Project Proposal

Organization	CMA (Christian Mission Aid)			
Project Title	Strengthening the capacity of primary health care facilities to deliver essential and emergency services in Fangak and Nyirol counties of Jonglei State			
Fund Code	SSD-15/SA1/H/INGO/216			
Primary Cluster	HEALTH		Secondary Cluster	None
Project Allocation	1st Round Standard Allocation		Allocation Category Type	
Project budget in US$	199,999.96		Planned project duration	6 months
Planned Start Date	01/01/2015		Planned End Date	30/06/2015
OPS Details	OPS Code	SSD-15/H/73114	OPS Budget	0.00
	OPS Project Ranking		OPS Gender Marker	

Project Summary

In response to the humanitarian crisis, the project aims to reverse the rising mortality rate and reduce morbidity from communicable diseases, malnutrition, kala-azar, unsafe child deliveries and victims of SGBV. The project will achieve this by: strengthening essential primary health and EmONC services including kala-azar and severe acute malnutrition; by enhancing immunization services and increasing capacity to monitor and report malnutrition rates and detect/respond to kala-azar, measles and other disease outbreaks; and by enhancing availability and access to treatment for SGBV. The project will focus on saving lives by reaching vulnerable children under 5 years, adolescent girls, pregnant and lactating women of IDP and women headed households. The differential needs of women and girls, men and boys and the different needs of IDP and hosting populations will be addressed by a combination of (1) consultations with the men and women leaders of host and IDPs communities to ensure the most vulnerable are reached and mobilized to access available services, and (2) outreach health services to ensure disadvantaged groups have access to emergency health services. Significant accomplishments of the project will be 2 centres established to deliver EmONC and kala-azar services; total direct beneficiaries will be 97,737 of which 39,094 will be children under 5 years; IDPs served 34,208; EmONC for 1,500 women; 770 severe acute malnourished children treated. Gender mainstreaming, accountability to affected populations, basic HIV services (including PMTCT, preventive education and supplies) and protection of vulnerable populations in need of accessing health facilities will be important cross-cutting issues. Training of health workers, and engaging payam health committees, men and women leaders of host and IDP communities will ensure these themes are integrated into project delivery. Feedback from target populations will be applied in ongoing health programming.

Direct beneficiaries

	Men	Women	Boys	Girls	Total
Beneficiary Summary	24434	34208	19547	19547	**97,736**
Total beneficiaries include the following:					
People in Host Communities	15882	22235	12706	12706	63529
Internally Displaced People	8552	11973	6842	6842	34209

Indirect Beneficiaries	85500	Catchment Population	301475 (estimated)

Link with the Allocation Strategy

The project will be implemented in Fangak and Nyirol counties in the opposition held areas. These counties are severely affected by the conflict and flooding. Both counties are rated Crisis – Level 4 on the vulnerability scale (HNO_DIaD_Group: Analysis Final Print ver_01 Oct 2014 PPP slide 8). As such, the project clearly fits the objectives of "emergency response in conflict affected areas" that are included in the strategic objectives of the SRP and the cluster. Based on ground-rules developed to guide CMA's humanitarian project planning and implementation in the context of conflict, CMA will apply its 'do-no-harm' principles and practices for project delivery. Project objective 1 will improve access to essential primary health care, basic HIV services, ante-natal and EmONC services by providing human and materials resources to enable delivery of emergency services. The project will provide human resources, training for national health workers and materials resources to add to existing RRHP resources, and target specific locations where there is a concentration of IDPs and other vulnerable populations not being served. The project will build the capacity of health facilities to deliver quality services for children under 5 years, EmONC services, treatments for kala-azar and treatment for children suffering severe acute malnutrition. In an effort to ensure the project achieves gender equality in opportunity to access health services, communities will be organized to provide protection for vulnerable women, adolescent girls and children of IDP and host communities so they can access essential health services. In this manner the project will deliver on the SRP objective 1 "to provide protection and services to conflict affected communities", and on cluster objective 1 "to improve access and responsiveness of essential and emergency health services including EmONC". Project objective 2 will enhance existing immunization services and increase capacity to report malnutrition rates and detect & respond to kala-azar, measles and other disease outbreaks. The project will link with RRHP initiatives to help deliver enhanced immunization services in the context of an emergency situation, especially in locations where there are large IDP populations and movements. CME training of national health workers will be implemented to raise the capacity for monitoring and recording disease trends with gender disaggregated data, and for reporting regularly to MoH/RRHP authorities for quick response. Of particular concern are measles and kala-azar. These project activities will deliver on the SRP objective 1 "to provide protection and services to conflict affected communities", and on cluster objective 2, "to enhance existing systems to prevent, detect and respond to disease outbreaks". Project objective 3 will enhance access to, and treatment for sexual and gender-based violence. The project will provide health professionals skilled in treatment and management of SGBV in the 2 centres targeted for EmONC services. These personnel will provide essential treatments and train national personnel on appropriate treatment at these 2 centres and 3 additional centres where IDPs are concentrated. To address the tendency to not report these incidents, the project will support health education outreaches on the sexual and reproductive rights of men, women, and adolescent girls and boys to raise awareness on SGBV. Communities will be mobilized to form committees charged with the protection of any person that requires access to emergency health care. By these actions, the project will deliver on SRP objectives 1 and 2, "to provide protection to conflict-affected communities and ensure access to services, and a coordinated lifesaving response to immediate humanitarian needs of conflict-affected people", and on cluster objective 3 "to improve availability, access and demand for services targeting highly vulnerable people".

Sub-Grants to Implementing Partners

Other funding Secured For the Same Project (to date)

Source	US$
MOH/Rapid Results Health Programme (RRHP)	706,798.00
	706,798.00

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BACKGROUND INFORMATION

1. Humanitarian context analysis.. Humanitarian context: Describe the current humanitarian situation in the specific locations where this project will be implemented

Targeted counties are in opposition held areas where there is high risk of access denied and disruption in project delivery. Insecurity in both Nyirol and Fangak counties, and severe late season flooding in Pullita, Nyadin and Toch areas of Fangak County (reported 11 November 2104 by CMA's teams on the ground and the CHD, Phom) have caused huge population movements (UNMISS Report July and OCHA data to 14 Oct 2014 show Fangak with 102,409 and Nyirol with 184,380 IDPs respectively but these figures are "unconfirmed" as data is from various sources). The floods and insecurity prompting population movement have had serious negative effects on both the target beneficiaries and service delivery. Flooding and insecurity affects women and men, and boys and girls differently. In this context, men have been able to sustain their mobility, but children under 5 and women and girls requiring reproductive health, EmONC services (HNO 2015 pg 5) have greatly restricted movement. While men are capable of protecting themselves, women, girls and boys have less access to health facilities as they often need protection or cannot cope with flooded conditions. Pregnant women requiring safe delivery services find the context of insecurity and flooding severely restricts their opportunity to access skilled birth attendants (HNO 2015 pg 5). IDP women and adolescent girls are particularly vulnerable, as they can be a target of SGBV. IDP children are also at risk. CMA's personnel monitor the security context, and use this evaluation to guide the planning of health service especially outreaches, designed to deliver services to women, girls and children to achieve gender equality in services. Also, these services must be delivered in a manner that adheres to CMA's ground rule to not participate in any political discussion or actions, and perform services applying the "do-no-harm" principles and practices. In the context of conflict, insecurity, flooding and population movement, the need for primary health services has sharply increased while the capacity to deliver services has declined. While ensuring services can be accessed equally by men, women, girls and boys, specific and urgent humanitarian needs are: • to treat an upsurge in rates of communicable diseases (malaria, measles and acute respiratory infections) caused by the stresses of population movement, malnutrition and congested living conditions; • to reduce the maternal mortality rate, provide safe deliveries and neo-natal care; • to detect, properly refer and/or treat outbreaks of kala-azar, measles and severe acute malnutrition. The CRP 2014 pg 49 has reported that skilled health workers have fled and primary healthcare facilities have been destroyed and/or closed. The destroyed and non-functional facilities in targeted counties is: • Fangak, County hospital damaged and 2 very poorly functioning. •

	Nyirol, 1 facility destroyed, 6 very poorly functioning and 2 non-functioning. The reduced number of functioning facilities, sustained insecurity and recent flooding have combined to greatly restrict access to health services. Even with restricted access to health facilities, the number of treatments has risen sharply where primary health services have been sustained. Data from PHCCs at Juiabor and Keew in Fangak show the total of individuals treated in 2013 was 44,900 compared to more than 113,000 in 9 months of 2014 (CMA's HMIS data). Patients have flocked to functional facilities. Four major disease conditions account for this increase: kala-azar, malaria, measles & respiratory infections. The number of kala-azar cases has spiked in Nyirol (HNO 2015 pg 3). Due to the challenging treatment protocol, proper treatment can only be provided from well-equipped centers. The MSF center at Lankien is suitably equipped. Men have more access to kala-azar treatment facilities, but insecurity often restricts access of women, adolescent girls and children.
2. Needs assessment. Explain the specific needs of the target group(s), explaining existing capacity and gaps. State how the needs assessment was conducted, list any baseline data and explain how the number of beneficiaries has been developed. Indicates references to assessments such as Multi-cluster/sector Initial Rapid Assessments (MIRA)	CMA is the lead agency for RRHP providing health services in both Nyirol and Fangak Counties. In collaboration with CHDs and health facility personnel, CMA continuously assesses health needs, and the related context issues that drive emerging and/or chronic health problems. The baseline used for planning this project has been derived from CMA's ongoing health program, and the HIMS established for RRHP. CMA's assessment shows the need for primary healthcare services has sharply increased while delivery capacity has declined. The specific needs of the target populations and that this project will address are: • Treatment for acute respiratory infections, acute watery diarrhea, malaria, malnutrition and measles; • Provision of EmONC to reduce the maternal mortality rate, provide safe deliveries and ante-natal care; • Treatment for patients with kala-azar, measles, and malnutrition, and assistance to establish a more effective referral system. In the current context of conflict/insecurity and flooding, the number of properly functioning health facilities has declined. However, CMA has seen the number of treatments rise sharply where primary healthcare services have been sustained. Data from PHCCs at Juiabor and Keew in Fangak show the total of individuals treated in 2013 was 44,900 compared to more than 113,000 in 9 months of 2014 (CMA's HMIS data). Patients flock to functional facilities when their local facility ceases to function. However, insecurity and floods restrict access of some to health services especially pregnant women, girls and children. Three major disease conditions account for the sharp increase in patient consultations: kala-azar, measles and acute respiratory infections. The IRNA report from New Fangak (1605 2014 IRNA New Fangak final), Chuil (IRNA Chuil 12092014) and data from UNMISS and OCHA (UN OCHA @www.SouthSudan_IDP%20Sites_12Oct2014) all illustrate the large numbers of IDPs in Nyirol and Fangak County. Recent fighting in Phom and November floods added to these IDP numbers. The DIaD Group Analysis (final version 01 Oct 2014 slide 4) shows Fangak and Nyirol as "severe" vulnerability. Food insecurity and crowded conditions of IDP and IDP hosting households are significant causes of increased morbidity. In addition, men have joined the armed forces (HNO 2015 pg 3), leaving women to maintain households. CMA estimates 60% of households are now women headed. IDP households experience food insecurity - IPC crisis (3) or emergency (4) due to displacement and since they were unable to plant in 2014 (From Crisis to Catastrophe pg 8-12). IDP and women headed households experience weakened immunity while being exposed to multiple disease burdens (CRP 2014 pg 47). CMA's on-ground experience is the same as the evidence provided in the HNO 2015 (pg 4). Mothers, pregnant women, and children under 5 years are most vulnerable. IDP households that are headed by women are also vulnerable to sexual abuse and exploitation. The project will provide awareness on this issue and provide the basic package for treatment of SGBV and basic HIV services. The reduced availability and access to health services is the critical humanitarian gap that this project will fill. This project will rehabilitate facilities, provide medical equipment, repair cold-chains and provide health workers to bring non-functioning facilities back into service. High priority will be given to filling specific gaps especially: • services for under 5 children to prevent and treat malaria, water borne diseases, acute respiratory infections, measles, other diseases and malnutrition. • services for women to provide ante-natal, EmOBN care, including services for victims of SCBV and exploitation. • high quality care for kala-azar patients, including training so that health workers can properly treat kala-azar patients. • enhanced monitoring and reporting disease outbreaks and malnutrition.
3. Description Of Beneficiaries	The population in Fangak and Nyirol counties is predominantly Nuer ethnicity, overwhelming rural and whose livelihoods are based on agro-pastoralism. The focus of this project will be on communities that are hosting concentrations of IDPs and where health services are not being provided by any other health sector humanitarian actor. CMA is the lead agency delivering RRHP in both Fangak and Nyirol counties. CMA has sustained its presence on-ground in these counties since the beginning of the current crisis. Through its on-ground presence, collaboration with the CHD and other humanitarian actors operating in these counties, CMA has identified the locations (Waat, Pultruk, Chuil in Nyirol, and Phom, Nyadin, Kuernyang, Pakan, Toch, Keew and Juaibor in Fangak) most in need of this project's assistance. Through UNOCHA's Integrated Rapid Needs Assessments (IRNAs), its on-ground presence and monitoring surveys, the most vulnerable and at-risk populations have been identified. The primary target beneficiaries of the project will be the IDPs and those households that are hosting IDPs. The target populations have been displaced by either conflict/insecurity or floods, or both floods and conflict. Even in non-crisis situations, this population has experienced the ravages of common communicable diseases caused by poor nutrition, poor water and sanitation standards, and lack of knowledge on preventions and managing common diseases. Recently measles and kala-azar outbreaks have emerged. The area is poorly served by health facilities. The target populations are the vulnerable under 5 children, adolescent girls, the elderly, and pregnant and lactating mothers of IDP and women headed households. CMA ensures its programs are accessible to all regardless of race, tribe, gender or religious belief. Services are available to combatants not uniformed and not carrying arms of any kind. IDP and IDP hosting households are seriously affected by poor nutrition and crowded conditions - a significant direct cause of their increased morbidity. Men have joined the armed forces (HNO 2015 pg 3) leaving women to maintain households. CMA's personnel estimate 60% of households are now women headed. IDP households are experiencing food insecurity - IPC crisis (3) or emergency (4) due to displacement and since they were unable to plant in 2014 (From Crisis to Catastrophe pg 8-12). Populations of IDP and women headed households experience weakened immunity while being exposed to multiple disease burdens (CRP 2014 pg 47). CMA's on-ground experience provides the same evidence provided in the HNO 2015 (pg 4). Common threats are acute respiratory infections, acute watery diarrhea, malaria, malnutrition and measles. Excluding IDPs from other counties, target counties have a total estimated population of 301,475 (IMA Adjusted Populations by County 2013). Authorities in Fangak confirm at least 46,000 IDPs spread over several payams (Fangak CHD Officer 29 November 2014). IDP estimates from Nyirol County indicate 116,000 IDPs with more than 50% of IDPs located in Waat Payam (Nyirol CHD Officer 29 November 2014). Each week that passes provides new reports of IDP movement prompted by conflict or floods. The project will reach areas where services have been disrupted by the conflict and where the health facilities need support in order to provide the services demanded by the concentration of the IDP population, and where facility structures, equipment, cold-chain and skilled health workers are inadequate for essential and emergency health services. • Total direct beneficiaries 97,737 (female – 53,755 and male – 43,981). • Total children under 5 direct beneficiaries (girls 19,547 and boys 19,547). • Total pregnant women direct beneficiaries 3,000. • Total IDP beneficiaries 34,208 (5 years and older female – 11,923 and male – 8,552) (under 5 girls 6,842 & boys 6,842).
4. Grant Request Justification.	CMA has worked in Fangak and Nyirol counties since 2000. CMA is the lead agency for implementation of RRHP in these counties. CMA's experience and capacity to sustain services in the context of the current crisis will ensure effective project delivery. In relation to EmONC, with grants from CIDA/CHF Canada, CMA has established centres for safe child delivery, and for a comprehensive reproductive health, children under 5 years nutrition monitoring and therapeutic feeding programs in Keew and Juaibor. CMA will use this experience to model and deliver effective EmONC services in 4 other centres in Nyirol and Fangak counties. Most recently in 2009 – 2011, CMA maintained kala-azar treatment centers in Keew and Juiabor. These centres received and successfully treated local and referred kala-azar patients. This experience will be utilized to design and deliver kala-azar treatments in 4 additional centres. (Proposed locations for EmONC and kala-azar centres are Waat and Pultruk in Nyriol, and Phom and Nyadin in Fangak). CMA has experience delivering its health services in a gender sensitive approach, including gender training for health workers, conducting awareness campaigns on sexual and reproductive rights and mobilizing communities to address gender issues, SGBV and enabling women, girls and boys to access health services when needed. CMA has past experience delivering programs that include IDPs without excluding host communities. CMA understands the high access and disruption risks in delivering projects in opposition held areas. CMA has experience delivering health services in the context of conflict with designated security focal point, and measures, evacuation plans and protocols and clear ground rules to ensure a "do-no-harm' approach to service delivery. Most importantly, CMA is known and trusted as a competent health service provider by community leaders, local authorities and the county and payam health departments. With this experience, CMA is best placed to manage these risks. While the RRHP support is spread over all health facilities, it does not have the mandate or funding to direct assistance to locations of IDP concentration. CMA will combine the resources of CHF with the RRHP to provide resources needed to fill critical gaps and meet the service demands where IDPs have concentrated. The relevant experience of CMA and the presence of CMA in the targeted counties place it in the best position to deliver the proposed project.Further justification for the project arises from the crisis and the humanitarian need of targeted populations. The DIaD Group Analysis (final version 01 Oct 2014 slide 4) shows Fangak and Nyirol as "severe" vulnerability. The reduced availability and access to health services specifically in locations hosting large IDP populations is the critical humanitarian gap that this project will fill. This project will rehabilitate facilities, provide medical equipment, repair cold-chains and provide health workers to bring non-functioning facilities back into service. High priority will be given to filling gaps especially: • services for under 5 children to prevent and treat malaria, water borne diseases, acute respiratory infections, measles, other diseases and malnutrition; • services for women to provide EmONC services, including services for victims of SGBV and exploitation; • high quality care for kala-azar patients, including training so that health workers can properly treat kala-azar patients; • enhanced monitoring and reporting disease outbreaks (kala-azar and measles) and malnutrition. The deteriorating humanitarian crisis requires urgent response.The CHF funded project will provide resources to hire & equip teams of Clinical Officers and Midwives/Nurses at the PHCC level, ensuring improved access EmONC services, capacity to treat the surge of kala-azar and other diseases brought by food insecurity, flooding, population movement and congested living conditions.
5. Complementarity. Explain how the project will complement previous or ongoing projects/activities implemented by your organization.	CMA has provided health services Fangak and Nyirol counties since 2000. CMA has established high quality PHCCs and PHCUs in these counties and these health facilities are currently providing high quality services to huge populations. Specialized services that have been provided from the facilities include EmONC and kala-azar treatment. For the CHF funded project, CMA will draw on the lessons learned over the past 15 years in order to establish additional EmONC services and kala-azar treatment facilities. CMA is currently implementing RRHP in both these counties. RRHP funding provides for basic services but does not have the mandate or funding capacity to direct assistance to locations of IDP concentration, nor to special needs services like kala-azar treatment and emergency obstetric services. CMA will combine the resources of CHF with the RRHP and other donors to provide the resources required to fill critical gaps and meet the service demands where IDPs have concentrated, were kala-azar treatments are needed most and where EmONC services are presently inadequate or non-existent. In this manner, the CHF funded project has been designed and will complement RRHP, and build on CMA past work by raising up the quality health service delivery at selected locations.
LOGICAL FRAMEWORK	
Overall project objective	The overall objective of this project is to reverse the rising mortality rate and reduce morbidity from communicable diseases, malnutrition, kala-azar, unsafe child deliveries and victims of gender-based violence, sexual abuse and trauma. The project will achieve this objective by: strengthening the health delivery system and improving access to essential primary health care, basic HIV services, ante-natal and EmONC services with a focus on reaching the most vulnerable children under 5 years, adolescent girls, pregnant and lactating women of IDP and women headed households; by enhancing immunization services and increasing capacity to monitor and report malnutrition rates and to detect and respond to kala-azar, measles and other disease outbreaks; and by enhancing availability and access to treatment for sexual and gender-based violence, and fill the critical humanitarian gap. The project will be implemented by CMA alongside RRHP in Fangak and Nyirol counties. CMA anticipated project delivery disruption and constrained access, and has well defined strategies in place to manage these risks. If the project can proceed as planned, it will increase the availability of health services by providing human and material resources in addition to and as a complement to RRHP resources targeting critical humanitarian gaps so that priority interventions as listed above can be successfully delivered. Rehabilitating, maintaining and providing the human resources for basic facilities at selected PHCCs so that EmONC services, kala-azar treatments, treatment of severe malnutrition and treatment for SGBV can be delivered will be a critical addition to the RRHP delivery capacity. In the context of constant insecurity and population movements, mainstreaming gender equality and accountability to affected populations and protection of vulnerable populations when they to need assistance to access health facilities will be important cross-cutting themes guiding the implementation of project activities. Fielding additional health personnel, training these health workers and

community-based health promoters and engaging payam health committees and men and women leaders of host and IDP communities will ensure that these themes are integrated into health service delivery. Feedback from target populations will be captured and applied in ongoing health program monitoring, regular health outreaches and regular meetings with community leaders, including the leaders of IDP communities. Guidance from the Health Cluster on gender mainstreaming and on protection will be important resources for training health personnel and for designing health interventions that strengthen the themes of gender and protection in CMA's health service delivery. The tools prepared by the Inter-agency Standing Committee (IASC) to ensure accountability to affected populations will be the critical reference for CMA's training on this particular theme. CMA will coordinate closely with other humanitarian actors, and collaborate wherever possible with organizations delivering WASH, Nutrition and FSLcluster projects.

Logical Framework details for HEALTH

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
2015 SSO 1: Improve access to, and responsiveness of, essential including emergency health care, and emergency obstetric care services	SO 1: Save lives and alleviate suffering by providing multi-sector assistance to people in need	70
2015 SSO 2: Enhance existing systems to prevent, detect and respond to disease outbreaks	SO 1: Save lives and alleviate suffering by providing multi-sector assistance to people in need	20
2015 SSO 3: Improve availability, access and demand for Gender Based Violence and Mental Health and Psycho-Social Support services targeting highly vulnerable people	SO 2: Protect the rights of the most vulnerable people, including their freedom of movement	10

Outcome 1	Project Outcome 1: Strengthened health delivery systems for the treatment of communicable diseases, malnutrition, kala-azar and trauma, and for safe child deliveries and newborn care, and designed to achieve gender equality in opportunity to access health services	
Code	**Description**	**Assumptions & Risks**
Output 1.1	Health facilities rehabilitated, maintained and equipped to enable the delivery of gender sensitive essential and emergency health services, basic HIV services, treatment for severe malnutrition, kala-azar treatment and EmONC services.	Access to the planned project locations will not be impeded by the conflict Local security situation will allow unimpeded delivery of materials, equipment and supplies for health facility rehabilitation Conflict and/or local insecurity could prevent delivery of materials for rehabilitation, equipment and supplies effectively disrupting establishment of kala-azar and EmONC centres.

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 1.1.1	HEALTH	[Frontline services] # of functional health facilities in conflict-affected and other vulnerable states					5
	Means of Verification:	CMA project reports.					
Indicator 1.1.2	HEALTH	[Frontline services] # of direct beneficiaries from emergency drugs supplies (IEHK / trauma kit / RH kit / PHCU kits)	24434	34208	19547	19547	97736
	Means of Verification:	Health facility HMIS data.					
Indicator 1.1.3	HEALTH	# of medicine kits provided to primary health care facilities					18
	Means of Verification:	CMA Project reports					

Activities

Activity 1.1.1	rehabilitating facilities and maintaining health facilities.
Activity 1.1.2	engaging men and women community leaders to take responsibility for the maintenance and protection of facilities
Activity 1.1.3	Providing medicines, medical equipment and supplies including condoms to help control HIV.
Activity 1.1.4	monitoring through monthly procurement and delivery reports, monthly HMIS reports from targeted facilities and quarterly field monitoring reports

Output 1.2	Health facilities adequately staffed with health professionals and community-based health support workers adequately trained to deliver the essential and emergency health services, basic HIV services, kala-azar treatment and EmONC services with gender sensitivity	Access to the affected population by health workers will not be impeded by the conflict Local security situation will allow project personnel to freely deliver health services Conflict and/or local insecurity could prevent health workers from working in some locations effectively disrupting delivery of planned services

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 1.2.1	HEALTH	# of new health worker hired to deliver gender sensitive essential and emergency health and basic HIV services					21
	Means of Verification:	CMA Project Reports					
Indicator 1.2.2	HEALTH	[Frontline services] # of health workers trained in MISP / communicable diseases / outbreaks / IMCI / CMR/trauma	11	5			16
	Means of Verification:	CMA Project Reports					
Indicator 1.2.3	HEALTH	[Frontline services] # of health personnel trained in community-based Mental Health and Psycho-social support in IDP settings	11	5			16
	Means of Verification:	CMA Project Reports					
Indicator 1.2.4	HEALTH	[Frontline services] # of EmONC centres established					2
	Means of Verification:	CMA Project Reports					
Indicator 1.2.5	HEALTH	# of kala-azar treatment centres established					2
	Means of Verification:	CMA Project Reports					

Activities

Activity 1.2.1	providing gender balanced human resource capacity (clinical officers, nurses, midwives, community health promoters) for the delivery of emergency primary health, basic HIV services and essential package of reproductive health services and EmONC services, and kala-azar treatment services
Activity 1.2.2	training through on- the-job and CME of health workers for essential primary healthcare delivery, HIV transmission prevention, safe disposal of sharps and other medical waste, reproductive health care including education on PMTCT, mental health and psycho-social support in IDP setting, including gender equality, gender sensitivity, and the importance of data collection disaggregated on the basis of gender
Activity 1.2.3	monitoring through monthly reports from targeted facilities and quarterly field monitoring reports

Output 1.3	Outpatient services reach most vulnerable children under 5 years, adolescent girls, pregnant and lactating women of IDP and women headed households, and inpatient services provided for kala-azar patients, patients suffering severe malnutrition and trauma	Access to the most vulnerable populations will not be impeded by the conflict Local security situation will allow unimpeded delivery of services to IDP and host community populations Leaders of IDP and host communities are prepared to organize for the protection of vulnerable populations to access health facilities Conflict and/or local insecurity could prevent health workers from conducting outreaches necessary to provide planned services to some of the most vulnerable target populations

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 1.3.1	HEALTH	[Frontline services] Total # of outpatient consultations in conflict-affected and other vulnerable states	24434	34208	19547	19547	97736
	Means of Verification:	Health Facility HMIS Data					
Indicator 1.3.2	HEALTH	[Frontline services] # of <5 outpatient consultations in conflict-affected and other vulnerable states			19547	19547	39094
	Means of Verification:	Health Facility HMIS Data					
Indicator 1.3.3	HEALTH	# of children treated for severe malnutrition					770
	Means of Verification:	State Nutrition Surveillance Reports					
Indicator 1.3.4	HEALTH	# of payams organized to protect children, adolescent girls and women who need access to health facilities					5
	Means of Verification:	CMA Project Reports					

Activities

Activity 1.3.1	providing essential basic curative primary health care services to men, women, girls and boys and specific outreach to IDP and women headed households to ensure the most vulnerable of these households receive available services
Activity 1.3.2	screening, referring and caring for children with medical complications as a result of severe acute malnutrition
Activity 1.3.3	ensuring men, youth and women leaders organize to provide protection for children, adolescent girls and women during episodes of insecurity so they can access health facilities for essential and reproductive health services
Activity 1.3.4	monitoring through monthly HMIS reports from facilities and quarterly field monitoring reports

Output 1.4	EmONC and reproductive health services and basic and referral HIV services reach women of child-bearing age and adolescent girls, and men, women, adolescent girls and boys sensitized to the value/importance of reproductive health for women and adolescent girls	Access to target population will not be impeded by the conflict Local security situation will allow unimpeded delivery of facility-based and outreach awareness of EmONC and reproductive health services Leaders of IDP and host communities are prepared to organize for the protection of vulnerable populations as they access EmONC and reproductive health services Conflict and/or local insecurity could prevent health workers from providing awareness outreaches and EmONC and reproductive health services

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 1.4.1	HEALTH	[Frontline services] Proportion of births attended by skilled birth attendants					15
	Means of Verification:	Health Facility HMIS Data					
Indicator 1.4.2	HEALTH	# of antenatal clients receiving IPT 2nd dose					1500
	Means of Verification:	CMA Project Reports					
Indicator 1.4.3	HEALTH	# of antenatal clients receiving 2nd dose of TT vaccination					1500
	Means of Verification:	CMA Project Reports					

Activities

Activity 1.4.1	providing the essential package of reproductive health, basic HIV and EmONC services
Activity 1.4.2	raising awareness among men and women leaders of host and IDPs communities of the vulnerability of women, adolescent girls and children, and the need to organize community-based approaches to enable women of childbearing age to access EmONC services
Activity 1.4.3	monitoring through monthly HMIS reports from facilities and quarterly field monitoring reports

Output 1.5	Gender sensitive health education outreach and health promotion reach host communities and IDP households, especially women headed households	Access to target population will not be impeded by the conflict Local security situation will allow unimpeded delivery of gender sensitive health education outreaches and health promotion activities

		Conflict and/or local insecurity could prevent health workers from providing awareness and health promotion activities to vulnerable IDP and women headed households

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 1.5.1	HEALTH	[Frontline services] # of people reached with health education and promotion messages	16100	30100	0	0	46200
	Means of Verification:	CMA Project Reports					
Indicator 1.5.2	HEALTH	# of communities and payams organized to mobilize disadvantaged and vulnerable populations to seek health services					5
	Means of Verification:	CMA Project Reports					

Activities

Activity 1.5.1	providing public health awareness to engage men and women leaders with a focus on hygiene promotion, vaccinations campaigns, gender awareness, reproductive health and the vulnerability of children, adolescent girls and women, HIV/AIDS prevention, prevention and control of other STIs
Activity 1.5.2	engaging men, women and community leaders of host and IDP communities in planning health interventions and reporting back to communities
Activity 1.5.3	monitoring through community surveys and quarterly field monitoring reports

Outcome 2	Increased reach of immunization services and increased capacity to monitor and report malnutrition rates and to detect and respond to kala-azar, measles and other disease outbreaks.	
Code	**Description**	**Assumptions & Risks**
Output 2.1	Essential preventive childhood (under 5 years) immunizations and measles vaccinations completed, and distributing ITNs supplied by UNICEF.	Access to under 5 children will not be impeded by the conflict Local security situation will allow unimpeded delivery of immunization and vaccination services, and outreach immunization campaigns, and allow mothers to access health facilities for vaccination services for their children Leaders of IDP and host communities will actively participate in mobilizing populations for vaccinations campaigns Conflict and/or local insecurity could prevent implementation of vaccination and immunization services

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 2.1.1	HEALTH	[Frontline services] # of children with 3 doses of pentavalent vaccine			1895	1895	3790
	Means of Verification:	Health Facility HMIS Data					
Indicator 2.1.2	HEALTH	[Frontline services] # of children under 5 who have received measles vaccinations in emergency or returnee situation			10144	10144	20288
	Means of Verification:	HMIS Vaccination Reports					
Indicator 2.1.3	HEALTH	# of ITNs issued to pregnant women, mothers of children under 5, women attended by skilled birth attendant & special needs IDP households					7424
	Means of Verification:	Health Facility HMIS Data					

Activities

Activity 2.1.1	providing pentavalent vaccinations to children under 1 year of age
Activity 2.1.2	conducting vaccinations against measles for children under 5 years through routine health facility based vaccinations and community outreach campaigns
Activity 2.1.3	as incentives providing mosquito nets (ITNs) to pregnant women completing IPT 2nd dose, mothers of children under 5 years completing pentavalent vaccination, women attended by skilled birth attendant and special needs IDP households
Activity 2.1.4	monitoring through monthly HMIS reports from facilities and quarterly field monitoring reports

Output 2.2	Disease outbreaks reported within 48 hours, and malnutrition rates reported promptly	Access to population suffering disease outbreaks and/or malnutrition will not be impeded by the conflict Local security situation will allow unimpeded provision of surveillance and malnutrition monitoring Conflict and/or local insecurity could prevent health workers from providing surveillance and malnutrition monitoring activities

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 2.2.1	HEALTH	[Frontline services] Proportion of communicable diseases alerts verified and responded to within 48 hours					90
	Means of Verification:	State Disease Surveillance Reports					
Indicator 2.2.2	HEALTH	# of health workers trained in diseases outbreaks surveillance and reporting					21
	Means of Verification:	IDSR Reports and CMA Project Reports					

Activities

Activity 2.2.1	selecting health workers to be responsible for weekly disease surveillance, ongoing monitoring and reporting disease trends and detecting outbreaks
Activity 2.2.2	training health workers through on-the-job and CME approaches, on required disease surveillance and reporting practice including reporting on gender and age disaggregated basis
Activity 2.2.3	monitoring through weekly IDSR reports from facilities and quarterly field monitoring reports

Outcome 3	Increased utilization of emergency and essential health care services by the highly vulnerable adolescent girls, women headed households in IDP setting	
Code	**Description**	**Assumptions & Risks**
Output 3.1	Outpatient services reach highly vulnerable adolescent girls, and women of IDP women headed households when victim of gender-based violence and sexual abuse including basic HIV services, counseling and education on HIV transmission and prevention	Access to target population will not be impeded by the conflict Local security situation will allow unimpeded provision of treatment for victims of SGBV and exploitation, and related awareness and outreach activities Affected populations and victims of SGBV will be supported by community leaders to come forward to access treatment Conflict and/or local insecurity could prevent health workers from providing treatment for victims of SGBV and exploitation

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 3.1.1	HEALTH	[Frontline services] # of health facilities providing basic package of GBV services in IDP setting					2
	Means of Verification:	CMA Project Reports					
Indicator 3.1.2	HEALTH	# of survivors of SGBV receive clinical management of rape treatment and basic HIV services, counseling and prevention education					100
	Means of Verification:	CMA Project Reports					

Activities

Activity 3.1.1	providing the basic package of HIV services and referrals and treatment and management of sexual and gender-based violence
Activity 3.1.2	ensuring vulnerable women and adolescent girls, men and women community leaders are aware of SGBV services and men and women leaders are engaged to support SGBV victims to access services
Activity 3.1.3	monitoring through community surveys, monthly reports from facilities and quarterly field monitoring reports

WORK PLAN

Project workplan for activities defined in the Logical framework

Activity Description (Month)	Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Activity 1.1.1 rehabilitating facilities and maintaining health facilities.	2015	X	X	X	X								
Activity 1.1.2 engaging men and women community leaders to take responsibility for the maintenance and protection of facilities	2015	X	X	X	X	X	X						
Activity 1.2.1 providing gender balanced human resource capacity (clinical officers, nurses, midwives, community health promoters) for the delivery of emergency primary health, basic HIV services and essential package of reproductive health services and EmONC services, and kala-azar treatment services	2015	X	X	X	X	X	X						
Activity 1.2.2 training through on- the-job and CME of health workers for essential primary healthcare delivery, HIV transmission prevention, safe disposal of sharps and other medical waste, reproductive health care including education on PMTCT, mental health and psycho-social support in IDP setting, including gender equality, gender sensitivity, and the importance of data collection disaggregated on the basis of gender	2015	X	X	X									
Activity 1.3.1 providing essential basic curative primary health care services to men, women, girls and boys and specific outreach to IDP and women headed households to ensure the most vulnerable of these households receive available services	2015	X	X	X	X	X	X						
Activity 1.3.2 screening, referring and caring for children with medical	2015	X	X	X	X	X	X						

complications as a result of severe acute malnutrition													
Activity 1.3.3 ensuring men, youth and women leaders organize to provide protection for children, adolescent girls and women during episodes of insecurity so they can access health facilities for essential and reproductive health services	2015	X	X	X	X	X	X						
Activity 1.4.1 providing the essential package of reproductive health, basic HIV and EmONC services	2015	X	X	X	X	X	X						
Activity 1.4.2 raising awareness among men and women leaders of host and IDPs communities of the vulnerability of women, adolescent girls and children, and the need to organize community-based approaches to enable women of childbearing age to access EmONC services	2015	X	X	X	X	X	X						
Activity 1.5.1 providing public health awareness to engage men and women leaders with a focus on hygiene promotion, vaccinations campaigns, gender awareness, reproductive health and the vulnerability of children, adolescent girls and women, HIV/AIDS prevention, prevention and control of other STIs	2015	X	X	X	X	X	X						
Activity 1.5.2 engaging men, women and community leaders of host and IDP communities in planning health interventions and reporting back to communities	2015	X	X										
Activity 2.1.1 providing pentavalent vaccinations to children under 1 year of age	2015	X	X	X	X	X	X						
Activity 2.1.2 conducting vaccinations against measles for children under 5 years through routine health facility based vaccinations and community outreach campaigns	2015	X	X	X	X	X	X						
Activity 2.1.3 as incentives providing mosquito nets (ITNs) to pregnant women completing IPT 2nd dose, mothers of children under 5 years completing pentavalent vaccination, women attended by skilled birth attendant and special needs IDP households	2015	X	X	X	X	X	X						
Activity 2.2.1 selecting health workers to be responsible for weekly disease surveillance, ongoing monitoring and reporting disease trends and detecting outbreaks	2015	X											
Activity 2.2.2 training health workers through on-the-job and CME approaches, on required disease surveillance and reporting practice including reporting on gender and age disaggregated basis	2015	X	X	X									
Activity 3.1.1 providing the basic package of HIV services and referrals and treatment and management of sexual and gender-based violence	2015	X	X	X	X	X	X						
Activity 3.1.2 ensuring vulnerable women and adolescent girls, men and women community leaders are aware of SGBV services and men and women leaders are engaged to support SGBV victims to access services	2015	X	X	X	X	X	X						
Activity 1.1.3 Providing medicines, medical equipment and supplies including condoms to help control HIV.	2015	X	X	X	X	X	X						
Activity 1.1.4 monitoring through monthly procurement and delivery reports, monthly HMIS reports from targeted facilities and quarterly field monitoring reports	2015	X	X	X	X	X	X						
Activity 1.2.3 monitoring through monthly reports from targeted facilities and quarterly field monitoring reports	2015	X	X	X	X	X	X						
Activity 1.3.4 monitoring through monthly HMIS reports from facilities and quarterly field monitoring reports	2015	X	X	X	X	X	X						
Activity 1.4.3 monitoring through monthly HMIS reports from facilities and quarterly field monitoring reports	2015	X	X	X	X	X	X						
Activity 1.5.3 monitoring through community surveys and quarterly field monitoring reports	2015	X		X			X						
Activity 2.1.4 monitoring through monthly HMIS reports from facilities and quarterly field monitoring reports	2015	X	X	X	X	X	X						
Activity 2.2.3 monitoring through weekly IDSR reports from facilities and quarterly field monitoring reports	2015	X	X	X	X	X							
Activity 3.1.3 monitoring through community surveys, monthly reports from facilities and quarterly field monitoring reports	2015	X	X	X	X	X	X						

M & R DETAILS

Monitoring & Reporting Plan:
Describe how you will monitor the implementation of each activity. Describe the tools you plan to use (checklist, photo, questionnaires, interviews, suggestion box etc.) in order to collect data and how you will store data. Explain the frequency type and protocol of reporting (how often do you report about what to whom?). State if, when and how you plan to evaluate your project .

Monitoring and Reporting plan The baseline data for this project has already been established through CMA's role in the RRHP. CMA will use the following tools monitor project activities: • Focused community surveys to monitor protection, impacts of awareness outreaches and IDP access to health facilities; • Monthly HMIS, weekly IDSR reports and immunization campaign reports from health facilities; • Monthly activity reports from health facilities focused on data not provided in the HMIS reports; • Quarterly project reports to donors; • Quarterly field monitoring and evaluation reports. Project reports will provide assessment of planned versus actual outcome and output results using the indicators identified in the logical framework. To monitor output achievement, health facilities will collect data on outpatient and inpatient treatments, growth monitoring of under 5 children, mothers and children served in the MCH and EmONC services, the number of participants in outreaches, HIV/AIDS and hygiene education activities and the number of patients treated for non-communicable disease conditions, and other data as required. To monitor the outcome of health services, the M and E Specialist attached to this project will maintain monitoring systems to gather data on changes in health seeking behavior, and change in disease prevalence, morbidity and mortality. For output monitoring, the primary data gathered from the outpatient/inpatient services and outreach health services will be analyzed at the PHCC level, and worsening trends in disease incidence, outbreak and malnutrition will be investigated, and IDSR reports prepared weekly. This analysis will be used to respond any outbreaks of diseases, including kala-azar, measles, and malnutrition. In relation to outcome monitoring, the M and E Specialist will lead the analysis of information gathered through the HMIS, community surveys and consultations with VHCs, local authorities, etc. Results of this analysis will be used by CMA for review of strategies and approaches to primary health care services in the current crisis. CMA will constantly monitor changes in local conditions that may affect the implementation of health activities (movement of IDPs, malaria, measles, kala-azar infections, flooding and conflict and security 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 MOH and other agencies, so that complementary, consistent and coordinated responses can be carried out. CMA will use HMIS for monthly reporting health sector data. This system serves both as an internal monitoring tool as well as reporting into the MOH and allows CMA to share and compare health data with other partners and NGOs. At the output level, the County Coordinators will work with CHD personnel to collect data, analyze and report it, including health emergency and crisis analysis. With assistance from the Program Manager and M and E Specialist, the County Coordinators will analyze this data and prepare monthly reports. The Program Manager will compile quarterly reports, and the final report will be compiled to close the project. When results are unsatisfactory, the Program Manager will ensure that measures are taken to improve performance. At the outcome level, the M and E Specialist will work with the Program Manager and County Coordinators to analyze and report data on the community-level effects of the program ensuring this data is applied both in future planning and for application at the county level the ongoing delivery of services.

OTHER INFORMATION

Accountability to Affected Populations

The project will be implemented in collaboration with CHDs, payam health departments, local authorities and payam health committees. These structures will participate in planning, implementing and monitoring the delivery of all primary health care services. CMA will work actively to engage the payam and boma health committees conducting monthly meetings to report on health issues and to obtain feedback from local populations. Specific outreach to IDP populations and women

	headed households will be conducted throughout the duration of the project to ensure that these populations are included in planning health services and in accessing health facilities. Additional promotion and awareness on sexual and reproductive health rights and EmONC services will be carried out to ensure all women, adolescent girls and boys, and men of IDPs and host community are aware of these rights and services. The structures noted above will be engaged for the purpose of ensuring accountability for project delivery and improving health outcomes. Further, the project will promote community-based strategies and practices to provide protection for the most vulnerable community members (children, adolescent girls and women, especially IDPs) so they can access health facilities. The project will engage men and women leaders of affected populations to take responsibility for the maintenance and protection of facilities, medicines, medical equipment and supplies, and for mobilizing protection so that disadvantaged and vulnerable populations have access to health services. The Clinical Officer (or his/her equivalent) as leader of the health facility, will be responsible for organizing and coordinating the engagement of the target communities. This person will report to CMA's County Coordinator and Program Manager on each monthly meeting or more frequently if required so that community feedback is available for management decision making. Further, the Program Manager and County Coordinators will regularly (at least once per quarter) visit and supervise health facilities, and during these supervisory visits, the managers will conduct meetings with local leaders of host and IDP communities, health committees and local authorities to ensure accountability to the populations being serviced. To adhere to the principles of "Do-No-Harm", the project will strive to deliver services in a balanced manner so that IDP and host community populations and all persons regardless of ethnicity will have equal access to health services. To achieve this balance, CMA will implement a strong program of promotion and awareness raising so that as far as feasible all who need health services will have access to them.
Implementation Plan: Describe for each activity how you plan to implement it and who is carrying out what.	As the contracted agent to implement RRHP in Fangak and Nyirol counties, CMA will implement the CHF funded activities in full collaboration with CHDs, and with the participation of local community-based groups and local authorities. No other NGOs or contractors will be involved in the delivery of this project. CMA's structure for delivering the this project will be headed by the Country Director and a Program Manager, experienced in delivering health services in the context of conflict in South Sudan. The Program Manager will hold the responsibility for overseeing the field teams and lead in collaboration with CHDs and MOH. The Program Manager will work with County Field Coordinators (one person for each county) to deliver field activities. The Program Manager will control the locations where personnel are assigned in order to ensure sufficient personnel gender-balanced will be located where most needed and ensure that they are provided with the requisite drugs, medical supplies, equipment etc. Each health facility team will be comprised of Clinical Officers, Midwives and Certified Nurses. Where ever possible, the Clinical Officer and Midwife / Nurse positions will be filled by South Sudanese nationals. This team of skilled personnel will supervise support personnel of the health facilities. Where qualified and skilled women national personnel are not available to achieve gender balance on the health services delivery teams, CMA will ensure that appropriately qualified international personnel are placed on these field teams. Each team will work under the supervision of the CHD and CMA's County Field Coordinator. Where required, CMA will ensure health teams are mobilized so they have capacity to reach IDPs in locations cut-off by floods and/or conflict. A Logistics Coordinator will be responsible for procuring and delivering all supplies necessary to maintain program operation. The Logistics Coordinator will 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 damaged health facilities. 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 emergency health, basic HIV and HIV referral services of the project reach the populations most vulnerable in the current emergency, and to implement the outreach services to special at-risk populations unable to access health services because of insecurity or other reasons; • Ensuring this project is delivering services in complement to 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 and available throughout the emergency; • 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 in order to be prepared to act in a timely manner and secure drugs supplies for the health facilities. 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 Health cluster, NGO Health Forum, UN agencies (UNICEF, WFP, UNOCHA, UNDP) and donor agencies (CHF, the Pooled Fund, USAID, IMA/World Bank) 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.

Coordination with other Organizations in project area

Name of the organization	Areas/activities of collaboration and rationale
1. IMA World Health	Implementation of RRHP, coordination for mass immunization and the supply of drug kits
2. MOH	Coordination in delivery of health services at county (CHD) and health facility levels
3. WFP	Food rations for kala-azar patients
4. EMF	Supplier of emergency medical supplies, drugs and laboratory regents
5. WHO	Supplier of medical drugs and testing kits for kala-azar treatment, for technical advice on surveillance and data management and information sharing in the multi-sector monthly coordination meetings.
6. UNICEF	Supplier of ITNs, support for cold chain maintenance and provision of ready to use therapeutic food (RUTF) for Kala-azar patients.

Environmental Marker Code	B+: Medium environmental impact with mitigation(sector guidance)
Gender Marker Code	2a-The project is designed to contribute significantly to gender equality
Justify Chosen Gender Marker Code	CMA's needs analysis shows that the drivers of the humanitarian crisis are insecurity and late season flooding. These crisis drivers affect women and men, and boys and girls differently. Men have remained mobile, and able to access health services. Most women, girls and boys access health services at considerable risk and often need protection. Women headed households, both IDP and host community, are particularly vulnerable. In consultation with IDP and host community leaders, CMA has gained an understanding of this context and designed health delivery strategies and activities designed to ensure equality of opportunity to access health services. CMA's needs analysis with the participation of men and women of IDP and host communities has enabled gender to be mainstreamed into the planning of project objectives, outcomes, outputs and activities. Specific measures to identify needs of men, women, boys and girls and integrate gender into ongoing planning, implementation and monitoring include: • training a gender balance team of health workers to deliver services with gender sensitivity and collect data disaggregated on the basis of gender; • engaging men and women leaders to take responsibility for mobilizing vulnerable populations (IDPs, children, adolescent girls, women, elderly) to seek health services, and to protect these populations so they have equal opportunity to access health facilities; • providing health services to men, women, girls and boys without gender bias and conduct outreach to IDP and women headed households to ensure the most vulnerable men, women, boys and girls receive available services; • providing health awareness to men and women of IDP and host communities to raise gender awareness and awareness on the vulnerability of children, girls and women, to promote reproductive health services, and engage men and women community leaders in planning interventions, monitoring impacts and revising service delivery as required.
Protection Mainstreaming	In the current context of the project areas, the main threats to personal safety are the conflict between the armed forces of the government and opposition force (rebels), conflict between host community members and IDPs, and sexual and gender based violence most often targeting women and adolescent girls. Households headed by women, especially IDP households head by women are particularly vulnerable to SGBV. These threats to personal safety are a direct restriction to accessing health facilities. The specific measures planned in this project to mainstream protection are: 1. raising awareness among men, women, boys and girls on sexual and reproductive rights and the prevalence of SGBV; 2. promoting community-based approaches and practices encouraging communities to organize committees empowered to assist vulnerable persons to access health facilities whenever needed; 3. balancing the delivery of health services so that host communities and IDPs have equal access to the benefits of health services as a measure to reduce/eliminate conflict between IDPs and host communities; 4. engage community leaders, and local authorities to organize themselves to protect community assets like health facilities from destruction by armed forces, and to advocate for peace between the armed forces. The project will provide the basic package of services for the management and dignified treatment of sexual assault and violence that will include counseling as measures to support victims of SGBV and also to encourage abused women and girls to report exploitation, abuse and SGBV as the first necessary step to stemming SGBV.
Safety and Security	CMA has established safety and security plans for each site where re-locatable personnel are assigned. These plans are based on UNDSS recommendations as well as InterAction's Minimum Operating Security Standards. The purpose of CMA's safety and security plans are to: • Guide the activities and behavior of employees working in South Sudan and as far as possible help them avoid security and safety risks; • Protect employees in the event of conflict, and as far as possible, define the conditions, responsibilities and operating procedures for safely while working in South Sudan and when required safe evacuation from locations in conflict. CMA has an officer located in the field who holds primary responsibility for the development and update of security and evacuation plans for each site. This officer works under the supervision of CMA's South Sudan management team (Country Director and Program Manager) to set overall guidelines and operating procedures for the safety and security of employees and authorized visitors. All sites have a common security handbook to guide employees on personal safety, and which provides standard operating procedures for employees and the officers responsible for implementing security practices and executing evacuations. CMA has established county and site specific security and evacuation plans which give details on specific procedures, required practice and priority secure destinations for the protection and safe evacuation of personnel. These plans are designed to take into account the seasonal changes in plausible escape routes, and site specific variables that impose upon evacuation plan. These plans are reviewed and updated annually or more frequently if factors change substantially. The designated officer is also responsible for verifying that all personnel are trained and prepared for both personal safety and security while working in the field and for evacuation in the case of insecurity and conflict.
Access	CMA has delivered health services in both Fangak and Nyirol counties since 2000. CMA is well known in the community, by the local authorities, and by the CHD personnel. When security challenges do arise, local authorities have been able to intervene so that CMA could continue service delivery. CMA intends to sustain these good relationships recognizing that these relationships are critical to enabling continued operation in the targeted counties. Access to almost all parts of these two counties is by charter air carriers only. CMA has longstanding good partnerships with critical air service providers, specifically AIM Air, MAF and Samaritan's

	Purse. Delivering this project requires that CMA sustains good operating relationships with these air service providers.
BUDGET	

1 **Staff and Other Personnel Costs** *(please itemize costs of staff, consultants and other personnel to be recruited directly by the implementing partner for project implementation)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015 Q1	2015 Q2	Quarterly Total
1.1	Country Director, South Sudan	S	1	4200	6	10.00%	2,520.00	1,260.00	1,260.00	2,520.00
	1 Country Director at $4,200 per month for 6months, 10% charged to CHF LOCATION: Juba, South Sudan									
1.2	Program Manager, South Sudan	S	1	2650	6	10.00%	1,590.00	795.00	795.00	1,590.00
	1 Program Manager, at $2,650 per month for 6months, 10% charged to CHF. LOCATION: Juba, South Sudan.									
1.3	M and E Officer, South Sudan	S	1	2750	6	10.00%	1,650.00	825.00	825.00	1,650.00
	1 M and E Officer, at $2,750 per month for 6months, 10% charged to CHF LOCATION: Juba, South Sudan									
1.4	Finance Officer, South Sudan	S	1	2750	6	10.00%	1,650.00	825.00	825.00	1,650.00
	1 Finance officer, at $2,750 for 6months , 10% charged to CHF LOCATION: Juba, South Sudan									
1.5	Project Senior Accountant, South Sudan	S	1	2350	6	10.00%	1,410.00	705.00	705.00	1,410.00
	1 Project Senior Accountant, at $2,350 for 6months, 10% charged to CHF LOCATION: Juba, South Sudan									
1.6	Project Accountant, South Sudan	S	1	1210	6	10.00%	726.00	363.00	363.00	726.00
	1 Project Accountant, at $1,210 for 6months,10% charged to CHF LOCATION: Juba, South Sudan									
1.7	Logistics Coordinator, South Sudan	S	1	2000	6	10.00%	1,200.00	600.00	600.00	1,200.00
	1 Logistical Coordinator, at $2,000 for 6months, 10 % charged to CHF LOCATION: Juba, 1 to support Fangak and Nyirol Counties									
1.8	Office Support Personnel	S	4	400	6	10.00%	960.00	480.00	480.00	960.00
	(Receptionist, Cleaner, Guard, Driver) including benefits. The total positions are 4, each at $400 for 6months, 10% charged to CHF. LOCATION: Juba, South Sudan									
1.9	Certified Midwives/Nurses (International) including benifits and upkeep	D	2	2000	6	100.00%	24,000.00	12,000.00	12,000.00	24,000.00
	2 Certified Midwives/Nurses, each at $2,000 for 6months, 100% charged to CHF LOCATION: Jonglei, 1 in Fangak County and 1 in Nyirol County									
1.10	Certified Midwives/Nurses (National) including benefits and upkeep	D	2	950	6	100.00%	11,400.00	5,700.00	5,700.00	11,400.00
	2 Certified Midwives/Nurses (National), each at $950 for 6months, 100% charged to CHF LOCATIONS: Jonglei, 1 will be based in Fangak County & 1 in Nyirol County									
1.11	CHWs/MCHWs (National) including benifits & upkeep	D	4	500	6	100.00%	12,000.00	6,000.00	6,000.00	12,000.00
	4 CHWs/MCHWs (National), each at $500 for 6months, 100% charged to CHF LOCATIONS: Jonglei, 2 in Fangak County , 2 Nyirol County									
1.12	EPI Workers and Health Promoters including benefits	D	8	250	6	100.00%	12,000.00	6,000.00	6,000.00	12,000.00
	8 EPI workers and health promoters, each at $250 for 6 months, 100% charged to CHF LOCATIONS: Jonglei, 5 Fangak County and 3 Nyirol County.									
1.13	Support Personnel including benifits	D	5	200	6	100.00%	6,000.00	3,000.00	3,000.00	6,000.00
	5 positions (clerks, Cleaners, Guards etc), each $200 for 6months, 100% charged to CHF LOCATION: Jonglei, 3 in Fangak County,and 2 in Nyirol County.									
	Section Total						77,106.00	38,553.00	38,553.00	77,106.00

2 **Supplies, Commodities, Materials** *(please itemize direct and indirect costs of consumables to be purchased under the project, including associated transportation, freight, storage and distribution costs)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015 Q1	2015 Q2	Quarterly Total
2.1	HF basic building rehabilitation 3sites, 1 units/site	D	3	1600	1	100.00%	4,800.00	2,400.00	2,400.00	4,800.00
	30 poles $ 50/unit, thatch roof $300/unit,door$500/unit,labour$300unit,twine$350/unit,rafters and other$100/unit) LOCATION: Fangak and Nyirol Counties, Jonglei State									
2.2	HF EmONC and Kala Azar buildings, 2 sites, 2 units/site	D	4	1600	1	100.00%	6,400.00	3,200.00	3,200.00	6,400.00
	30 poles $50/unit, thatch roof $300/unit,door$500/unit,labour$300unit,twine$350/unit,raftersand other$100/unit) LOCATION: Fangak &and Nyirol Counties, Jonglei State (Proposed locations for EmONC and kala-azar centres are Waat in Nyirol, and Nyadin in Fangak)									
2.3	Amenities toilets and showers, 2 sites	D	2	2200	1	100.00%	4,400.00	2,200.00	2,200.00	4,400.00
	($500/toilet,1 toilet/site and $600/shower, 1 showes/site) LOCATION: Fangak and Nyirol Counties, Jonglei State									
2.4	Materials for EmONC services 2 units	D	2	1340	1	100.00%	2,680.00	1,340.00	1,340.00	2,680.00
	(hospital beds $220/bed 2 beds/unit,bedsheets $30/unit,delivery couch $600 1/unit,examination table $210/table 1/unit,plastic sheets $60/unit) LOCATION:For EmONC are Waat and Nyirol, and Nyadin in Fangak, Jonglei State									
2.5	Materials for Kala-Azar treatment 2units	D	2	1880	1	100.00%	3,760.00	1,880.00	1,880.00	3,760.00
	(Hospital beds $220/bed 8 beds/unit,bedsheets $120/unit) LOCATION: For kala-azar centres are Waat in Nyirol, and Nyadin in Fangak, Jonglie State									
2.6	Transportation of materials and supplies	D	2	8750	1	100.00%	17,500.00	8,750.00	8,750.00	17,500.00
	Transportation of materials & supplies Juba - field locations 2 sites (1 cargo flight shared cost 50% / site $6,000 / flight, 1 caravan charter / site $4,500 / flight, overland transport 1 trip shared 25% / site $2,500 / trip) LOCATION: Fangak and Nyirol Counties, Jonglei State									
2.7	EmONC medicines, vitamins and Supplements 2 units	D	2	500	1	100.00%	1,000.00	500.00	500.00	1,000.00
	2units not supplied by other partners ($500/site) LOCATION:For EmONC are Waat in Nyirol, and Nyadin in Fangak, Jonglei State									
2.8	Medical materials not supplied by RRHP	D	2	1200	1	100.00%	2,400.00	1,200.00	1,200.00	2,400.00
	2 units supplied with lab reagents and kerosene for EmONC Location Fangak and Nyirol Counties									

	Section Total						42,940.00	21,470.00	21,470.00	42,940.00

3 **Equipment** *(please itemize costs of non-consumables to be purchased under the project)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015		Quarterly Total
								Q1	Q2	
3.1	Equipment for EmONC services 2units	D	2	1600	1	100.00%	3,200.00	3,200.00	0.00	3,200.00
	(drip stand $65/stand 2 pc/unit, feotal stethoscope $110/scope 4 scopes/unit, baby scale $55/scale 2 scales/unit, blood pressure machine $55/mach 2 pc/unit, adult stethoscope $90/pc 2 pc/unit, delivery sets $75/set 2 sets/unit, autoclave $300/pc 1 pc/unit, manual vacuum asirator $90/pc 2 pc/unit) LOCATION:For EmONC are Waat in Nyirol, and Nyadin in Fangak, Jonglei State									
3.2	Equipment for emergency and security communication 2sites	D	2	1500	1	100.00%	3,000.00	1,500.00	1,500.00	3,000.00
	(Thuraya $750 1 pc/site, Qmac repairs and batteries $750 2 pc/site LOCATION: Fangak and Nyirol Counties, Jonglei State									
	Section Total						6,200.00	4,700.00	1,500.00	6,200.00

4 **Contractual Services** *(please list works and services to be contracted under the project)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015		Quarterly Total
								Q1	Q2	
	Section Total						0.00	0	0	0.00

5 **Travel** *(please itemize travel costs of staff, consultants and other personnel for project implementation)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015		Quarterly Total
								Q1	Q2	
5.1	Commercial Flights Juba-Nairobi Round trip for Management Personnel	S	0	800	1	100.00%	0.00	0.00	0.00	
	Commercial flights for management personnel									
5.2	Transport to/from airports for Management Personnel Round Trip	S	0	220	1	100.00%	0.00	0.00	0.00	
	taxi and transport for management personnel									
5.3	Accommodation Meals for In-Transit Management Personnel per Round Trip	S	0	870	1	100.00%	0.00	0.00	0.00	
	Accommodation for management personnel									
5.4	Charters (Juba-Health Facilities) for County Co-ordination Personnel	D	4	4490	1	100.00%	17,960.00	8,980.00	8,980.00	17,960.00
	Charters (Juba-HF) for County Coordination Personnel 2 sites (4 trips, 1 at start and every 2nd month) per Round Trip									
5.5	Commercial Flights (Juba-Nairobi), Accommodation and Ground Transport	D	0	1800	1	100.00%	0.00	0.00	0.00	
	For County Coordination Personnel per Round Trip									
5.6	Charters (Juba-Health Facilities) for Health Facilities Personnel per Round Trip	D	8	4490	1	100.00%	35,920.00	17,960.00	17,960.00	35,920.00
	Charters (Juba-HF) for HF Personnel (8 Rtrips, 1 per month plus 1 at start and 1 at end) per Round Trip									
5.7	Commercial Flights (Juba-Nairobi) and Ground Transport	D	0	800	1	100.00%	0.00	0.00	0.00	
	for Health Facilities Personnel per Round Trip									
5.8	Visas Accommodation and in transit expenses for health facility personnel per round trip	D	0	1250	1	100.00%	0.00	0.00	0.00	
	visas and travel docs for health facility personnel									
	Section Total						53,880.00	26,940.00	26,940.00	53,880.00

6 **Transfers and Grants to Counterparts** *(please list transfers and sub-grants to project implementing partners)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015		Quarterly Total
								Q1	Q2	
	Section Total						0.00	0	0	0.00

7 **General Operating and Other Direct Costs** *(please include general operating expenses and other direct costs for project implementation)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015		Quarterly Total
								Q1	Q2	
7.1	Communications Juba Office monthly cost	S	1	600	6	10.00%	360.00	180.00	180.00	360.00
7.2	Communications County Offices and HFs monthly cost	D	1	800	6	10.00%	480.00	240.00	240.00	480.00
7.3	Supplies: Office and stationaries Juba Office monthly cost	S	1	150	6	10.00%	90.00	45.00	45.00	90.00
7.4	Supplies; Office and stationaries County and health facility monthly cost	D	1	250	6	10.00%	150.00	75.00	75.00	150.00
7.5										

	Security services Juba Offices monthly cost	S	1	100	6	10.00%	60.00	30.00	30.00	60.00
7.6	Office rent: Juba office monthly cost	S	1	3600	6	10.00%	2,160.00	1,080.00	1,080.00	2,160.00
7.7	Office utilities Juba monthly costs	S	1	150	6	10.00%	90.00	45.00	45.00	90.00
7.8	Vehicle Running Costs Juba office monthly	S	1	400	6	10.00%	240.00	120.00	120.00	240.00
7.9	Vehicle running costs County monthly costs	D	1	200	6	10.00%	120.00	60.00	60.00	120.00
7.10	Generator running costs Juba office monthly costs	S	1	300	6	10.00%	180.00	90.00	90.00	180.00
7.11	Licence/insurances-vehicle and property Juba office montlhly costs	S	1	382	6	10.00%	229.20	114.60	114.60	229.20
7.12	Licence/insurances - vehicle,radios Counties and HF monthly costs	D	1	500	6	10.00%	300.00	150.00	150.00	300.00
7.13	Registrations, Professional Services monthly cost	S	1	800	6	10.00%	480.00	240.00	240.00	480.00
	Section Total						4,939.20	2,469.60	2,469.60	4,939.20

Sub Total Direct Cost	185,065.20
Indirect Programme Support Cost *PSC rate (insert percentage, not to exceed 7 per cent)*	7%
Audit Cost *(For NGO, in percent)*	1%
PSC Amount	12,954.56

Quarterly Budget Details for PSC Amount

2015		**Total**
Q1	Q2	
6,477.28	6,477.28	12,954.56

Total Fund Project Cost	198,019.76

Project Locations

Location	Estimated percentage of budget for each location	Beneficiary Men	Women	Boy	Girl	Total	Activity
Jonglei -> Fangak	58	32019	44216	25412	25412	127059	
Jonglei -> Nyirol	42	17241	23809	13683	13683	68416	

Project Locations (first admin location where activities will be implemented. If the project is covering more than one State please indicate percentage per State)

DOCUMENTS

Document Description
1. CMA CHF Project Notes to the Budget (03 Dec 14).docx
2. CMA CHF Project Notes to the Budget (16 Dec 14).docx
3. CMA CHF Project Notes to the Budget (19 Dec 14).docx
4. CMA CHF Project Notes to the Budget (24 Dec 14).docx