South Sudan
2012 CHF Standard Allocation Project Proposal

Proposal for CHF funding against Consolidated Appeal

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

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

SECTION I:

CAP Cluster	Health

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

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

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

Requesting Organization

CHRISTIAN MISSION AID (CMA)

Project CAP Code

SSD-12/H/46180/6088

CAP Project Title

Provision of gender-senitive basic health services, health education, emergency referral and capacity development assistance in remote communities of Jonglei and Upper Nile States, South Sudan.

Project Location(s) (list State, County and if possible Payam where CHF activities will be implemented)

Jonglei State:
Fangak County; Manajang & Paguir Payams

Upper Nile State:
Longechuk County; Dajo & Mathiang Payams

Total Project Budget in South Sudan CAP	Amount Requested from CHF	Other Resources Secured
USD$ 983,814	**US$350,000**	**US$0**

Direct Beneficiaries	
Women: > 15 years	38,000
Men: > 15 years	28,900
Girls: <15 years	24,500
Boys <15 years	24,500

Total Indirect Beneficiary
38,600

Catchment Population (if applicable)
154,500

Implementing Partners (Indicate partners who will be sub-contracted if applicable and corresponding sub-grant amounts)

none

Project Duration (max. of 12 months, starting from allocation date)

Start Date (mm/dd/yy): 04/02/12

End Date (mm/dd/yy): 03/29/13

Address of Country Office

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SECTION II

A. Humanitarian Context Analysis

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

The project areas experience chronic poor health caused mainly by:

- Inadequate health facilities, long distances between facilities, and long distances for populations to access facilities;
- Lack of knowledge of ways to prevent common communicable diseases;
- Lack of women's empowerment, low response to reproductive health / ANC & EPI services, and a high rate of violence (especially GBV);
- Insecurity that restricts access to, and delivery of health services. OCHA's data shows that Fangak reported 229 deaths by conflict during 2011, resulting in a corresponding high number of IDPs.

Currently, new factors are contributing to a worsening in the health of the population, and causing the present emergency. The main new factors are:

- Influx of IDPs & returnees with inadequate housing, no viable means of livelihood and now stressing community food supplies, health and water services – OCHA's returnee data shows 4,276 in Fangak & 6,784 in Longechuk, up to 31 January 2012, and the majority of returnees have concentrated near functioning health facilities. The returnee population near the Mathiang PHCC is estimated at greater than 50% by local authorities;
- Late season rains and floods in 2011 caused wide-spread loss of food grains in what appeared to be a promising harvest (CMA's reports from PHCCs);
- Closure of the border with North Sudan, greatly reducing the trade routes for food grains and other commodities;
- Kala-azar epidemic - a new health threat, especially among women & children; CMA's data December 2010 – January 2012 shows treatments have increased to about 100 new cases per month.

Data from SSHHS 2006 Household Survey shows that maternal mortality is very high at 2,034 /100,000 (SSHHS 2006). Kala-azar is endemic in both Jonglei & Upper Nile and without prompt treatment, 95% of kala-azar patients die (Kala-azar Epidemiology and Control, South Sudan in EID Journal, Vol. 14, 2008). Since November 2010, CMA has treated a sharply increasing case load, now up to 100 cases per month (CMA's data 2010 to 2012). Reasons for this new kala-azar epidemic are related to insecurity, and the current context of increased population movements (IDPs & returnees). Also, displacement & associated health stressors leave people more exposed to sand flies and rapid onset once infected. Women & children are more vulnerable than men. The cyclical nature of kala-azar plus population movement show an epidemic is at hand. Kala-azar has placed a huge case load on existing health services.

The ANLA 2011 report on the nutritional status of children shows the GAM rate for Fangak County is >20% (very critical) and the rate for Longechuk County in just below 15% (serious). GAM levels above 15% are considered critical. The influx of returnees & IDPs, the poor yield of 2011 and the trade route closures all combine to create the potential for increased malnutrition related illnesses which will further increase the demand for health services. The status of hygiene is poor. ANLA's report showed that 90% of households in Jonglei State & 74% in Upper Nile State use "open air" and/or designated defecation areas for latrines.

Taken all together, these factors have resulted in a chronic situation becoming an extremely fragile humanitarian emergency situation.

B. Grant Request Justification

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

CMA presented a budget for the CAP of $983,814. This budget did not include any other funding from OFDA or MOH (in-kind for pharmaceuticals). Thus, the total budget of $983,814 is the total gap in funding for CMA health services program. The $983,814 was CMA's total request to CHF as presented in the HWP application. In respect of guidance provided by CHF, CMA has revised the budget request for CHF 2012 first round allocation down to $620, 435. These funds will enable CMA to increase personnel, and related operational activities to sustain the safety net of emergency health services, increase efforts to combat the kala-azar epidemic, the increase of IDPs and returnees, and the fact that conflict prompted population movement is concentrating people in the areas served by this project. OFDA funds will provide for core health services, but will provide for added costs of coping with the current humanitarian emergency.

In Jonglei State, insecurity has become a constant threat and Upper Nile has become fragile. According to OCHA's data for 2011, of the total of 488 reported conflict incidences, at least 208 (43%) were in Jonglei State and 35 (7%) were in Upper Nile. The 2011 number of reported conflict incidences more than doubled the 2010 number in Jonglei, and more than tripled the 2010 number in Upper Nile. A sharp increase in the number of IDPs has also been recorded. Combined, more than 11,000 returnees have arrived in Fangak & Longechuk Counties during the 1 year period ending 31 January 2012. These factors point to a critical situation where several drivers of conflict have drawn the project

[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.

areas into sustained insecurity, and adding to current humanitarian emergency by severely overstretching and disrupting access to health services.

Sustaining emergency health services is a vital means of reducing the main drivers of conflict. This project will increase South Sudanese capacity to provide a safety net of gender-sensitive basic health & emergency referral services in remote & underserved communities. The project includes health delivery system strengthening and will strengthen preparedness capacity to respond to the current humanitarian crisis. The focus of the emergency services will be on the most vulnerable groups, especially women, children, IDPs, returnees, and those suffering blindness and low vision.

Value added provided by CMA includes:

- CMA has sustained a presence in all communities targeted (>10 years in some) and engaged communities in peace building as well as health services. Through these program, CMA has achieved a good reputation with vulnerable populations, community leaders and local authorities. This enables CMA to sustain high quality basic health services even in the context of the current emergency.
- CMA has a core staff of experienced South Sudanese health workers able to guide the delivery of health services so that the critical drivers of conflict are mitigated effectively.
- Several of CMA's South Sudanese personnel who are now professionally trained and experienced. These personnel will sustain health services even in the context of insecurity and the current emergency.
- Finally, CMA has built up a cadre of health promoters and community leaders, and integrated peace building messages and activities into education outreaches and workshops. This approach has empowered the health promoters and local leaders to be effective brokers for peace between competing factions in their own communities.

C. Project Description (For CHF Component only)

i) Purpose of the grant

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

The CHF grant will enable CMA to fill critical funding gaps in its on going primary health care programme. USAID/OFDA has committed funding for core health services on a cost shared basis up to 30 June 2012. The CHF grant will enable CMA complete the year long program of emergency health services, and provide essential capacity strengthening in the health systems and increase reach of basic services so that a stronger response to the current emergency can be delivered. The focus of basic health services will be on the most vulnerable groups, especially women, children, blind persons and IDPs and returnees. The CHF grant will enable CMA to provide these emergency health services in a gender-sensitive way, and the project will help save lives of many women, children and IDPs and returnees in remote & underserved areas where no alternative health services presently exist. Through MCH and antenatal clinics, the CHF grant will enable CMA to address issues of GBV, and through community workshops and health education outreaches issues around sexual and reproductive rights of women and girls will be addressed. And at the same time, these services will sustain the existing safety net by serving the health needs of pregnant women, mothers and children. Monthly reports form CMA's PHCCs indicate that they are presently coping with a very high incidence of kala-azar (increased from 25 to more than 100 cases per month), and the incidence of malnutrition is rapidly increasing (increased from 0 to 150 per month). Further, the project areas continue to receive a large number of returnees, and recent conflicts have resulted in a new population of IDPs. The CHF grant will enable CMA to increase personnel, improve facilities, acquire & preposition essential drugs so that the required measures to combat kala-azar and other common health problems will be available. The CHF grant will enable CMA to ensure that health services reach vulnerable local populations, as well as returnees and new IDPs. And the CHF grant will enable CMA to engage and strengthen community capacity to cope with health issues resulting from the current emergency, and enable CMA to strengthen the delivery capacity of all levels of the county health system, so that the counties targeted in this project will be better prepared to effectively respond to the current and future emergencies.

ii) Objective

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

The overall objective of the project is to maintain the existing safety net of basic health services and emergency referral services. The specific objectives are:

1. To increase the population reached with gender-sensitive emergency health services in the current emergency and to focus on the most vulnerable mothers, children, blind persons, IDPs & returnees of target areas;
2. To improve the quality of gender-sensitive basic health services with the pre-positioning of essential drugs, medical equipment & supplies to ensure that the needs of current and potential emergencies can be met throughout the duration of the project;
3. To increase South Sudanese preparedness and capacity to deliver and sustain gender-sensitive and high quality emergency health services throughout the duration of the project.

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.

1. Providing gender-sensitive emergency health services.

1.1. Providing emergency outpatient & inpatient services, health education, EPI, reproductive health and ANC services through 4 PHCCs & 8 PHCUs with 113 appropriately skilled medical personnel plus 54 support workers. Total outpatients (110,000 individuals) & inpatients (5,900 individuals) treated – females (61,100), males (54,800), including children <5 (26,250 – females 13,125, males 13,125) & IDPs/returnees 48,680.
1.2. Providing integrated management of childhood illnesses (IMCI) through enhanced child survival package from 4 PHCCs & 8 PHCUs. Total of 9,200 children reached with IMCI, (1,200 LLITNs, DPT3 40% coverage; measles 15% coverage).
1.3. Providing weekly IDSR reports to MOH focused on kala-azar and measles, rates of malnutrition, and evidence of GBV, and other disease outbreaks should they occur. Total of 1,200 kala-azar cases reported, 2 disease outbreaks reported, 3,000 malnutrition cases reported, and incidents of GBV treated and reported to local authorities.
1.4. Providing health education to 102,800 participants on GBV, on causes of diseases, and application of practices that prevent malaria, ARI, diarrhea, AIDS, trachoma and kala-azar. Totals of 21,000 persons undertaking disease prevention & management practices; 7,700 school children washing hands & faces to control trachoma; 5,600 WCBA able to identify practices to prevent malaria & when to seek treatment of children for respiratory difficulty, fever & diarrhea.
1.5. Providing awareness on GBV, sexual and reproductive rights of women & girls, and on the reproductive health issues, the value of ANC services and the need to ensure child deliveries in facilities with professionally skilled delivery providers. Total of 5,000 men & 5,000 women undertake health messages related to reproductive health and gender sensitization; 1,000 pregnant women attend 2+ ANC clinics; 1,000 women are delivered by nurses, midwives & doctors.

2. Pre-positioning essential drugs, medical equipment and supplies.

2.1. Pre-positioning supplies of essential drugs ensuring adequate supplies to cope with emergencies, and regularly supply laboratory & medical equipment & reproductive health, EPI supplies to PHCC & PHCU facilities. Total of 4 PHCC kits and 8 PHCU kits of medicine, medical equipment & supplies delivered per month.

3. Maintaining and improving basic health delivery systems in the context of complex emergency situation.

3.1. Training South Sudanese medical personnel to provide and sustain basic health services (ANC, safe motherhood & appropriate referral services) during emergencies. Total of 14 South Sudanese professional health personnel trained (4 clinical officers, 4 nurses/midwives, 2 public health officers and 4 laboratory technicians); 113 South Sudanese workers trained on-the-job (laboratory workers, pharmacy assistants, CHWs, community health promoters & EPI workers).
3.2. Maintaining emergency supplies of medical consumables and equipment by trained South Sudanese personnel. Total of 4 pharmacy assistants and 8 CHWs skilled on proper storage, FEFO, and proper handling of expired medicines; 8 nurses & 8 CHWs skilled on the disposal of used medical materials with an emphasis on biohazard prevention.
3.3. Establishing teams of men & women health promoters, boma health committees, payam health departments & strengthening CHDs to sustain and coordinate services during emergencies, including health education outreaches, EPI services, and actively spreading reproductive health messages and gender awareness among men & women community members. Total of 2 CHDs (Fangak & Longechuk), 4 payam health departments (Manajang, Paguir, Dajo & Mathiang) & 8 boma health committees (comprised of 50% women) operating, and 60 men & 60 women health promoters (30 per PHCC cluster) delivering health messages & gender awareness.

iv). Cross Cutting Issues

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

Gender: CMA's gender analysis shows women have low status, low education and almost no access to household resources that would enable them to access reproductive health, MCH & ANC programs. As such there is very 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 birthing. In addition, distance, insecurity and the harsh climate are deterrents for pregnant women to seek health and birthing assistance from 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 community workshops and regular health education outreaches 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. CMA will ensure that women participate in decision making; through inclusion in leadership positions in Boma/Village health committees and Payam Health Departments. Community workshops 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

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

1. Gender-sensitive emergency health services delivered and sustained:

1.1 Outpatient & inpatient services, health education, EPI, reproductive health and ANC services delivered through 4 PHCCs & 8 PHCUs in 4 payams of 2 counties staffed with 113 appropriately skilled medical personnel plus 54 support workers;

- Indicator: Number of outpatients & inpatients treated,
- Targets: Total 115,900 persons, female (61,100), male (54,800), including children <5 (26,250 - females 13,125, males 13,125) & IDPs/returnees 48,680.

1.2 IMCI enhanced child survival package delivered from 4 PHCCs & 8 PHCUs;

- Indicator: Number of children reached with IMCI, (LLITNs, DPT3 & measles vaccination),
- Targets: Total of 9,200 children (females 4,600, males 4,600) reached, 400 LLITNs distributed, DPT3 40% coverage; measles 15% coverage.

1.3 IDSR reports completed weekly & diseases including kala-azar and measles, rates of malnutrition and GBV monitored effectively;

- Indicator: Number of IDSR reports submitted to MOH with kala-azar and other disease outbreaks & malnutrition cases reported,
- Target: 1,200 kala-zar cases, 2 disease outbreaks, 100 incidents of GBV and 3,000 malnutrition cases reported.

1.4 Increased knowledge among 102,800 persons on causes of diseases, and application of practices that prevent malaria, ARI, diarrhea, HIV/AIDS, trachoma and kala-azar;

- Indicator: Number of community members undertaking health education message practices.
- Targets: total 21,000 persons (20% of 102,800 people reached); 7,700 school children washing hands & faces to control trachoma; 5,600 WCBA able to identify transmission & prevention of malaria & when to seek treatment for children with respiratory difficulty, fever & diarrhea; 7,700 accept & practice the health messages promoted in outreaches.

1.5 Increased knowledge of 10,000 persons (50% men) on GBV, sexual & reproductive rights of women & girls and reproductive health issues, the value of ANC services and the need to ensure child deliveries in facilities with professionally skilled delivery providers;

- Indicator: Number of men and women participating in, and undertaking reproductive education messages,
- Targets: total 5,000 men and 5,000 women undertake health messages promoted in reproductive health and gender sensitization education sessions. 1,000 pregnant women attend 2+ ANC clinics, 1,000 pregnant women are delivered in maternity clinics with clean delivery kits by nurses, midwives & doctors.

2. Essential drugs, medical equipment and supplies pre-positioned to remote health facilities:

2.1 Essential drugs, medical, laboratory & medical equipment & reproductive health, EPI supplies pre-positioned to the health facilities (4 PHCCs & 8 PHCUs), prior to and throughout the emergency;

- Indicator: Number of medical kits with equipment and consumables distributed,
- Targets: 144 kits of medicine, supplies & equipment delivered; 4 PHCC kits and 8 PHCU kits delivered per month.

3. Basic health delivery systems maintained and strengthened to cope with emergencies:

3.1 Medical personnel skilled and providing basic health services (ANC, safe motherhood & appropriate referral services) during emergency situations;

- Indicator: Number of health care providers trained:
- Targets: 14 South Sudanese professional health personnel trained (4 clinical officers, 4 nurses/midwives, 2 public health officers and 4 laboratory technicians); 113 workers trained on-the-job & through seminars (nurses, laboratory workers, pharmacy assistants, CHWs and EPI workers):

3.2 Personnel maintaining medical consumables and equipment;

- Indicator: Number of people skilled in the use and disposal of medical equipment and consumables,
- Targets: 4 pharmacy assistants at 4 PHCCs and 8 CHWs at 8 PHCUs skilled on proper storage, FEFO, and proper handling of expired medicines, and 8 nurses, 8 CHWs skilled on the disposal of used medical materials with an emphasis on biohazard prevention:

3.3 Men & women health promoters, boma health committees & CHDs coordinating and maintaining health services in

the context of the humanitarian emergency, and delivering health education outreaches, EPI services, and actively spreading reproductive health messages and gender awareness among men & women community members;

- Indicator: Number of committees & health promoters actively working,
- Targets: 2 CHDs, 4 payam health departments & 8 boma health committees (comprised of 50% women) operating to combat the negative effects of emergency humanitarian situation , and 60 men & 60 women health promoters delivering health messages & gender awareness.

	Indicator	Target (indicate numbers or percentages)
1	Total direct beneficiaries	Women >15 (38,000); Men > 15 (28,900); Girls (24,500); Boys (24,500)
2	Number of < 5 consultations	Boys (13,125): Girls (13,125)
3	Number of births attended by skilled birth attendants	1,000 births
4	Number of health facilities providing BPHS	4 PHCCs & 8 PHCUs
5	Number of health workers trained	14 health professionals & 113 health workers trained on the job

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 emergencies similar to the present situation. CMA will implement this project in 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 the emergency health care program is headed by a Medical Coordinator 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. Each PHCC team will be comprised of senior personnel including a field coordinator, a clinical officer, nurse / midwife trainers 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 trainer positions are filled by expatriates.

Each PHCC team will divide the work of the PHCC into that of outpatient & inpatient, MCH/ANC, laboratory, pharmacy, EPI, and the gender awareness and health education outreach activities. There is one laboratory technologist who holds the responsibility of traveling to all sites to train 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.

Three other positions complete the team for implementing this project. An Emergency Planning & Security Officer will be responsible to ensure that each PHCC has a plan to manage emergencies (in terms of personnel, facilities, pre-positioning of essential pharmaceuticals, etc), an updated security and evacuation plan, with a designated and trained emergency preparedness focal person identified in each PHCC. A Capacity Development Officer will lead the preparation of the CHDs, payam health departments and each PHCC to establish emergency plans that will be put into action in the event of a prolonged period of insecurity and conflict, and ensure that preparation for such emergencies are actually carried out. A Logistics Coordinator will be responsible for procuring and delivering all the supplies necessary to maintain program operations through the period of the emergency, and to sustain the ongoing health services.

This project will provide emergency primary health services as part of the MOH BPHS. To adequately coordinate the delivery of the proposed health services in the current emergency context, mechanisms have been established at the state and county levels to liaise with MOH and County Commissioners. CMA will continue to be very closely linked to the MOH to ensure all protocols and guidelines provided by the MOH, as detailed in the BPHS and PHCC/PHCU checklists are followed as far as possible. Through CMA's management and logistical personnel located in Juba, CMA will remain in close contact with senior levels of the MOH.

CMA has consulted extensively with County Commissioners and MOH in relation to selecting areas for this project 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 reach populations not otherwise served;
- Ensuring the pharmaceuticals are pre-positioned to ensure stock is 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.

At the national level, CMA will coordinate with other health service stakeholders ensuring an adequate exchange of knowledge and information on the emergency with peer organizations and networking bodies such as the NGO Health Forum/cluster, UN agencies (UNICEF, WFP, UNOCHA, UNDP) and donor agencies (CHF, MDTF, 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 and EWARN.

At the state level, CMA will collaborate with MOH as follows:

- Identifying project locations to ensure that assistance reaches remote and underserved areas worst affected by the emergency;
- Developing and sharing plans with MOH on training of Sudanese and ensure project implementation is done according to policies established by MOH, and address the needs of delivering services in the context of the present emergency;
- Link with MOH to secure drugs supplied from the national level, and ensure these resources are delivered to the CHDs, and PHCCs that need them.

At the county and payam levels, CMA will ensure regular consultation with CHDs and the County Commissioners and links with other agencies to facilitate delivery of emergency food, mass EPI services and medical relief assistance, and other services as required to cope with the emergency. CMA will work with county and payam officials to establish contingency plans for the maintenance of basic PHC services in the event of emergencies caused by prolonged insecurity and conflict.

At the payam level, CMA's orientation in coordination will be on mobilizing the local stakeholders to take increasing responsibility for emergency health services, especially preventive practices; ensuring PHC services meet priority needs of local and IDP/returnee populations, and blind persons, vulnerable women and children; monitoring and reporting disease outbreaks; growth monitoring; monitoring and reporting security and potential for conflict; and ensuring the safety of all personnel located in the PHCCs/PHCUs. 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. Community workshops will be continued as means to coordinate this local planning and feedback and to draw a high level of community participation into the planning and implementation of PHC services in the context of the current emergency.

Other agencies that provide critical funding and with whom CMA collaborates include:

- UNICEF & WFP provide support for the EPI, inpatient and food assistance if required;
- OFDA is also providing funding support for this program.

vii) Monitoring Plan

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

1. Overview of Monitoring Plans

CMA's program monitoring effort will be aimed at:

- Improving project effectiveness in the context of the emergency, 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;
- Regularly assessing emergency situation, especially 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 has been 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 shown in the log frame.

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.

To monitor output achievement, each PHCU and PHCC will collect the data on each outpatient & inpatient treatment; 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. 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 Program Manager and in collaboration with the Field Coordinators leading each PHCC. CHWs and EPI workers selected from the cadre of Sudanese personnel of each PHCC will be trained for the purpose of implementing health surveys and community-based data gathering.

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 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 Program Manager to feed back conclusions and recommendations 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, changes in climate and security, the potential for conflict between communities etc) in order to plan appropriate and timely responses to any emerging 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 emergency and crisis analysis. With assistance from the Medical Program Manager, the Field Coordinators will analyze this data, interpret the results and prepare monthly reports for submission to CMA's South Sudan Program Manager and 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 Program 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 Program 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 Program Manager and Sudan Director. CMA's Accountant will complete the quarterly financial reports for the 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. Committed funding
Please add details of committed funds for the project from other sources including in-kind supports in monetary terms (USD)

Source/donor and date (month, year)	**Amount** (USD)
No sources of funds have been identified toward the Budget of $983,814 presented in the CAP	0

SECTION III:

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

LOGFRAME		
CHF ref. Code: SSD-12/H/46180	**Project title:** Provision of gender-sensitive basic health services, health education, emergency referral and health system delivery assistance in remote communities of Jonglei and Upper Nile States, South Sudan.	**Organisation: Christian Mission Aid (CMA)**

Overall Objective: To maintain the existing safety net by sustaining basic health & emergency referrals services for communities in Fangak and Longechuk Counties with a focus on women, children & IDPs/returnees.	**Indicators of progress:** Improved health status of communities, IDPs and returnees in Fangak and Longechuk Counties of South Sudan affecting a population of approximately 154,500 people.	**How indicators will be measured:** *What are the sources of information on these indicators?* • Health data & economic statistics from MOH and State sources.	
Specific Project Objective/s: 4. To increase the population reached with gender-sensitive emergency health services in the current emergency and to focus on the most vulnerable mothers, children, blind persons, IDPs & returnees; 5. To improve the quality of gender-sensitive basic health services with the pre-positioning of essential drugs, medical equipment & supplies to ensure that current and potential emergencies can be met; 6. To increase South Sudanese preparedness and capacity to deliver and sustain gender-sensitive and high quality emergency health services.	**Indicators of progress:** 1. 115,900 outpatients & inpatients treated through basic health services delivered by skilled and qualified Sudanese health workers. 2. 144 kits of drugs, equipment & supplies regularly delivered to 4 PHCCs & 8 PHCUs. 3. 127 South Sudanese personnel trained, 2 CHDs, 4 payam health departments, 8 boma health committees established & 120 health promoters trained.	**How indicators will be measured:** *What are the sources of information that exist and can be collected? What are the methods required to get this information?* • End-of-project report. • Community-based Knowledge, Attitude, Practices (KAP) survey.	**Assumptions & risks:** *What are the factors and conditions not under the direct control of the project, which are necessary to achieve these objectives? What risks have to be considered?* • Post-independence political situation remains stable. • No deterioration in security. • Food security does not deteriorate further. If communities cannot access PHCCs/PHCUs & participate in health education outreaches, project objectives will not be achieved.

Results - Outputs (tangible) and Outcomes (intangible):	**Indicators of progress:** *What are the indicators to measure whether and to what extent the project achieves the envisaged results and effects?*	**How indicators will be measured:** *What are the sources of information on these indicators?*	**Assumptions & risks:** *What external factors and conditions must be realised to obtain the expected outcomes and results on schedule?*
Outcome 1: Gender-sensitive emergency health services delivered and sustained			
Output 1.1: Basic health services, health education, reproductive health & ANC services delivered through 4 PHCCs & 8 PHCUs in 4 payams of 2 counties staffed with 113 appropriately skilled health personnel plus.	a. Total persons treated 115,900, (outpatients 110,000 & inpatients 5,900) female (61,100), male (54,800), including children <5 (26,250 - females 13,125, males 13,125) & IDPs/returnees 48,680.	• Semi-annual project reports. • Data from inpatient/outpatient clinics.	• Communities can access health facilities. • Security permits delivery of health & referral services.
Output 1.2: IMCI enhanced child survival package with EPI delivered from 4 PHCCs & 8 PHCUs.	b. Total number of children reached with IMCI, (LLITNs, DPT3 & measles vaccination) 9,200 children (females 4,600, males 4,600) reached, 400 LLITNs distributed, DPT3 40% coverage; measles 15% coverage.	• Semi-annual project reports. • Data from EPI services units.	• Leaders & health promoters can mobilize communities to receive IMCI services.
Output 1.3: IDSR reports completed weekly & diseases including kala-azar and measles, rates of malnutrition and GBV monitored effectively.	c. The number of IDSR reports submitted to MOH with 1,200 kala-azar cases, 2 other disease outbreaks, 100 incidents of GBV & 3,000 malnutrition cases reported,	• Semi-annual project reports. • IDSR reports generated weekly.	
Output 1.4: Increased knowledge among 102,800 persons on causes of diseases, and application of practices that prevent malaria, ARI, diarrhea, HIV/AIDS, trachoma and kala-azar.	**d.** Total of 21,000 persons (20% of 102,800 people reached) undertaking health education message practices (7,700 school children washing hands & faces to control trachoma; 5,600 WCBA identify transmission & prevention of malaria & when to seek treatment for children with ARI, fever & diarrhea; 7,700 accept & practice the health messages promoted in outreaches).	• Semi-annual project reports. • Data from health education outreaches on participants. • Data from community-based KAP on application of message practices.	• Leaders & health promoters can mobilize communities to receive health education. • Security permits delivery of health education outreaches.
Output 1.5: Increased knowledge of 10,000 persons (50% men) on GBV, sexual & reproductive rights of women & girls and reproductive health issues, the value of ANC services and the need to ensure child deliveries in facilities with professionally skilled providers.	e. Total 5,000 men & 5,000 women participate in, and undertake reproductive education messages promoted in reproductive health & gender sensitization sessions; 1,000 pregnant women attend 2+ ANC clinics; 1,000 pregnant women are delivered in maternity clinics with clean delivery kits by nurses, midwives & doctors.	• Semi-annual project reports. • Data from health education outreaches on participants. • Data from community-based KAP on application of message practices.	• Men are prepared to participate in reproductive health awareness.

Outcome 2: Essential drugs, medical equipment and supplies pre-positioned to remote health facilities			
Output 2.1: Essential drugs, medical, laboratory & medical equipment & reproductive health, EPI supplies pre-positioned to the health facilities (4 PHCCs & 8 PHCUs), prior to and throughout the emergency.	f. 4 PHCC kits and 8 PHCU kits of medicine, supplies, consumables & equipment delivered per month.	• Semi-annual project reports. • Data from PHCCs/PHCUs.	• State MOH are able to procure & deliver vaccines & essential pharmaceuticals.
Outcome 3: Basic health delivery systems maintained & strengthened to cope with emergencies.			
Output 3.1: Medical personnel skilled & providing basic health services (ANC, safe motherhood & appropriate referral services) during emergency situations.	g. Total of 14 South Sudanese professional health personnel trained (4 clinical officers, 4 nurses/midwives, 2 public health officers & 4 laboratory technicians); 113 health care providers trained on-the-job & through seminars (nurses, laboratory workers, pharmacy assistants, CHWs and EPI workers).	• Semi-annual project reports. • Data from PHCCs/PHCUs.	• South Sudanese candidates with adequate education can be found for professional health training.
Output 3.2: Personnel skilled & properly maintaining medical consumables and equipment.	h. Total of 4 pharmacy assistants at 4 PHCCs and 8 CHWs at 8 PHCUs skilled on proper storage, FEFO, and proper handling of expired medicines, & 8 nurses, 8 CHWs skilled on the disposal of used medical materials with an emphasis on biohazard prevention.	• Semi-annual project reports. • Data from PHCCs/PHCUs.	
Output 3.3: Men & women health promoters, boma health committees & CHDs coordinating and maintaining health & EPI services, health education outreaches in the emergency & actively spreading reproductive health messages & gender awareness among men & women.	i. Total of 2 CHDs, 4 payam health departments & 8 boma health committees (comprised of 50% women) operating to combat the negative effects of emergency humanitarian situation, & 60 men & 60 women health promoters delivering health messages & gender awareness.	• Semi-annual project reports. • Data from capacity development unit	• South Sudanese personnel, community leaders & health promoters are able to respond possitively to capacity development interventions.

Activities:	**Inputs:** *What inputs are required to implement these activities, e.g. staff time, equipment, mobilities, publications etc.?*		**Assumptions, risks and pre-conditions:** *What pre-conditions are required before the project starts? What conditions outside the project's direct control have to be present for the implementation of the planned activities?*
1 Providing gender-sensitive emergency health services. 1.1 Outpatient & inpatient services, EPI, reproductive health and ANC services through 4 PHCCs & 8 PHCUs. 1.2 IMCI through enhanced child survival package from 4 PHCCs & 8 PHCUs. 1.3 IDSR reports to MOH focused on kala-azar & measles, malnutrition, and evidence of GBV treated and reported to local authorities. 1.4 Health education (102,000 participants) on causes & prevention of malaria, ARI, diarrhea, AIDS, trachoma & kala-azar. 1.5 Awareness on GBV, sexual and reproductive rights of women & girls, reproductive health issues, ANC & child deliveries by skilled providers.	• Building materials to improve health facilities, camp supplies & rations, kerosene for EPI, equipment for PHCC offices. • Transportation for personnel, materials & supplies, and vehicle lease & operations. • Technical health personnel & support staff, Juba Office, PHCCs & PHCUs & international staff permits & expenses, medical care & insurance. • Office rents, utilities, supplies, communication & bank charges.		• MOH & local authorities endorse & support implementation of project activities. • Community leaders are prepared to collaborate and actively participate in project activities.
2 Pre-positioning essential drugs, medical equipment and supplies. 2.1 Supply of adequate essential drugs, laboratory & medical equipment & reproductive health, EPI supplies to cope with emergencies.	• Essential drugs, medical materials & equipment, LLITNs. • Transportation for these essential supplies.		
3 Maintaining and improving basic health delivery systems. 3.1 Training medical personnel to sustain basic health services, ANC, referral services during emergencies. 3.2 Training to maintain supplies of medical consumables & equipment. 3.3 Establishing health promoters, boma health committees, payam health departments & strengthening CHDs to sustain services during emergencies.	• Funding assistance for training fees, materials, & supplies. • Health trainers to conduct on-the-job & refresher training. • Consultants/facilitators to lead emergency preparedness, monitoring & community workshops & workshops with CHDs.		

PROJECT WORK PLAN

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

Activity	**Q1 / 2012**			**Q2 / 2012**			**Q3 / 2012**			**Q4 / 2012**			**Q1 / 2013**		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Result 1: Gender-sensitive emergency health services delivered and sustained.															
Activity (1.1) Outpatient & inpatient services, EPI, reproductive health and ANC services			X	X	X	X	X	X	X	X	X	X	X	X	X
Activity (1.2) IMCI through enhanced child survival package from 4 PHCCs & 8 PHCUs			X	X	X	X	X	X	X	X	X	X	X	X	X
Activity (1.3) IDSR reports on kala-azar & measles, malnutrition & GBV			X	X	X	X	X	X	X	X	X	X	X	X	X
Activity (1.4) Health education on prevention of common diseases & kala-azar.			X	X	X	X	X	X	X	X	X	X	X	X	X
Activity (1.5) Awareness on GBV, sexual & reproductive rights, ANC & child deliveries.				X				X			X			X	X
Result 2: Essential drugs, medical equipment and supplies pre-positioned to remote health facilities.															
Activity (2.1) Supply essential drugs, lab. & medical equipment to cope with emergencies				X				X			X		X	X	
Result 3: Basic health delivery systems maintained & strengthened to cope with emergencies.															
Activity (3.1) Training medical personnel to sustain health & referral services in emergencies.			X	X	X	X	X	X	X	X	X	X	X	X	X
Activity (3.2) Training to maintain supplies of medical consumables & equipment.				X											
Activity (3.3) Establishing health promoters, committees & strengthening CHDs.				X			X			X			X		

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