OCHA Coordination Saves Lives

Project Proposal

Requesting Organization :	Christian Mission Aid
Allocation Type :	2nd Round Standard Allocation

Primary Cluster	Sub Cluster	Percentage
HEALTH		100.00
		100

Project Title :	Strengthening the capacity of primary health care facilities to deliver lifesaving emergency health services integrated with nutrition services in Fangak & Nyirol counties of Jonglei State		
Allocation Type Category :	Frontline services		
OPS Details			
Project Code :	SSD-16/H/89696	**Fund Project Code :**	SSD-16/HSS10/SA2/H/INGO/3493
Cluster :	Health	**Project Budget in US$:**	365,999.92
Planned project duration :	4 months	**Priority:**	3
Planned Start Date :	01/09/2016	**Planned End Date :**	31/12/2016
Actual Start Date:	01/09/2016	**Actual End Date:**	31/12/2016

Project Summary :

Project objective is to reverse the rising mortality rate and reduce morbidity caused by malaria, diarrhea and pneumonia, epidemic prone vaccine preventable diseases, medically complicated cases of SAM of children <5 years and unsafe child deliveries and malnutrition among PLW. Priority will be to reach areas of high need where vulnerable IDPs and communities hosting large IDP populations live, and to reach locations without access to any health services. Priority will be to reach the most vulnerable children <5 years, but also focus on adolescent girls, PLW women of IDP and women headed households. This overall objective will be achieved by: (1) Improving access to, and scaling-up responsiveness to, essential emergency health care, referrals for emergency obstetric and new born care services and treatment for children < 5 suffering medical complications from SAM; (2) Preventing and responding to disease outbreaks with emergency immunization services. This project will provide gap-funding since RRHP ended in May and there is still no date for next phase of funding.

The critical humanitarian gap that this project will fill is the reduced access to lifesaving primary health services for the most vulnerable < 5 children and PLW of unserved IDPs and communities hosting large IDP populations. To address this gap, CMA will maintain and strengthen functioning health facilities (previously supported by RRHP) and use these facilities to conduct lifesaving mobile outreach health services (of 2-3 day durations) to penetrate into locations where large unserved IDP and IDP hosting populations live. The functioning facilities to be maintained and used to deliver health outreaches will be Keew, Juaibor, Nyadin and Pakan in Fangak, and Pultruk and Chuil in Nyirol. The priority health services in static facilities and to be provided in outreaches will be: (1) treatment for malaria, acute respiratory infections, AWD, SAM screening and referral of SAM cases with medical complications and IEC for cholera prevention; (2) provision of BEmONC, and referrals for safe delivery and emergency obstetric services; (3) provision of emergency vaccinations if/when required. This project will provide COs, nurses, midwives and CHWs to address the rising rate of deaths in the current crisis. To facilitate a robust health services outreach approach, strong incentives will be provided to health workers and community based volunteers.

Direct beneficiaries :

Men	Women	Boys	Girls	Total
5,605	4,936	6,464	7,003	24,008

Other Beneficiaries :

Beneficiary name	Men	Women	Boys	Girls	Total
Children under 5	0	0	3,000	3,500	6,500
Internally Displaced People	2,000	2,500	1,500	1,600	7,600
People in Host Communities	800	700	1,000	1,200	3,700
Pregnant and Lactating Women	0	900	0	0	900

Indirect Beneficiaries :

Estimate of 18,000

Catchment Population:

Catchment populations inclusive of IDPs in Payams served: Fangak 84,369; Nyirol 30,156 – Total 114,525

Link with allocation strategy :

(1) Reaching Locations of Most Critical Need:
In terms of location and populations that are most vulnerable and most in need, this project fits the HRP 2016 MYR and Health Cluster strategy for SSHF Allocation 2 2016 in the following ways: (1) this project will cover areas of Fangak & Nyirol counties of Jonglei listed as high priority areas being severely affected by insecurity, flooding and displacement; (2) by maintaining functioning health facilities and using these facilities to conduct mobile lifesaving health services outreaches (comprised 3 – 4 health professionals including a midwife with support personnel for 2-3 day durations) to penetrate areas where large unserved IDP and IDP hosting populations live. The project will deliver lifesaving health services to populations that are currently unserved due collapsed/destroyed/closed facilities and insufficient personnel.

(2) Delivering Essential Humanitarian Services Pertaining to Lifesaving Strategies:
In terms of lifesaving activities, and alleviating suffering, this project fits the HRP 2016 MYR and Health Cluster strategy for SSHF Allocation 2 2016 in the following ways: (1) by focusing health service outreaches on treating <5 children for the major causes of mortality (malaria, diarrhea and pneumonia), SAM with medical complications and providing IEC for cholera prevention; (2) by providing BEmONC services, safe deliveries and referrals for emergency obstetric services; (3) by delivering emergency immunizations in case of outbreaks.

Data from Fangak shows 95,658 IDPs (ROSS Coordinator 22 October 2015). In Nyirol, OCHA's South Sudan Crisis Displacement Count Monitor 01 Oct 2015 shows 41,857 IDPs (excluding Waat) with at least 40,000 IDPs in Waat. 38% of the populations of target counties are IDPs. CMA's data shows that only 4 of 30 health facilities (13%) are functioning as they should. The remaining 26 facilities (87%) have either been destroyed (Fangak County Hospital) or are in various states of collapse due to lack of maintenance since the crisis erupted and skilled personnel have departed.

It is estimated that 65% of the direct beneficiaries will be IDPs. This is because of the high burden of morbidity and malnutrition suffered by IDPs owing to the stress and trauma of displacement, their overcrowded and poor quality living arrangements and exceptionally high level of food insecurity. These factors combined create a high level of need. In addition, the project will employ an approach that emphasizes health and immunization outreaches to penetrate into unserved locations where IDPs are concentrated and where health facilities have ceased functioning. To ensure gender equality in access to health services, CMA through the local authorities has organized communities to provide protection of vulnerable women, adolescent girls and children of IDP and host communities. In this manner the project will deliver on the "dignity" aspect of SO1. Although the health service outreaches will be focused on treatments and medical support that saves lives, the outreach teams will deliver health education and promotion integrated with IYCF and WASH messages.

Sub-Grants to Implementing Partners :

Partner Name	Partner Type	Budget in US$

Other funding secured for the same project (to date) :

Other Funding Source	Other Funding Amount
RRHP (estimated)	450,000.00
UNICEF (estimated)	75,000.00
CMA (Confirmed)	125,000.00
	650,000.00

Organization focal point :

Name	Title	Email	Phone
Esau Otieno Riaroh	Country Director	sudandirector@cmaidafrica.org	0954166375
Dr Robert Napoleon	Health Manager	sudanmedical@cmaidafrica.org	0955142222

BACKGROUND

1. Humanitarian context analysis

Fangak and Nyirol are insecure areas where service disruption is common. Conflict forced a large number of IDPs into these counties. Data from Fangak shows 95,658 IDPs (ROSS Coordinator 22 October 2015). In Nyirol, OCHA's South Sudan Crisis Displacement Count Monitor 01 Oct 2015 shows 81,857 IDPs with at least 40,000 IDPs in Waat. Approximately 37% of the population of target counties are IDPs.

Both counties are currently rated IPC 3 Crisis (IPC Alert Issue 5, 29 June 2016) and Severity Level 4 (2016 HNO South Sudan pg 13). GAM rates for Fangak and Nyirol are 21.5 and 22.1 respectively (20151027 Nutrition Cluster Case Load 2016). Reports from CMA personnel on ground indicate that on average households planted less than 40% of normal acreage in 2016 (Choul Thompson - CHD Officer Phom, Abraham Lilly - Clinical Officer Juiabor, Terisia Masila - Nurse Keew). Reasons cited were insecurity, consumption of seeds, lack of male labor, lack of tools, lack of access to land for IDPs and the need to gather wild foods or search for food aid which took time away from planting. Among IDP families, it is common for children to bring children to health facilities. Their mothers have left them to search for food aid or wild foods (Abraham Lilly - Clinical Officer Juiabor, Terisia Masila - Nurse Keew, 06 Nov 2015).

MEDAIR and CMA assessments in Juaibor, Nyadin and Keew May-Jun 2015 indicated: (1) 65%-75% of adult IDPs were women; (2) IDPs subsisted on wild foods for long periods; (3) influx of IDPs overwhelmed functional health services, and (4) closed facilities left large populations without access to any services. Weakened natural immunity caused by malnutrition, exposure stress, lack of sanitation and crowded living spaces has caused an increase in disease occurrence (2016 HRP South Sudan pg 20). CMA's DHIS data for quarter 1 of 2016 shows very high number of consultations (56,302 Fangak, 54,137 Nyirol) and this number is rising with malaria counting for 19% of consultations (Data file:DHIS_#SS_South_Sudan.mdb). Persons in need of health services are 79,500 in Fangak and 67,500 in Nyirol (2016 HNO South Sudan pg 9).

While capacity has declined, the need for health service has increased. Health workers have left and their facilities have been closed. 55% of health facilities in GUN were not functioning as at September 2015 (2016 HNO South Sudan pg 5). The tally of non-functional facilities in Fangak and Nyirol shows the County Hospital has been destroyed and 19 of 26 facilities do not function well, causing overwhelming demand on the few functioning facilities. Of 26 health facilities, 8 require complete reconstruction. Of 14 facilities designated for cold chains, 7 require repairs or new installation. Only 2 hospitals and 4 PHCCs provide EmONC services. In Nyirol County, during a one week assessment period, 3 women experienced spontaneous abortion without skilled birth attendants (MEDAIR's Report Nov 2014). In the period Mar to Sep 2015, there were 16 maternal deaths due to complicated delivery without skilled birth attendants (CMA's Report on Chuil 28 Oct 2015). The situation of maternal mortality in Fangak is similar.

Conflict, insecurity and floods affect women, men, boys and girls differently. Men maintain mobility, but IDPs, children <5, and women have restricted movement (2016 HNO South Sudan pg 6). Men can protect themselves, but women, girls and boys need protection to access facilities. Insecurity and flooding restrict access of pregnant women to skilled birth attendants (2016 HNO South Sudan pg 6). IDP women and girls are vulnerable to SGBV. With great distance between facilities, women face daunting challenges accessing services. In conflict-affected Jonglei State, outpatient consultations data showed that only 37% were female, indicating lower access of the most vulnerable to health services (HRP MYR 2015 pg. 25).

2. Needs assessment

Health Cluster MYR shows the critical needs/gaps for intervention include:
• Inadequate access to lifesaving primary and secondary health care in areas of high need;
• Inadequate access to comprehensive emergency obstetric care, surgical care and case referral;
• Lack of reliable and sufficient stock of lifesaving drugs and medical supplies;
• Recurrent outbreaks and communicable disease threats (Cluster Minutes of 15 Aug 16 Meeting).

As lead agent for RRHP in Fangak and Nyirol, CMA's on ground experience shows less than 30% of health facilities are functioning well. Most PHCUs have stopped delivering services. In these counties, vulnerable children <5 and PLW of IDP and host communities cannot access health facilities due to foods and frequent insecurity, and because of destroyed, damaged and closed health facilities, the remaining functional facilities are beyond the walking distance of vulnerable populations. Functional health facilities lack capacity to deliver outreach health services on a sustained basis. The priority services needed are: (1) treatment for malaria, acute respiratory infections, acute watery diarrhoea, SAM screening and referral of SAM cases with medical complications and IEC for cholera prevention; (2) BEmONC and safe delivery services and referrals for emergency obstetric services; (3) provision of emergency vaccinations if/when required. The populations with greatest need are IDPs and communities/households hosting a large IDP population. Persons in need of health services are 79,500 in Fangak and 67,500 in Nyirol (2016 HNO South Sudan pg 9). CMA's data for quarter 1 of 2016 from the DHIS shows very high number of consultations (56,302 Fangak, 54,137 Nyirol) and this number is rising with malaria counting for 19% of consultations (Data file:DHIS_#SS_South_Sudan.mdb).

The overall need that this project will fill is inadequate access to lifesaving primary health care in areas of high need for vulnerable IDPs and communities hosting large IDP populations. The project will reach locations without access to any health services. The project will scale-up and strengthen the capacity of functioning health facilities to deliver needed services, and conduct health outreaches to locations where IDPs are concentrated and where needs are greatest. By securing the functional capacity of static facilities, the implementation of regular health outreaches will be put in place. This approach will enable frequent and comprehensive disease monitoring so that outbreaks of measles and other diseases can be detected and responded to swiftly and thoroughly. This approach will also fill the need for screening to detect severe cases of malnutrition or the need for emergency obstetric services. These cases will be immediately referred to the static clinics for effective treatment or onward referral.

The critical humanitarian gap that this project will fill is the reduced access to lifesaving primary health care services for the most vulnerable < 5 children and PLW of unserved IDPs communities and communities hosting large IDP populations. With CHF funding support, CMA will address this gap by strengthening functioning health facilities and sale up delivery of lifesaving outreach health services (of 2-3 day durations) to penetrate into locations where large unserved IDP and IDP hosting populations live. The functioning facilities from which health outreaches will be delivered are Keew, Juaibor, Nyadin and Pakan in Fangak, and Pultruk and Chuil in Nyirol. The priority outreach health services to be provided will be: (1) treatment for malaria, acute respiratory infections, acute watery diarrhoea, SAM screening and referral of SAM cases with medical complications and IEC for cholera prevention; (2) provision of BEmONC, and referrals for safe delivery and emergency obstetric services; (3) provision of emergency vaccinations if/when required.

3. Description Of Beneficiaries

The population in Fangak and Nyirol is predominantly Nuer ethnicity, 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. As the lead agent for RRHP, CMA has sustained its presence on-ground since the beginning of the current crisis. Through its on-ground presence, collaboration with CHDs and other humanitarian actors operating in these counties, CMA has identified the locations (Nyadin, Pakan, Keew and Juaibor in Fangak, and Pultruk and Chuil in Nyirol) most in need of this project's assistance. The most vulnerable and at-risk populations within these target areas have been identified through IRNAs (conducted by MEDAIR) and CMA's on-ground presence and monitoring surveys. 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. The target populations within these households are the vulnerable <5 children, adolescent girls and PLW. 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.

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 management of common diseases. 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 that community-wide 50% of households are now women headed, and among IDP households 70% are women headed. Targeted locations are experiencing food insecurity - IPC crisis (3) due to displacement and insufficient acreage planted (Choul Thompson - CHD Officer Fangak, Abraham Lilly - Clinical Officer Juiabor, Terisia Masila - Nurse Keew). Populations of IDP and women headed households experience weakened immunity while being exposed to multiple disease burdens (2016 HRP South Sudan pg 20). CMA's on-ground experience shows the common threats are acute respiratory infections, acute watery diarrhea, malaria, malnutrition and measles.

In Fangak, the estimated IDP population of 95,658 (ROSS Coordinator 22 October 2015) which adds to the estimated base host community population of 169,102 (IMA Adjusted Populations by County 2015) resulting in a total population of 264,760. In Nyirol, OCHA's South Sudan Crisis Displacement Count Monitor 01 Oct 2015 shows 81,857 IDPs and an estimated base host community population of 129,440 (IMA Adjusted Populations by County 2015) for a total population of 211,299. The estimated total of two counties is 476,059. The project will employ an outreach approach to reach areas where services have been closed or inadequate for essential lifesaving health services. Total direct beneficiaries will be 96,196 (female – 44,618 and male – 36,504) of which 52,908 (55%) will be IDPs. The total children U5 direct beneficiaries will be 20,202 (girls 10,505 and boys 9,697) and total pregnant and lactating women direct beneficiaries will be 7,696.

4. Grant Request Justification

The critical humanitarian gap that this project will fill is the reduced access to lifesaving primary health services for the most vulnerable < 5 children and PLW of unserved IDPs communities and communities hosting large IDP populations. The project is justified on the basis that due to the crisis of the past 3 years, 18 of 26 facilities are damaged or closed clearly reducing capacity to provide health services. For a host of reasons, the need for health service has greatly increased, while delivery capacity has declined leaving large populations of IDPs and communities hosting large IDP populations without any health service. With CHF funding support, CMA will address this gap by maintaining services of functioning health facilities and scale-up and deliver lifesaving health service outreaches (of 2-3 day durations) to penetrate into locations where large unserved IDP and IDP hosting populations live.

The functioning facilities from which health outreaches will be delivered are Keew, Juaibor, Nyadin and Pakan in Fangak, and Pultruk and Chuil in Nyirol. The priority services to be provided will be: (1) treatment for malaria, acute respiratory infections, acute watery diarrhoea, referral of SAM cases with medical complications and IEC for cholera prevention; (2) provision of BEmONC, referrals for safe delivery and emergency obstetric services; (3) provision of emergency vaccinations if/when required. CHF assistance will provide salaries for facility based and outreach health workers, equipment and supplies needed to implement the outreach approach and provide robust incentives to facilitate implementation of the health service outreach model.

CMA has worked in Fangak and Nyirol counties since 2000. CMA has established capacity to sustain services in the current crisis. CMA has established units for safe child delivery, and for a comprehensive program covering reproductive health, nutrition monitoring of children <5 years and therapeutic feeding. CMA is also delivering targeted feeding programs in Pultruk and Chuil in Nyirol. Further, CMA has experience delivering health services in a gender sensitive approach, conducting awareness on sexual and reproductive rights, mobilizing communities to address SGBV and enabling women, girls and boys to access services in the context of conflict and insecurity. CMA has experience delivering programs that include IDPs without excluding host communities. CMA understands the high risk of delivering projects in insecure areas. CMA has a designated security focal point, and evacuation plans, protocols and 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 the risks of delivering health services in targeted areas.

CMA's strategy is to maintain and use the capacity of the 6 functioning PHCCs to conduct the robust outreach approach to reach unserved IDP and host populations. Priority will be to reach those with greatest needs. The relevant experience and the presence of CMA in the targeted counties place it in the best position to deliver the proposed project.

RRHP funding ended in May, and there is no date set for the resumption of RRHP. While CMA has approached UNICEF for EPI and iCCM support, there is no scope in these funding sources to conduct health outreaches to reach unserved populations. At present, there is urgent need to provide gap-funding to maintain basic lifesaving primary health care services in these counties. The humanitarian crisis coupled with RRHP funding gap requires urgent response and this project will provide that response in locations where it is most needed.

5. Complementarity

CMA has provided health services in Fangak and Nyirol counties since 2000. CMA has established PHCCs and PHCUs in these counties and these health facilities are currently providing services to huge populations. Specialized services that have been provided from the facilities include treatment of SAM cases with medical complications, BEmONC and kala-azar treatment. For the CHF funded project, CMA will draw on the lessons learned over the past 16 years in order to effective services in the current emergency context.

CMA is currently the lead agent for RRHP in Fangak. 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, emergency obstetric services and SAM cases with medical complications. CMA has also completed an SSFA with UNICEF and is preparing a proposal for a longer-term PCA for nutrition and health sector interventions. The health component will focus on expanding < 5 immunization coverage. CMA will combine the resources of CHF with the RRHP and UNICEF 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 BEmONC services are presently inadequate or non-existent. Further, CMA will integrate WASH messages and IYCF messages into medical and health promotion outreaches that will include reaching schools, churches and community groups. In this manner, the CHF funded project has been designed and will complement RRHP in targeted locations, and build on CMA past work by raising up the quality of health service delivery employing a robust medical and health promotion outreach approach to reach the unserved and those with greatest need.

CMA is an active member of the association of humanitarian actors in both Fangak and Nyirol counties and in the health and nutrition clusters. Through these channels CMA ensure effective and timely coordination with all humanitarian actors delivering programs in the targeted counties of this project.

LOGICAL FRAMEWORK

Overall project objective

The urgent needs in Fangak and Nyirol are: (1) treatment for common communicable diseases (pneumonia, AWD, malaria, and SAM with medical complications); (2) reduction of the maternal mortality; (3) reduction in outbreaks of preventable diseases (measles, cholera and polio). Further, there is urgent need for health service providers to reach unserved areas with populations of IDPs and communities hosting IDPs. To address these needs, the overall objective of this project is to reverse the rising mortality rate and reduce morbidity caused by malaria, diarrhea and pneumonia of children <5 years, epidemic prone vaccine preventable diseases, medically complicated cases of SAM and unsafe child deliveries. The overall objective will be achieved by: (1) Scaling-up and improving access to lifesaving primary health care, referrals (to the nearest equipped facilities) for emergency obstetric care, and treatment for children < 5 suffering medical complications from SAM; (2) Preventing, detecting and responding to epidemic prone disease outbreaks (measles, polio, cholera).

To address the decline in number of properly functioning health facilities and the access restrictions experienced by vulnerable people, the project will implement three strategies: (1) maintain lifesaving services of selected functional facilities until RRHP funding is resumed; (2) conduct mobile health services outreaches to reach unserved communities; (3) understanding that insecurity creates a situation of vulnerability for PLW, adolescent girls and children < 5, the project will help communities implement appropriate protection practices to enable these vulnerable groups to access outreach health services and facility-based nutrition services. By applying these strategies, the project will ensure that the unserved and most vulnerable single parent and women headed households of IDP and affected host populations have access to high quality lifesaving health services.

Important cross-cutting themes guiding implementation will be (1) mainstreaming gender equality; (2) accountability to affected populations; (3) protection of vulnerable populations so they can access health services. Fielding additional health workers, training these workers, and engaging payam health committees and men and women leaders of host and IDP communities will ensure that gender, accountability and protection are integrated into health service delivery. Feedback from target populations will be applied in ongoing programming through robust monitoring, regular outreaches and regular meetings with host community and IDP leaders. Guidance from the Health Cluster on gender mainstreaming and protection will be important resources for training personnel and for designing health interventions that strengthen the themes of gender and protection in the delivery of health services. Tools prepared by IASC to ensure accountability to affected populations will be critical references for CMA's training. In the context of constant insecurity, flooding and population movement, CMA has anticipated disruption and constrained access as well as a significant increase in need and demand for health services. The economic crisis adds additional risk to implementation. CMA has strategies to manage these risks: (1) ensuring national personnel are well trained to carry on services even when insecurity limits access of international personnel; (2) as far as possible maintain a one month inventory stock of essential health supplies; (3) always maintain good relationships with local authorities and leaders as they are best placed to provide security of personnel and supplies in an emergency.

Complementarity will be achieved by coordinating closely with other humanitarian actors, and collaborate wherever possible with organizations delivering NFIs, WASH, Nutrition, Education and FSL cluster projects.

HEALTH

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
CO1: Improve access, and scale-up responsiveness to, essential emergency health care, including addressing the major causes of mortality among U5C (malaria, diarrhea and Pneumonia), emergency obstetric care and neonate services in conflict affected and vulnerable populations	HRP 2016 SO1: Save lives and alleviate suffering through safe access to services and resources with dignity	90
CO2: Prevent, detect and respond to epidemic prone disease outbreaks in conflict affected and vulnerable populations	HRP 2016 SO1: Save lives and alleviate suffering through safe access to services and resources with dignity	10

Contribution to Cluster/Sector Objectives : The project will be implemented in Fangak and Nyirol Counties listed as a counties in Jonglei State with greatest needs and displacements. Fangak hosts an estimated 95,658 IDPs (Fangak ROSS Coordinator 22 Oct 2015). Nyirol hosts an estimated 81,857 IDPs (OCHA's South Sudan Crisis Displacement Count Monitor 01 Oct 2015). This project will add to RRHP and UNICEF support to deliver outreach health services, with a focus on unreached locations where there are large IDP populations. Persons in need of health services are 79,500 in Fangak and 67,500 in Nyirol (2016 HNO South Sudan pg 9). Toward this need this project will reach 16,806 in Fangak and 7,203 in Nyirol.

Project objective 1 will scale-up and increase access to lifesaving primary health care, basic EmONC services, integrated with WASH and nutrition services for treatment of children <5 suffering medical complications from SAM, and focused on reaching the most vulnerable children <5 years, adolescent girls, PLW of IDP and women headed HHs. The project will provide midwives/nurses and health professionals skilled in MISP for static facility services and on outreach teams so to ensure an effective referral system for victims of GBV, women requiring safe deliveries and emergency obstetric services and < 5 children suffering SAM and medical complication from SAM. Continuous training of national health workers will cover the MISP, gender sensitivity and mental health and psycho-social support for IDPs. The project will provide human resources, equipment and supplies to maintain services from static facilities and enable mobile health teams to reach and serve areas where there are no services presently. The project will target treatments for main causes of mortality (malaria, AWD, ARI/pneumonia, measles and medical complications related to SAM). Through combined static facility services and outreaches, an estimated 24,009 outpatient consultations will be achieve, of which 13,467 will be children < 5 years including 626 receiving treatment for medical complications related to SAM and 2,616 will be PLW. In this manner, the project will deliver on cluster objective 1 "improve access, and scale-up responsiveness to, essential and emergency health care", including addressing the major causes of mortality among U5 (malaria, diarrhea pneumonia, medical complications related to SAM), and maternal mortality related to unsafe and home deliveries. Through health outreaches to PHCU and other locations where IDPs have concentrated, a large unserved population of IDPs (estimates at 15,606 people) will be reached. In addition, a host community population of 8,403 will be reached. To ensure the project achieves gender equality in access to 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 services.

Project objective 2 will increase capacity of existing health systems to prevent, detect and respond to epidemic prone disease outbreaks with emergency immunization services and an increased outreach capacity to monitor/report/respond to disease outbreaks and increases in malnutrition rates. With these actions, the project will directly deliver on cluster objective 2, "to prevent, detect and respond to epidemic prone disease outbreaks in conflict affected and vulnerable states". Key outputs from the project that support cluster objectives will be 90% of disease outbreaks verified and responded to within 48 hours. In addition, 1,548 children will receive pentavalent vaccine, and 32 workers will be trained in disease surveillance and reporting. Further, about 21,797 people will be reached with health promotion, WASH and IYCF education messages, and 32 national health workers will be trained in MISP, communicable diseases, IMCI and mental health and psycho-social support for IDPs.

Outcome 1

The most vulnerable children <5 years, adolescent girls, PLW of IDP, women headed HHs of unreached areas with greatest need have increased access to lifesaving essential primary health care, basic EmONC, emergency obstetric referral services and nutrition services for children <5 suffering medical complications from SAM.

Output 1.1

Description

Inadequate and damaged non-functional heath facilities addressed

Assumptions & Risks

CMA can sustain functional health facilities as bases for mobilizing outreach health teams, and can recruit and sustain personnel for mobile health teams in the context of insecurity and the economic crisis. Risks: Political unrest/conflict and the economic crisis will disrupt delivery of project materials and inputs, and deployment of personnel in unserved areas. To mitigate this risk, CMA will procure materials and inputs in advance of utilization, and as last resort, procure materials from Kenya. Further, CMA will focus recruitment and training on skilled South Sudanese personnel and sensitize personnel to the stress and trauma experienced by target populations.

Activities

Activity 1.1.1

Provide maintenance of functioning base health facilities to facilitate health outreach services

Activity 1.1.2

Provide equipment and supplies to enable outreach health teams to deliver mobile and swift interventions where HFs have not been functioning

Activity 1.1.3

Provide mobile teams of health workers (Nurse/midwife, CHWs, support personnel) to scale-up delivery of lifesaving primary health service outreaches

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 1.1.1	HEALTH	Frontline # Number of functional health facilities in conflict -affected and other vulnerable states					6
Means of Verification : CMA quarterly project reports.							
Indicator 1.1.2	HEALTH	Number of mobile outreach and rapid response interventions completed.					60
Means of Verification : CMA quarterly project reports							
Indicator 1.1.3	HEALTH	Number of additional health workers provided.					52
Means of Verification : CMA quarterly project reports.							

Output 1.2

Description

Manage and treat common life-threatening illness through delivery of lifesaving primary health service outreaches

Assumptions & Risks

CMA can access areas and IDP populations where health services are most needed, populations can access services, especially survivors of SGBV, PLW, U 5 children and elderly. Risks: Localized insecurity and conflict could disrupt project delivery and prevent populations from accessing services, and cultural factors could prevent survivors of SGBV from presenting their situations to health facilities for treatment, especially in IDP and woman headed household circumstances. To mitigate this risk, CMA will engage leaders of affected populations and host communities in community-based assessments, and in planning and implementing health service outreaches, and apply the “do-no-harm” approach to reduce the potential for conflict. CMA will mobilize community-based protection committees to ensure vulnerable persons especially women and victims of SGBV have access to needed services.

Activities

Activity 1.2.1

Provide lifesaving treatment of common communicable diseases (malaria, URI/pneumonia and diarrhea) including outbreaks of measles and cholera, and record deaths of U5 children, and record total deaths

Activity 1.2.2

Provide referrals for women requiring safe deliveries and emergency obstetric services through outreaches and ensure vulnerable women, adolescent girls, men and community leaders are aware of services and support women to access services

Activity 1.2.3

Screen and provide care for children with life-threatening medical complications as a result of SAM, and refer children with MAM and SAM to nutrition facilities for treatment

Activity 1.2.4

Provide basic package of treatment and management of SGBV

Activity 1.2.5

Raise gender awareness with men and women, the sexual and reproductive rights of adolescent girls and women and HIV/AIDS awareness of SGBV victims

Activity 1.2.6

Ensure vulnerable women and adolescent girls, and men and women community leaders are aware of SGBV referral services and men and women leaders support victims to access services.

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 1.2.1	HEALTH	Number of outpatient consultations in conflict-affected and other vulnerable states					24,009
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.2	HEALTH	Frontline Total number of deaths recorded within the facility	8	6	4	4	22

Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.3	HEALTH	Frontline Total number of U5 deaths recorded within the facility			4	4	8
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.4	HEALTH	Frontline # of births attended by skilled birth attendants in conflict-affected and other vulnerable states		36			36
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.5	HEALTH	Frontline # Number of facilities providing BEmONC services					6
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.6	HEALTH	Frontline # of children under 5 with severe acute malnutrition with medical complications, who are clinically managed in stabilization centers			301	325	626
Means of Verification : CMA quarterly project reports							
Indicator 1.2.7	HEALTH	Frontline # of health facilities providing SGBV services					6
Means of Verification : CMA monthly health reports							

Outcome 2

Increased capacity of existing health systems to prevent, detect and respond to epidemic prone disease outbreaks with enhanced immunization services and increased capacity to monitor/report malnutrition rates, and prevent malnutrition and water borne diseases

Output 2.1

Description

Scaled-up delivery of vaccinations, Vitamin A and de-worming treatments and promotion of health messages through outreaches to serve IDPs and other vulnerable groups

Assumptions & Risks

Localized insecurity will not prevent personnel from accessing target populations through community outreach approach to deliver EPI services, Vitamin A and de-worming service and health messages combined with IYCF and WASH messages. Risk: Localized conflict could prevent implementation of outreaches intended to deliver routine and emergency vaccinations. To mitigate this risk, CMA will recruit and train community-based health promoters, and engage schools and mother-to-mother support groups to assist in EPI, IYCF and WASH message delivery.

Activities

Activity 2.1.1

Provide routine EPI service through outreaches to serve IDPs and other vulnerable groups

Activity 2.1.2

Provide mosquito nets (ITNs) to mothers of children <5 years through outreaches to serve IDPs and other vulnerable groups

Activity 2.1.3

Provide de worming treatment to children 12-59 months through outreaches to serve IDPs and other vulnerable groups

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 2.1.1	HEALTH	Frontline # of children with 3 doses of pentavalent vaccine			149	161	310
Means of Verification : CMA monthly HMIS reports							
Indicator 2.1.2	HEALTH	Frontline # of children 6 to 59 months receiving measles vaccinations in emergency or returnee situation			137	149	286
Means of Verification : CMA monthly HMIS reports							
Indicator 2.1.3	HEALTH	Number of ITNs issued					310
Means of Verification : CMA monthly HMIS reports							

Indicator 2.1.4	HEALTH	Number of children 12 to 59 months received deworming					4,695

Means of Verification : CMA's monthly HMIS reports

Additional Targets :

M & R

Monitoring & Reporting plan

The baseline data for this project has already been established in the DHIS through CMA's role in the RRHP. CMA will use the following tools monitor project activities: (1) Focused community surveys to monitor protection, impacts of awareness outreaches and IDP access to health facilities; (2) Monthly HMIS, weekly IDSR reports and immunization campaign reports from health facilities; (3) Monthly activity reports from health facilities focused on data not provided in the HMIS reports; (4) Quarterly project reports to donors; (5) Quarterly field monitoring and evaluation reports.

Project reports will provide assessment of planned versus actual output results using the indicators identified in the logical framework. To monitor output achievement, health facilities will collect data on outpatient and inpatient treatments, mothers and children served in the MCH and BEmONC services, the number of participants in health outreaches and the number of patients treated for non-communicable disease conditions, SAM with medical complications, mortality data and other data as required. 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 to 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.

In order to plan appropriate and timely responses to any emerging health emergencies, 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.). 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 of health sector data. This system serves both as an internal monitoring tool as well as reporting into the MOH data system and allows CMA to share and compare health data with other partners and NGOs. At the output level, the CMA County Health Coordinators will work with CHD personnel to collect data, analyze and report it, including health emergency and crisis analysis. With assistance from the Medical Program Manager and M and E Specialist, the County Health Coordinators will analyze this data and prepare monthly reports. The Medical Program Manager will compile quarterly reports, and the final report will be compiled to close the project. When results are unsatisfactory, the Medical Program Manager will ensure that measures are taken to improve performance. At the outcome level, the M and E Specialist will work with the Medical Program Manager and County Health 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.

Workplan

Activitydescription	Year	1	2	3	4	5	6	7	8	9	10	11	12
Activity 1.1.1: Provide maintenance of functioning base health facilities to facilitate health outreach services	2016									X	X	X	X
Activity 1.1.2: Provide equipment and supplies to enable outreach health teams to deliver mobile and swift interventions where HFs have not been functioning	2016										X	X	X
Activity 1.1.3: Provide mobile teams of health workers (Nurse/midwife, CHWs, support personnel) to scale-up delivery of lifesaving primary health service outreaches	2016									X	X	X	X
Activity 1.2.1: Provide lifesaving treatment of common communicable diseases (malaria, URI/pneumonia and diarrhea) including outbreaks of measles and cholera, and record deaths of U5 children, and record total deaths	2016									X	X	X	X
Activity 1.2.2: Provide referrals for women requiring safe deliveries and emergency obstetric services through outreaches and ensure vulnerable women, adolescent girls, men and community leaders are aware of services and support women to access services	2016									X	X	X	X
Activity 1.2.3: Screen and provide care for children with life-threatening medical complications as a result of SAM, and refer children with MAM and SAM to nutrition facilities for treatment	2016									X	X	X	X
Activity 1.2.4: Provide basic package of treatment and management of SGBV	2016										X	X	X
Activity 1.2.5: Raise gender awareness with men and women, the sexual and reproductive rights of adolescent girls and women and HIV/AIDS awareness of SGBV victims	2016									X	X	X	X

Activity 1.2.6: Ensure vulnerable women and adolescent girls, and men and women community leaders are aware of SGBV referral services and men and women leaders support victims to access services.	2016									X	X	X	X
Activity 2.1.1: Provide routine EPI service through outreaches to serve IDPs and other vulnerable groups	2016									X	X	X	X
Activity 2.1.2: Provide mosquito nets (ITNs) to mothers of children <5 years through outreaches to serve IDPs and other vulnerable groups	2016										X	X	X
Activity 2.1.3: Provide de worming treatment to children 12-59 months through outreaches to serve IDPs and other vulnerable groups	2016									X	X	X	X

OTHER INFO

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. Health outreaches 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 are able to access health facilities. Additional promotion and awareness on sexual and reproductive health rights and BEmONC 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 availability of 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 Medical 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 awareness promotion so that as far as feasible all who need health services will have access to them.

Implementation Plan

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 subcontract to deliver this project.

The project will be headed by the Country Director and a Medical Program Manager, experienced in delivering health services in the context of conflict in South Sudan. The Medical Program Manager will hold the responsibility for overseeing the field teams and lead in collaboration with CHDs and MOH. The Medical Program Manager will work with County Coordinator to deliver field activities. The Medical 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 and those implementing health outreaches. 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 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 Supply Chain Manager will be responsible for procuring and delivering all supplies necessary to maintain program operation. The Supply Chain Manager 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:
(1) 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;
(2) 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;
(3) Ensuring the pharmaceuticals are pre-positioned and available throughout the emergency;
(4) 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, UN agencies (UNICEF, WFP, UNOCHA, UNDP) and donor agencies (CHF Health Cluster, the health Pooled Fund, USAID, IMA/World Bank) through meetings, participating in 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
County Health Department	Supervision of health facilities using Quantitative Supervisory checklist. Coordinating health care provision activities such as planning for routine and episodic mass EPI campaigns including coordination of disease surveillance, planning, sourcing and distribution of medical supplies.
County Health Forum	Planning and reporting response to health and nutrition crisis, determining and filling gaps, especially disease outbreaks and SAM.
UNICEF	Cold-chain rehabilitation and installation, and delivery of immunizations, Vitamin A and deworming.

Environment Marker Of The Project

A+: Neutral Impact on environment with mitigation or enhancement

Gender Marker Of The Project

2a-The project is designed to contribute significantly to gender equality

Justify Chosen Gender Marker Code

CMA's experience in Fangak and Nyirol counties dates back to 2000. CMA's analysis shows that the drivers of the humanitarian crisis are conflict, insecurity and seasonal flooding. These crisis drivers affect women, men, boys and girls differently. In consultation with IDP and host community leaders, CMA has gained an understanding of the differential needs of women, men and children. 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 most vulnerable. For this project, CMA has designed a health services outreach delivery strategy with gender balanced teams and activities to ensure gender equality of opportunity to access health services. CMA's health personnel are sensitized to gender issues and skilled to apply gender equity principles in their approach to health service delivery. CMA's needs analysis with the participation of men and women of IDP and host communities has enabled gender to be mainstreamed into project objectives, outcomes, outputs and activities.

Specific measures to identify different needs of men, women, boys and girls and integrate gender into ongoing implementation and monitoring of health service delivery include: (1) training of gender balanced teams of health workers to deliver services with gender sensitivity and collect data disaggregated on the basis of gender; (2) engaging men and women leaders to take responsibility for mobilizing vulnerable populations (IDPs, children, adolescent girls, women) to seek services, and to protect these populations so they have equal opportunity to access health facilities; (3) 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; (4) providing IEC to men and women of IDP and host communities to raise gender awareness, awareness on the vulnerability of children, girls and women; and (5) engage men and women leaders of host communities and IDPs in planning interventions, monitoring impacts and revising service delivery as required.

Through these measures, CMA will make significant contributions toward gender equality in the delivery of this project.

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) delivering a balanced approach to static health services and outreach 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) engaging 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.

CMA 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.

Country Specific Information

Safety and Security

CMA has established safety and security plans for each site where re-locatable personnel are assigned including personnel who work in, or transit through Juba. 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:
(1) Guide the activities and behavior of employees working in South Sudan and as far as possible help them avoid security risks and preventing them inadvertently putting themselves at risk;
(2) 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 and for office personnel in Juba. This officer works under the supervision of CMA's South Sudan management team (Country Director and Medical Program Manager) to set overall guidelines and operating procedures for the safety and security of employees and authorized visitors. CMA constantly monitors the security context to ensure full awareness of any potentials for conflict fare-up.

All sites including the Juba office site 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, and is experienced in delivering health services from the logistical base-station of Juba. 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 county. Access to all parts of the project target area 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

Code	Budget Line Description	D / S	Quantity	Unit cost	Duration Recurrance	% charged to CHF	Total Cost
Staff and Other Personnel Costs							
1.1	Medical Program Manager	D	1	3,680.00	4	50.00	7,360.00
	Medical Program Coordinator, South Sudan [Supervise field planning and implementation, supervise field personnel performance, monitor budget utilization, output achievements and compile reports] [fte 50% is based on proportion of this project budget of the total estimated health program budget for this period] [cost based on monthly salary and benefits (social security, medical and life insurance cover)]						
1.2	County Health Coordinator	D	1	2,400.00	4	50.00	4,800.00
	County Health Coordinator, [Conduct field planning and coordination; delivery of health services, supervise personnel performance, monitor output achievements and compile reports] [fte 50% is based on proportion of this project budget of the total estimated health program budget for this period] [cost based on monthly salary and benefits (social security, medical and life insurance cover)]						
1.3	Clinical Officers/Nurses	D	8	1,450.00	4	75.00	34,800.00
	Clinical Officers/Nurses (National) Lead in the delivery of static services & outreaches to IDPs, including supervision of CHWs, compile weekly HMIS reports, and other reports as required] [based on 75% fte on project activities] [Monthly salary rate inclusive of social security benefits] (4 Fangak, 4 Nyirol - 1 each for Fangak PHCCs, 2 each for Nyirol PHCCs)						
1.4	Certified Midwives/Nurses	D	4	1,650.00	4	75.00	19,800.00
	Certified Midwives/Nurses (International) [Lead in the delivery of project field activities, including training of National Personnel as required, compile weekly HMIS reports, and other reports as required] [Working 75% fte on project activities] [Monthly salary rate inclusive of social security benefits] (2 Fangak, 2 Nyirol)						
1.5	CHWs/MCHWs	D	36	450.00	4	75.00	48,600.00
	CHWs/MCHWs (National) [Deliver project static services and outreaches to IDPs, maintain clinical records and compile reports] [Working 75% fte on project activities] [Monthly salary rate includes social security benefits] (24 Fangak, 12 Nyirol - 3 each for 6 PHCCs, 3 each for 6 outreach teams)						
1.6	EPI and Health Promoters	D	30	250.00	4	75.00	22,500.00
	Health Promoters [Deliver community-based health promotion activities and outreaches to IDPs] [Monthly salary rate includes any applicable benefits] (Fangak - 12, Nyirol 8 for outreach locations)						
1.7	Casual Support Personnel (Cooks, Guards, Porters)	D	30	180.00	4	75.00	16,200.00
	Support Personnel (Cooks, Guards, Porters) Support delivery of static services and outreach activities. [Working 75% fte on project activities] [Monthly salary inclusive of any applicable benefits] (Fangak - 18, Nyirol 12 - 2 casuals for each PHCC, 3 casuals for each outreach team)						
1.8	Incentives for CHWs/MCHWs and Community-Based Health Promoters	D	56	62.50	4	75.00	10,500.00
	Incentives for CHWs/MCHWs and Community-Based Health Promoters to incentivize outreach activities to PHCUs and locations where IDPs are concentrated (kits of t-shirts, boots & gear for caring water etc. @ $50 per worker / volunteer + Cash $25/outreach) [34 Fangak, 22 Nyirol]						
1.9	Field Accommodation and Upkeep for Eligible Personnel	D	14	45.00	105	75.00	49,612.50
	Upkeep ($ 25 per day), medical, hardship and accommodation expenses and allowances ($ 20 per day) for eligible relocatable personnel working in the County and PHCCs based on rate of $45 / day and average of 105 days in the field during a four month period						

	Section Total						**214,172.50**
Supplies, Commodities, Materials							
2.1	Base PHCC Facility Maintenance	D	12	3,100.00	1	50.00	18,600.00
	Basic maintenance of Base HF structures, cost based on a per unit cost of $3,100 / unit and for 2 units per health facility, 6 sites identified for this assistance (4 Fangak, 2 Nyirol)						
2.2	Medical Materials and Supplies	D	6	2,550.00	1	50.00	7,650.00
	Medical materials and supplies for outreaches not provided by RRHP etc. (per unit) - emergency kits of needles, syringes, lab regents, bandages, gloves, kerosene, etc.) [4 Fangak, 2 Nyirol]						
2.3	Transportation of Materials and Supplies	D	12	5,500.00	1	50.00	33,000.00
	Transportation of materials and supplies Juba - field locations 6 sites (2 caravan flight / site, $4,500 / flight, overland transport 2 trips shared for all site $6,000 / trip)						
	Section Total						**59,250.00**
Equipment							
3.1	Equipment for emergency and security communication 6 sites	D	6	1,520.00	1	75.00	6,840.00
	Equipment for emergency and security communication for 6 outreach teams 6 sites (Thruway, Began, Quack) 1 set/site) [4 Fangak, 2 Nyirol]						
	Section Total						**6,840.00**
Travel							
5.1	Charter Travel (Juba-HF) for Coordinator and Health Facility Personnel	D	13	1,480.00	2	75.00	28,860.00
	Charters (Juba-HF) and ground transport for eligible health personnel - Program Coordinator (1), 4 Midwives/Nurses and 8 Clinical Officers personnel (per person cost per rtrip, based on 1 round trip/person/quarter at 75%)						
5.2	Charter Travel (Juba-HF) for Technical Support Personnel	S	1	1,480.00	0	100.00	0.00
	Charters (Juba-HF) and ground transport for M&E Specialist for disease trend monitoring surveys (per person cost per rtrip, 1 round trip/person)						
5.3	Ground and Boat Transportation for Outreaches	D	2	2,280.00	4	75.00	13,680.00
	Ground/boat transport, accom & supplies for delivery of distant/extended health outreaches (8 outreaches. 2/month @ $2,280/outreach @ 75%)						
5.4	Accommodation and Upkeep for In-Transit Technical Personnel	D	13	300.00	2	75.00	5,850.00
	Accommodation and Upkeep for In-Transit Health Personnel per rtrip for Health Program Coordinator (1), 4 Midwives/Nurses and 8 Clinical Officers/Nurses personnel (per person cost per rtrip, based on 1 round trip/person/quarter @ $100 per day and 3 days per rtrip at 75%)						
5.5	Accommodation and Upkeep for In-Transit Technical Support Personnel	S	0	0.00	0	100.00	0.00
	Accommodation and Upkeep for In-Transit Management Personnel per rtrip for M&E Specialist (per person cost per rtrip, 1 round trip/person@ $100/day and 3 days / rtrip at 75%)						
5.6	Travel Visas and Permits for International Health Personnel and Technical Support Personnel	D	5	250.00	1	75.00	937.50
	Visa's, Alien Permits for Management Support Personnel per person / rtrip (2 personnel 1 trip / person)						
	Section Total						**49,327.50**

General Operating and Other Direct Costs							
7.1	Communications Juba Office	S	1	0.00	0	34.00	0.00
	monthly cost prorated @ 30% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.2	Communications County Offices and project field sites monthly cost	D	1	1,470.00	4	50.00	2,940.00
	monthly cost prorated @ 50% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.3	Supplies and Equipment: office, and stationaries Juba Office monthly cost	S	1	0.00	0	100.00	0.00
	monthly cost prorated @ 30% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.4	Supplies and Equipment Replacement: office, and stationaries County and project field sites monthly cost	D	1	2,613.00	4	50.00	5,226.00
	monthly cost prorated @ 50% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.5	Security Services: Juba Office monthly cost	S	0	0.00	0	100.00	0.00
	monthly cost prorated @ 30% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.6	Office Rent: Juba Offices monthly cost	S	0	0.00	0	100.00	0.00
	monthly cost prorated @ 30% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.7	Office Utilities: Juba Offices monthly cost	S	0	0.00	0	100.00	0.00
	monthly cost prorated @ 30% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.8	Vehicle Running Costs: Juba office monthly cost	S	0	0.00	0	100.00	0.00
	monthly cost prorated @ 30% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.9	Vehicle Running Costs: County monthly cost	D	1	1,350.00	4	50.00	2,700.00
	monthly cost prorated @ 50% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.10	Generator Running Costs: Juba Office monthly cost	S	0	0.00	0	100.00	0.00
	monthly cost prorated @ 30% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.11	Licence/insurances - vehicles and property Juba Office, monthly cost	S	0	0.00	0	34.00	0.00
	monthly cost prorated @ 30% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.12	Licence/insurances - vehicles, radios, Counties and project field sites monthly cost	D	1	800.00	4	50.00	1,600.00
	monthly cost prorated @ 50% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.13	Registrations, Professional Services monthly cost	S	0	0.00	0	34.00	0.00

	monthly cost prorated @ 20% based on proportion of this project's budget of the total estimated South Sudan program budget for this period			
	Section Total			**12,466.00**
SubTotal		256.00		**342,056.00**
Direct				342,056.00
Support				0.00
PSC Cost				
PSC Cost Percent				7.00
PSC Amount				23,943.92
Total Cost				**365,999.92**
Grand Total CHF Cost				**365,999.92**

Project Locations

Location	Estimated percentage of budget for each location	Estimated number of beneficiaries for each location					Activity Name
		Men	Women	Boys	Girls	Total	
Jonglei -> Fangak	60	3,643	3,208	4,202	4,552	15,605	
Jonglei -> Nyirol	40	1,962	1,727	2,263	2,451	8,403	

Documents

Category Name	Document Description
Project Supporting Documents	CMA's Response to TR Queries on CHF 2016 SA 2 Proposal.docx