover.
(f) Quantity: the amount in relation to the unit of measurement, such as number of people, number of months etc
(g) Unit Cost: the cost of one item.

(h) Total CHF Cost: the sheet automatically calculates once column e, f and g are filled in

(i) Other funding to this project including in kind: indicate if there is any other funding or resources (cash or in-kind) received toward activities of this project. e.g supplies received from the pipelines.

Note iii) Guidance on Direct and Indirect Costs

1. RELIEF ITEMS and TRANSPORTATION

- If relevant to the project all cost fall under **direct** cost
- Cost for supplies should be presented separately from cost of transport in the budget sheet

2. PERSONNEL

Direct costs:

- All Staff costs, including entitlements, of personnel **directly** involved in the implementation of the project and based at project location. *(Remember to provide in the budget a detailed description of staff members title & post location.)*

Indirect costs:

- All Staff costs and entitlements of personnel not directly involved in the implementation of the project (Juba/other state capital headquarters staff). (*For Juba/ other state capital HQs staff, charged to the project please provide in the budget a detailed description of staff members title, location and percentage of time devoted to the project and equivalent dollar amount. For example for an M&E officer at Juba level, devoting 10% of his/her time for six months, the row will be filled as follows:*

Item Description	Location	Cost type (Direct or Indirect)	Unit of measurement	Percentage/ FTE	Quantity	Unit Cost	**Total**
One M&E officer	Juba	I	months	10%	6	1,200	**720**

Please note, the budget sheet will automatically calculate the total cost.

3. STAFF TRAVEL

Direct costs:

- Travel cost of staff **directly** involved in the implementation of the project (staff based at project area) are direct. Please specify in the budget line where from and where to is travel intended.

Indirect costs:

- Travel cost for support staff not directly involved in the implementation of the project (e.g. headquarters staff travelling on mission to the project location).

4. TRAININGS, WORKSHOPS, SEMINARS, CAMPAIGNS

Direct costs:

- All costs of training, workshop, seminars and campaigns if they are directly related to the outcome of the project (e.g. mobilization campaign to promote hygiene and sanitation; training of nurses on safe delivery). *(Remember to describe in the budget the type of training, the number of participants, location and duration of the training).*

5. CONTRACTS

- All costs under contracts fall under **direct.** Please remember to provide a description of the services provided.

6. VEHICLE OPERATING & MAINTENANCE COSTS

Direct costs: if related to vehicles used at the project implementation area

Indirect costs: if related to vehicles outside project areas (e.g. vehicle cost in Juba for a project being implemented in Bor)

7. OFFICE EQUIPMENT & COMMUNICATIONS

Direct costs:

- If items/service is used at the project implementation area

Indirect costs:

- If items/service is used outside of the project implementation area (e.g. Cost of services in Juba Country Office for a project being implemented in Bor).

8. OTHER COSTS (bank charges, …)

Direct costs:

- If items/service is used at the project implementation area costs

Indirect costs:

- If items/service is used outside of the project implementation.
- Visibility is considered Indirect cost.

9. Programme Support costs (Indirect cost)

10. AUDIT COSTS for NGO implemented projects (Indirect Cost)

SECTION III:

This section is NOT required at the first submission of a proposal to the cluster coordinator/co-coordinator. However it is required to be filled for proposals recommended for funding by the Advisory Board.

LOGICAL FRAMEWORK		
CHF ref./CAP Code: SSD-13/H/55436	**Project title:** Provision of essential gender-sensitive high-impact health services, emergency referral and health system strengthening assistance in underserved Fangak, Nyirol & Pigi Counties in Jonglei and Longechuk County in Upper Nile, South Sudan.	**Organisation: Christian Mission Aid (CMA)**

Overall Objective	**Cluster Priority Activities for this CHF Allocation:** • Maintain the existing safety net by providing basic health packages and emergency referral services; • Strengthen emergency preparedness including surgical interventions; • Respond to health related emergencies including controlling the spread of communicable diseases.	**Indicators of progress:** • Reduced morbidity & mortality among vulnerable populations in underserved Fangak & Longechuk counties.	**How indicators will be measured:** • Health data & economic statistics from MOH and State sources.	
Purpose	**CHF Project Objective:** The specific objectives are: • To maintain the existing safety net of basic health packages and emergency referral services; • To strengthen capacity and preparedness to respond to emergencies caused by in-climate weather, conflict, insecurity and drug stock-outs, etc.; • To respond to health related emergencies including kala-azar, the threat of measles, and the potential for malnutrition related conditions, etc.	**Indicators of progress:** • Access to basic & emergency health services; • Health facilities with capacity to maintain basic & emergency health services; • Health emergencies successfully responded to during project time-frame.	**How indicators will be measured:** • MOH health data; • Community-based monitoring surveys; • End-of-project report.	**Assumptions & risks:** • Political situation remains stable; • No further deterioration in security; • Food security does not deteriorate further. If communities cannot access PHCCs/PHCUs to receive services & participate in health education outreaches, project objectives will not be achieved.
Results	**Results - Outcomes (intangible):** • Populations in 2 underserved counties access life-saving basic health and referral services; • Health facilities in underserved areas deliver life-saving BPHS & emergency health & referral services; • Health facilities respond to health emergencies caused by kala-azar, measles outbreak, malnutrition & other health emergencies.	**Indicators of progress:** • 51,500 individuals directly access health services & 10,400 receive indirect assistance; • 12 health facilities deliver life-saving health services; • 4,800 individuals assisted with life-saving services to address health emergencies.	**How indicators will be measured:** • Semi-annual project reports; • End-of-project report.	**Assumptions & risks:** • Communities can access health facilities; • Security permits delivery of emergency health services.

	Immediate-Results - Outputs (tangible):	Indicators of progress:	How indicators will be measured:	Assumptions & risks:
	1. Life-saving basic health & referral services: • Individual consultations for emergency health & common disease conditions;	• Total consultations - women – 18,190, girls – 10,410, men – 12,490, boys – 10,410; • Total consultations 5+>5 - female - 22,990, male - 17,300); • Total consultations <5 - girls 5,605, boys 5,605.	• Data from inpatient/outpatient clinics; • Semi-annual project reports.	• Leaders & health promoters can mobilize communities to receive outpatient/inpatient, IMCI, EPI & ANC services; • Security permits delivery of health education outreaches; • Men are prepared to participate in reproductive health awareness.
	• Measles vaccinations provided for <5 children;	• Total of 1,200 individual vaccinations (girls 600, boys 600).	• Data from EPI services units; • Semi-annual project reports.	
	• IMCI package & micronutrient supplements & nutrition action deliver for <5 children;	• Total consultations of <5 children 2,400 (1,200 female, 1,200 male) - 1,200 receive LLITNs, 1,200 receive DPT3, 1,200 severely malnourished children assisted.	• Data from PHCCs/PHCUs; • Semi-annual project reports.	
	• Pregnant women receive birth assistance from skilled birth attendants;	• 300 births attended by trained attendants.	• Data from PHCCs/PHCUs; • Participant data from health education outreaches;	
	• Pregnant women will attend 2+ ANC clinics & receive IPT2 second dose;	• 600 pregnant women attend 2+ ANC clinics & receive IPT2 second dose;	• Data from community-based monitoring on application of message practices;	
	• Adults sensitized on sexual/reproductive rights & related health issues.	• 1,550 men & 1,550 women sensitized on reproductive rights & related health issues.	• Semi-annual project reports.	
	2. Health facilities deliver emergency & referral health services: • Health facilities repaired, equipped & supplied to secure capacity to maintain life-saving emergency & referral services;	• 4 PHCCs & 8 PHCUs in 2 counties provide BPHS;	• Reports from PHCCs/PHCUs; • Semi-annual project reports.	• CMA can deliver materials & community can provide unskilled labour to repair health facilities; • CMA & State MOH are able to procure & deliver vaccines, essential medical materials & pharmaceuticals.
	• Health facilities with inpatient & maternity wards, laboratories & pharmacies equipped to maintain life-saving & referral health services;	• 4 PHCCs with 3 maternity wards in 2 counties;		
	• Medical kits with drugs & supplies provided to health facilities.	• 24 kits delivered to 4 PHCCs (1 kit / month / PHCC).		
	3. Health facilities respond to health emergencies: • Emergencies like kala-azar, measles & childhood malnutrition monitored & weekly IDSR reports submitted;	• 2 disease outbreaks reported (measles, kala-azar) & 2,400 malnourished children reported;	• IDSR reports generated weekly; • Data from inpatient/outpatient clinics; • Semi-annual project reports.	• Health emergencies do not overwhelm available health facilities & personnel; • CMA & State MOH are able to procure & deliver essential medical materials & pharmaceuticals sufficient for health

	• Kala-azar patients diagnosed & treated; • Measles patients diagnosed & treated; • Childhood malnutrition cased assessed & treated.	• 1,200 kala-azar patients treated; • 1,200 <5 children (600 girls, 600 boys) treated; • 2,400 <5 malnourished children identified (1,200 girls, 1,200 boys)		emergencies.
	Activities: **1. Provide basic packages of life-saving health services** 1.1 provide life-saving outpatient, inpatient & maternity services with adequate laboratories & pharmacies; 1.2 implement IMCI for <5 children including growth monitoring, promote breast-feeding, micronutrient supplements, nutrition action for severely malnourished children, promotion of LLITNs, EPI & vaccination for measles, & health education on childhood diseases; 1.3 provide ANC/reproductive health services & sensitize men & women on reproductive health issues, ANC & safe motherhood & infant delivery with professionally trained birth attendants. **2. Repair health facility structures & provide essential health materials** 2.1 conduct major repairs of health facilities to secure capacity to deliver life-saving health and referral services; 2.2 maintain/replace equipment necessary to deliver life-saving health & referral services; 2.3 maintain/replace equipment necessary for adequate maternity services & health service outreaches; 2.4 manage procurement of essential medicines and medical supplies to mitigate stock-outs. **3. Provide life-saving emergency health services** 3.1 conduct IDSR with weekly reports submitted with specifics on monitoring caseloads for kala-azar, measles and malnutrition; 3.2 diagnose & provide inpatient treatment	**Inputs:** • Salaries/maintenance of technical health personnel & support staff at health facilities & permits for international staff, medical care & insurance; • Transportation for personnel, camp supplies/rations & supplies; • Vehicle lease & operations, office rents, utilities, supplies, communication, bank & audit charges. • Building materials to repair health facilities; • Skilled labour for health facility repairs & maintenance; • Essential medicines, supplies & materials; • Transportation for building materials, medicines & medical equipment & supplies. • Salaries/maintenance of technical health personnel & support staff; • Medicines & medical supplies.		**Assumptions, risks and pre-conditions:** • MOH & local authorities endorse & support implementation of project activities; • Community leaders are prepared to collaborate and actively participate in project activities.

	services for kala-azar; 3.3 diagnose & treat measles, and provide inpatient services as required; 3.4 report and respond to cases of childhood malnutrition.			

PROJECT WORK PLAN

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

Activities	**Q1/2013**			**Q2/2013**			**Q3/2013**			**Q4/2013**			**Q1/2014**		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Activity 1.1 outpatient, inpatient & maternity services with adequate laboratories & pharmacies				X	X	X	X	X	X						
Activity 1.2 implement IMCI, nutrition action for severely malnourished, EPI & vaccination for measles				X	X	X	X	X	X						
Activity 1.3 provide ANC/reproductive health services & sensitize men & women on reproductive health				X	X	X	X	X	X						
Activity 2.1 conduct repairs of health facilities to secure capacity to deliver health services				X	X	X									
Activity 2.2 maintain/replace equipment necessary to deliver health services				X	X	X									
Activity 2.3 maintain/replace equipment necessary for adequate maternity services				X	X	X									
Activity 2.4 manage procurement of essential medicines & medical supplies to mitigate stock-outs					X	X	X	X							
Activity 3.1 conduct IDSR with weekly reports submitted to monitor kala-azar, measles & malnutrition				X	X	X	X	X	X						
Activity 3.2 diagnose & provide inpatient treatment services for kala-azar				X	X	X	X	X	X						
Activity 3.3 diagnose & treat measles, and provide inpatient services as required				X	X	X	X	X	X						
Activity 3.4 report and respond to cases of childhood malnutrition				X	X	X	X	X	X						

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