OCHA Coordination Saves Lives

Project Proposal

Requesting Organization :	Christian Mission Aid
Allocation Type :	1st Round Standard Allocation

Primary Cluster	Sub Cluster	Percentage
HEALTH		100.00
		100

Project Title :	Strengthening the capacity of life saving emergency primary healthcare services integrated with SAM services and including clinical management of SGBV in Fangak of Jonglei State.
Allocation Type Category :	Frontline services

OPS Details

Project Code :	SSD-17/H/103763	**Fund Project Code :**	SSD-17/HSS10/SA1/H/INGO/5089
Cluster :	Health	**Project Budget in US$:**	183,999.59
Planned project duration :	6 months	**Priority:**	
Planned Start Date :	01/03/2017	**Planned End Date :**	31/08/2017
Actual Start Date:	01/03/2017	**Actual End Date:**	31/08/2017

Project Summary :

The project will be implemented in Fangak County rated as Severity of Need Level 5, for health needs (SS HNO 2017, UNOCHA pg 10) and IPC 3 Crisis (IPC SS February 2017, FEWS Net, pg 3). CMA's experience in Fangak shows only 24% of facilities are delivering services. Four PHCCs (Juaibor, Keew, Nyadin, Pakan) plus one hospital (Old Fangak) reach only 46% of the total population and cover 57% of IDPs. Data for the final quarter of 2016 indicates clinical treatments were: 46% malaria, 14% diarrhea and 6% pneumonia, and data from Nyadin PHCC in Mareang payam showed 6 deaths of U5 children and 8 maternal deaths (CMA HMIS Data Oct-Dec 2016). CMA's data shows 10 cases of suspected kala-azar in Pakan, New Fangak payam and 15 cases of suspected cholera treated in Paguer and Manajang payams so far in 2017. February 2017 data of screening children U5 in Paguer and Manajang payams showed a proxy GAM rate of 38.2% (12.1 SAM, 26.1 MAM) with increasing incidence of SAM with medical complications. The rise in SGBV has heightened the need for comprehensive care for the survivors of rape.

The critical humanitarian gap that needs to be filled is the lack of access to lifesaving primary healthcare services for the most vulnerable U5 children and PLW of unserved IDP populations. Health Cluster estimates for Fangak show a total of 76,200 IDPs of which CMA estimates 46,460 have settled in the payams targeted in this project. Targeted areas comprise an estimated 65% of the total population of Fangak, and 61% of the IDP population.

Project objective 1 aims to improve access and scale-up in emergency responsiveness to an integrated primary healthcare package focusing on the major causes of mortality among U5 children (malaria, diarrhea, pneumonia, measles) and SAM with medical complications, and emergency HIV/AIDS, TB referrals and BEmONC focused on PLW. CMA expects to reach 21,319 individuals of which 58% will be IDPs, and the most vulnerable U5 children 7,392 and PLW 3,616 individuals.

Project objective 2 will deliver emergency response to epidemic prone disease outbreaks targeting kala-azar, measles and cholera through both static services and mobile medical outreaches, including surveillance to detect new outbreaks. The targeted individuals directly benefiting from these interventions is 2,296.

Project objective 3 will improve access to essential clinical health services that are inclusive and implemented with dignity and targeted to the specific needs of vulnerable populations (women and adolescents) by offering essential SGBV and clinical management of rape services. And project objective 4 will improve access to MHPSS for the vulnerable people by providing psychosocial support and mental health services for the highly vulnerable population. A total of 100 individuals are expected to directly benefit from these services.

The project will provide skilled health workers to deliver static services and conduct the medical outreaches to bomas not served by static facilities. The project will provide equipment, supplies to maintain services from static facilities and add transportation support (boat hire for long distance outreaches and walking for short distance outreaches) to enable mobile teams to serve unreached areas. An estimated 53,752 outpatient consultations will be achieved, of which 14,785 will be children U5 years including 136 receiving treatment for medical complications related to SAM. A further 22,470 people will be reached with health education and promotion messages. 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 so they can access services. Through outreaches to PHCU and other locations where IDPs have concentrated, a large unserved population of IDPs estimated at 12,365 people will be reached.

Direct beneficiaries :

Men	Women	Boys	Girls	Total
3,077	4,936	6,387	6,919	21,319

Other Beneficiaries :

Beneficiary name	Men	Women	Boys	Girls	Total
Internally Displaced People	1,394	3,253	3,704	4,013	12,364
People in Host Communities	1,683	1,683	2,683	2,906	8,955

Indirect Beneficiaries :

9,500

Catchment Population:

Host population - 94,345
IDPs - 46,460
Total - 140,805

Link with allocation strategy :

The CHF SA1 2017 funded project will deliver a vital and timely injection of resources into critical life-saving frontline health services as it comes immediately on the conclusion CHF SA2 2016 funding, will complement funding still in place with CMA's PCA with UNICEF, and while waiting for RRHP 2 funding. Further, the project will provide resources in the dry season which provides opportunity to use mobile outreach approaches for clinical and EPI services so that all IDPs and vulnerable populations can be reached. And most critically, the project will combat seasonality related drivers of morbidity and mortality specifically, the hunger season, the rise of SAM with medical complications, controlling malaria and combating persistent outbreaks of kala-azar and cholera.

The project will focus on priority locations where humanitarian needs are most severe. It will cover those locations not reached by others and where IDP populations have settled. Of the 76,200 IDPs in Fangak, this project will cover an estimated 46,460 IDPs settled in targeted payams. The project will focus on the Manajang, Paguer, Mareang and Barbuoi payams where flooding destroyed the 2016 harvest and hunger is most severe. As suspected cases of cholera have emerged along the River Nile in Manajang (Juaibor PHCC) and Paguer (Keew PHCC) and kala-azar in New Fangak (Pakan PHCC), these centers will be sustained and equipped to respond to these outbreaks. Fangak County has been rated as Severity of Need Level 5, for the health needs (SS HNO 2017, UNOCHA pg 10) and IPC 3 Crisis (IPC SS February 2017, FEWS Net, pg 3).

With the PCA focussed on EPI and prevention activities (vitamin supplementation, deworming, ITNs, health education and promotion), CHF funding will be applied to cost share provision of other priority frontline services. Also, the project will be delivered along with nutrition services in a fully integrated approach, with UNICEF, WFP and CHF Nutrition Cluster (potentially) providing funding assistance for nutrition activities. To maximize funding leverage, the nutrition services will target same locations as health, use common facility, transportation and human resources as health services. The project will promote WASH messages and support communities to implement protection activities to ensure children U5, adolescent girls and WCBA have unimpeded access to services. CMA has been the lead agent for RRHP in Fangak, and serves as key humanitarian actor in county forums for coordinating and collaborating within the health sector and across other sectors. This will be sustained to maximize synergies across all sectors.

Critical project qualities will include:
1. providing life-saving services in accordance with the CERF life-saving criteria.
2. providing frontline services fully aligned with the cluster priorities specifically on major causes of mortality among U5 children (malaria, diarrhoea, pneumonia), SAM with complications, basic emergency obstetric and neonatal care including the clinical management of SGBV.
3. being on-ground in 4 PHCCs ready to immediately expand to an additional PHCC and reach the catchment areas of an additional 4 PHCUs through mobile medical outreaches.
4. capacity to respond to new disease outbreaks and the likelihood of further populations movements, new influx of IDPs and potential for service disruption due to insecurity.
5. providing services that are feasible, cost effective and impactful by addressing community-based protection challenges, mainstreaming gender, applying the do-no-harm approach in all activities and engaging community leaders in planning, implementing and monitoring to strengthen accountability to affected populations.

CMA has not experienced any disruptions in services so far in 2017. In respect of the needs and security context, CMA has designed project approaches and activities to ensure best outcome for the target populations.

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
UNICEF	221,335.11
	221,335.11

Organization focal point :

Name	Title	Email	Phone
Esau .O. Riaroh	Country Director	sudandirector@cmaidafrica.org	+211954166375
Dr. Robert Napoleon	Health Manager	sudanmedical@cmaidafrica.org	211955142222

BACKGROUND

1. Humanitarian context analysis

Conflict in July 2016 and ongoing conflict in GUN has deepened the humanitarian crisis in Fangak County. Severe flooding of the area between the River Nile and River Jurwel/Zeraf during the last quarter of 2016 destroyed the harvest of most households harvesting no food at all. The deteriorating economic situation, insecurity and market disruptions are exacerbating the shocks of conflict and flooding. Fangak has been placed in the group of counties rated as Severity of Need Level 5 (South Sudan HNO 2017, UNOCHA pg 10).

Presently, Fangak is hosting an estimated 76,200 IDPs (Health Cluster Target by County 2017 Response). MEDAIR and CMA assessments in Juaibor, Nyadin and Keew May-Jun 2015 indicated: 65%-75% of adult IDPs were women; IDPs subsisted on wild foods for long periods; influx of IDPs overwhelmed functional health services; and closed facilities left large IDP populations without access to any services. The situation has worsened since 2015.

Hunger and malnutrition have reached historic levels (South Sudan HRP 2017, UNOCHA pg 4). The coping mechanisms of vulnerable households have been totally eroded and there is a risk of severe malnutrition if the cereal deficit is not met particularly through the lean season of 2017 (South Sudan HRP 2017, UNOCHA pg 6). In Jonglei, the populations experiencing IPC 3 Crisis and IPC 4 Emergency will rise from 53.5% in the February to 65.6% by May 2017 and the IPC for acute malnutrition stands at Phase 4 Critical for Fangak (IPC South Sudan February 2017, FEWS Net, pgs 3-5).

“After three years of conflict, the population is highly susceptible to disease. Outbreaks of cholera, measles, malaria, and kala-azar affect large parts of the country due to poor living conditions, poor sanitation and overcrowding” (South Sudan HNO 2017, UNOCH, pg 22). Cholera is infecting fishing communities close to the River Nile. Weekly Epidemiological Bulletin IDSR W7 shows 270 cases have been reported in Fangak with 4 deaths. Morbidity is high and rising. In the month of January 2017, consultations were 1,116 at four functioning health facilities, a jump of 61% compared to same four facilities in January 2016 with majority of treatment consults were for malaria, followed by diarrhea, then pneumonia. Children U5 represent more than 30% of total consults. Increasing malnutrition and SAM with medical complications for children U5 has added to the already high disease burden.

Nationwide, “it is estimated that only 43 per cent of the country’s health facilities remain operational. Even those that are open are providing a minimal range of services constrained by a chronic lack of essential medicines and limited funding” (South Sudan HNO, UNOCH, pg 22). The end of RRHP funding in June 2016 caused health workers to leave and facilities to close. Only 4 of 17 health facilities and one hospital were operational in Fangak during the final quarter of 2016 due to lack funds for personnel salaries, stock-outs of medicines and lack of maintenance. These are the only facilities that provide EmONC services. Of the 13 dysfunctional facilities, at least 8 require complete reconstruction.

Conflict, insecurity and floods affect women, men, boys and girls differently. Men maintain mobility, but IDPs, children U5, and women have restricted movement (South Sudan HNO 2016 UNOCHA pg 6). With great distance to reach health facilities, women and children face immediate risks of violence when attempting to access services. Men can protect themselves, but women and children need protection to access facilities. “Survivors of GBV have inadequate access to services and women have inadequate access to skilled personnel during pregnancy and childbirth” (South Sudan HNO 2017, UNOCH, pg 22). In Jonglei State, outpatient 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

The Health Cluster has presented the humanitarian gaps/needs and set response targets for 2017. The total number of people in need is 99,597 in Fangak. Of this population, the cluster is targeting 97,047 individuals – IDP 76,200 and host community 20,847 (Health Cluster Targets by County 2017).

Critical gaps/needs identified in the Health Cluster Strategy for SSHF SA1 2017 include:
• Need to increase access to lifesaving primary health services;
• Need to improve early warning and alert reporting to better manage multiple outbreaks;
• Need to improve integration of health related programmes to increase leverage and reinforce support for comprehensive positive health and humanitarian outcomes;
• Need to improve coordination of humanitarian response that links health, WASH, nutrition and protection to the seasonality needs of vulnerable populations;
• Need to strengthen practices of communication with communities to ensure accountability to affected populations.

Health cluster data shows that most clinical consultations were for treatment of malaria (50%), diarrhea (17%) and pneumonia (10%) (SS Health Cluster HNO, 25 Sep 2016). In Fangak, CMA's on-ground experience mirrors the evidence shown above. Only 24% of facilities are delivering services. Four PHCCs (Juaibor, Keew, Nyadin, Pakan) plus one hospital (Old Fangak) reach only 46% of the total population and cover 57% of IDPs. Data for the final quarter of 2016 indicates clinical treatments were: 46% malaria, 14% diarrhea and 6% pneumonia, and data from Nyadin PHCC in Mareang payam showed 6 deaths of U5 children and 8 maternal deaths (CMA HMIS Data Oct-Dec 2016). CMA's data shows 10 cases of suspected kala-azar in Pakan, New Fangak payam and 15 cases of suspected cholera treated in Pulita and Manajang payams so far in 2017. February 2017 data of screening children U5 in Pulita and Manajang payams shows a proxy GAM rate of 38.2% (12.1 SAM, 26.1 MAM) with increasing incidence of medical complications from SAM. The rise in SGBV has heightened the need for comprehensive care for the survivors of rape.

The critical humanitarian gap that needs to be filled is the lack of access to lifesaving primary health care services for the most vulnerable U5 children and PLW of unserved IDPs populations. The forgoing data demonstrates the priority services needed are: (1) treatment for malaria, acute watery diarrhoea, acute respiratory infections, SAM cases with medical complications, cholera and kala-azar; (2) BEmONC services; (3) provision of EPI and emergency vaccinations; (4) clinical management of SGBV and rape. There is clear need to (1) sustain the emergency services of the current four PHCCs, (2) scale-up to reach the 43% (32,760) of unserved IDPs who are in greatest need, and (3) provide a well-integrated health and nutrition response which also delivers WASH and protection messages. The most feasible approach in the dry season to expand the reach of an integrated emergency response is through medical outreaches of long duration (2-3 weeks) to locations with large unserved IDP and host populations. Outreaches will target New Fangak, Mareang and Barbuoi payams. Due to distance and insecurity, outreaches and community-based protection measures are also needed to ensure IDPs, PLW and children have access to services. These approaches will enable frequent and comprehensive disease surveillance so that outbreaks of measles, cholera and kala-azar can be detected and responded to effectively, and ensure accountability to affected populations. These approaches will also fill the need for screening to detect severe cases of SAM or the need for emergency obstetric services, which will be referred to the static clinics for effective treatment. With CHF funding support, CMA will sustain functioning health facilities and sale-up lifesaving medical outreaches to locations where large unserved IDP populations live.

3. Description Of Beneficiaries

The population in Fangak County is predominantly Nuer ethnicity, overwhelming rural and whose livelihoods are based on agro-pastoralism. The focus of this project will be on reaching locations where large IDP populations have settled and where health services are not being provided by any other health sector humanitarian actor. As the lead agent for RRHP in Fangak, CMA has sustained its presence on-ground since the beginning of the current crisis. Through its on-ground presence, CMA has identified the locations of beneficiaries most in need of this project's assistance. The bomas where beneficiaries will be targeted are: Buom and Wanglei in Barbuoi payam; Juaibor and Kuernyang in Manajang payam; Nyadin and Toch in Mareang payam; Keew, Kuerpon and Thokchak in Paguer payam and Pakan in New Fangak payam. These bomas comprise an estimated catchment population of 140,805, 65% of the total population of Fangak county, and 46,460 IDPs, 61% of the county IDP population. The most vulnerable and at-risk populations within these target areas have been identified through CMA's monitoring surveys. The primary target beneficiaries of the project will be the IDPs and those households that are hosting IDPs. The beneficiary populations have been displaced by either conflict/insecurity or floods, or both floods and conflict. The target beneficiaries within these households are the vulnerable U5 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 malnutrition 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. The coping mechanisms of these vulnerable households have been totally eroded (South Sudan HRP 2017, UNOCHA pg 6). The target beneficiaries are experiencing IPC 3 Crisis in February, but are expected to deteriorate to IPC 4 Emergency by May 2017 (IPC South Sudan February 2017, FEWS Net, pgs 3-5). Fangak has been placed in the group of counties rated as Severity of Need Level 5 for health (South Sudan HNO 2017, UNOCHA pg 22). CMA's on-ground experience provides the same evidence provided in the HRP - HNO 2017. Common health threats are acute respiratory infections, acute watery diarrhea, malaria and severe acute malnutrition as well as high risk of outbreaks of measles, kala-azar and cholera.

The project will sustain static services at 5 PHCC locations, and from these facilities, CMA will employ a mobile medical outreach approach to reach 5 additional PHCU locations where services have been disrupted by the conflict and where the health facilities need support in order to provide the services demanded by the concentration of the IDP population, and where facility structures, equipment, cold-chain and skilled health workers are lacking for essential and emergency health services. Total individual direct beneficiaries who receive clinical treatments will be 21,319 (female – 11,364 and male – 9,955) of which 12,365 (58%) will be IDPs. The total children U5 direct beneficiaries will be 7,392 (girls 3,844 and boys 3,548) and total PLW beneficiaries will be 3,616. The total individual indirect beneficiaries who receive health promotion IEC message, and WASH and protection messages but who do not clinical treatments will be an estimated 9,500 adults.

4. Grant Request Justification

The critical humanitarian gap that this project will fill is the reduced access to lifesaving health care focusing on major causes of mortality among U5 children (malaria, diarrhoea, pneumonia), SAM with complications, and the major causes of mortality among PLW focusing on maternal deaths and rising morbidity from malnutrition. The priority services will be: (1) treatment for malaria, acute respiratory infections, AWD, and SAM cases with medical complications; (2) provision of BEmONC, and safe delivery services; (3) provision of emergency vaccinations when required, and immediate treatment responses to outbreaks of measles, kala-azar and cholera. 90% of the funding request to CHF will be directed to delivering these priority services.

The project is justified on the basis that due to the crisis of the past 3 years, only 5 of 17 health facilities (4 PHCCs and one hospital) are functioning but at reduced capacity. For a host of reasons, the need for health service has greatly increased, while delivery capacity has declined leaving large populations of IDPs and host communities without any service. CMA's strategy is to maintain and use the capacity of functioning PHCCs and to scale-up and deliver lifesaving medical outreaches to serve the emergency needs in locations where large unserved IDP populations have settled in the catchment areas of 5 PHCUs. CHF assistance will open one additional PHCC, and add services through the mobile approach to reach the populations in 5 PHCU catchment areas. The project 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 to reach those with greatest needs.

RRHP funding ended in May 2016, and there is no date set for its resumption. While CMA has a PCA with UNICEF for EPI, iCCM, health promotion and prevention interventions, there is need to add funding to deliver outreaches to unserved populations. At present, there is urgent need to provide gap-funding to maintain basic lifesaving primary health care services.

The humanitarian crisis coupled with delayed resumption of RRHP funding requires urgent response and this project will provide that response in locations where it is most needed.
CMA has worked in Fangak County since 2000. CMA has established capacity to sustain services in the current crisis. CMA has experience establishing units for safe child delivery, for a comprehensive program covering reproductive health, and treatment of SAM with medical complications for children U5, as well as other primary health services. With UNICEF and WFP assistance, CMA is also delivering OTP and TSFP services in Juaibor and Keew fully integrated with health service delivery. CMA plans to expand nutrition services to 3 additional PHCCs and serve the targeted PHCU locations through the mobile approach fully integrated with health services. Further, CMA has experience delivering health services in a gender sensitive approach, conducting awareness on sexual and reproductive rights, providing cinical management of rape including MHPSS, mobilizing communities to address SGBV and protection practices to enable women, girls and boys to access services in the context of insecurity. CMA has experience delivering programs that target 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. Most importantly, CMA is known and trusted as a competent health service provider by community leaders, local authorities, CHD and payam health committees. CMA's relevant experience and the on-ground presence of CMA in targeted counties place it in the best position to deliver the proposed project.

5. Complementarity

CMA has provided health services in Fangak County since 2000. For this CHF funded project, CMA will draw on the lessons learned over the past 17 years in order to deliver effective services in the current crisis of conflict and economic hardship. Currently, CMA has committed assistance from a UNICEF PCA for health services, and second UNICEF PCA and WFP FLA for nutrition services covering the targeted areas. These agreements form the funding foundation for a complementary approach in delivery of CHF's health sector assistance.

Complementarity in Populations Reached: Current committed resources from UNICEF support static services delivered from functional PHCCs. The CHF project will add health outreach teams and mobility capacity to conduct outreaches targeting locations where IDPs are concentrated and reach populations in areas of non-functional PHCU locations. Outreaches are planned at the rate of 2 per month for 6 months, with flexible capacity to increase this number should outbreaks of measles, cholera and kala-azar become more serious. Further, an additional PHCC will be raised to functional status and serve a large population in the Kuernyang area of Manajang payam. The CHF project will enable delivery of lifesaving health services to a larger population of the most vulnerable people.

Complementarity within Health Sector; Current committed resources from UNICEF deliver support for iCCM, EPI and maternal and child health. The CHF project will scale up OPD services and add human resource capacity to manage increased prevalence of common communicable diseases (malaria, diarrhea, pneumonia), SAM with medical complications, outbreaks of kala-azar, cholera and other diseases, and MISP and MHPSS services for survivors of SCBV. Further, the CHF project will add equipment and materials targeting 3 PHCCs to enable delivery of BEmONC services raising the total number of PHCCs providing these services from 2 to 5 in Fangak County. The combination of enhanced outreach and increased human resource capacity will also enable strengthened disease surveillance, especially in unreached locations.

Complementarity Across Sectors (Health – Nutrition – WASH – Protection): The CHF funded health services will be fully integrated with nutrition services at the level of static services and outreach services achieving efficiency and effectiveness of the integrated approach and related synergy and complementarity. Further, from both the static services and outreach services, WASH messages and protection awareness will be constantly delivered through community promotion, meetings with affected populations and IEC sessions. Further, CMA is an active member of the association of humanitarian actors in Fangak County. Through these channels CMA will ensure effective and timely coordination with all humanitarian actors delivering programs in the targeted locations of this project. The functional PHCCs supported under this project all have effective working relationships with local authorities and community leaders and well-maintained landing strips. These attributes will provide ideal bases for the delivery of more complete WASH, FSL, BSFP and other emergency assistance whenever partners can avail this assistance to the areas covered through this project.

LOGICAL FRAMEWORK

Overall project objective

The overall objective is to reverse the rising mortality rate from communicable diseases, severe acute malnutrition with medical complications, cholera, kala azar, unsafe child deliveries and support victims of SGBV with a focus on reaching the most vulnerable U5 children, adolescent girls and women.

The specific project objectives are to:
1. Improve access to essential health care for conflict-affected and vulnerable populations;
2. Prevent, detect and respond to epidemic prone disease outbreaks in conflict-affected and vulnerable states especially kala-azar, measles and cholera;
3. Provide clinical health services that are inclusive and implemented with dignity targeting specific needs of vulnerable populations (women and adolescents);
4. Improve access to MHPSS services for the vulnerable people, including those services related to the GBV response.

The project will implement three strategies to achieve these objectives, expand the reach of the few functioning health facilities and the address access constraints: (1) maintain lifesaving services of targeted functional facilities; (2) conduct mobile medical outreaches to serve unreached communities; and (3) help communities implement protection practices to enable the vulnerable groups (PLW, adolescent girls and children U5) to access outreach and static health 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 experiencing the threat of constant insecurity have access to lifesaving health services.

Important cross-cutting themes guiding implementation will be (1) mainstreaming gender equality; (2) ensuring accountability to affected populations; (3) protection of vulnerable populations so they can access health services. Fielding additional health workers, conducting in-service training of 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 through regular outreaches and meetings with host community and IDP leaders will be applied in ongoing programming. 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 insecurity and population movement, CMA has anticipated access disruption and a significant increase in need and demand for health services. The economic and political crisis adds additional risk. CMA's strategies for managing these risks are: (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 medicines and 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 conducting a completely integrated approach to health and nutrition programming, and coordinating and collaborating closely with other humanitarian actors delivering WASH, nutrition and protection projects. Currently, CMA has two PCAs with UNICEF for health and nutrition programming that are expected to be renewed through 31 August 2017. The full integration of health with nutrition allows maximum leverage and impact from available funding as both programs target same locations, and use common facility, transportation and human resources for delivery of the integrated program.

HEALTH

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Prevent, detect and respond to epidemic prone disease outbreaks in conflict-affected and vulnerable populations	SO1: Save lives and alleviate the suffering of those most in need of assistance and protection	90
Essential clinical health services are inclusive and implemented with dignity targeting specific needs of vulnerable populations	SO2: Protect the rights and uphold the dignity of the most vulnerable	5
Improve access to essential health care for conflict-affected and vulnerable populations.	SO1: Save lives and alleviate the suffering of those most in need of assistance and protection	5

Contribution to Cluster/Sector Objectives : The project will be implemented in Fangak County rated as Severity of Need Level 5, for health needs (SS HNO 2017, UNOCHA pg 22) and IPC 3 Crisis (IPC SS February 2017, FEWS Net, pg 3). Health cluster estimates for Fangak show a total of 76,200 IDPs of which CMA estimates 46,460 have settled in the payams targeted in this project. The bomas targeted are: Buom and Wanglei in Barbuoi payam; Juaibor and Kuernyang in Manajang payam; Nyadin and Toch in Mareang payam; Keew, Kuerpon and Thokchak in Paguer payam and Pakan in New Fangak payam. These bomas comprise an estimated 65% of the total population of Fangak County, and 61% of the IDP population.
The health cluster has targeted 82,047 individuals for assistance through CO1.
Project objective 1 aims to improve access and scale-up in emergency responsiveness to an integrated primary healthcare package focusing on the major causes of mortality among U5 children (malaria, diarrhea, pneumonia, measles) and SAM with medical complications, and emergency HIV/AIDS, TB referrals and BEmONC focused on PLW. CMA expects to reach 21,319 individuals with these services of which 58% are expected to be IDPs.
Further, project objective 2 will deliver emergency response to epidemic prone disease outbreaks targeting kala-azar, measles and cholera. Currently, CMA is treating suspected cases of cholera and kala-azar in Juaibor, Keew and Pakan PHCCs. This will be sustained and CMA will respond to emergencies in other locations and measles in all locations through both static services and mobile medical outreaches, including surveillance to detect emerging new outbreaks. The targeted individuals directly benefiting from these interventions is 2,296.
To achieve these targets, the project will provide clinical officers, midwives/nurses and CHWs/MCHWs for delivery of static services and conduct the medical outreaches to bomas not served by static facilities. The project will provide equipment, supplies to maintain services from static facilities and add transportation support (boat hire for long distance outreaches and walking for short distance outreaches) to enable mobile health teams to serve unreached areas. 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 53,752 outpatient consultations will be achieved, of which 14,785 will be children U5 years including 136 receiving treatment for medical complications related to SAM and 3,616 will be PLW. A further 22,470 people will be reached with health education and promotion messages including WASH, nutrition, IYCF and protection messages.
In this manner, the project will deliver on CO1.
Project objective 3 will improve access to essential clinical health services that are inclusive and implemented with dignity and targeted to the specific needs of vulnerable populations (women and adolescents) by offering essential SGBV and clinical management of rape services. And project objective 4 will improve access to MHPSS for the vulnerable people by providing psychosocial support and mental health services for the highly vulnerable population (adolescent girls, and women of IDP and women headed households). A total of 100 individuals are expected to directly benefit from these services.
In this manner, this project directly contributes to CO2 and CO3.
To ensure the project achieves Cluster expectations to reach vulnerable IDPs, women and children 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. Through health outreaches to PHCU and other locations where IDPs have concentrated, a large unserved population of IDPs (estimated at 12,365 people) will be reached. In addition, a host community population of 8,954 will be reached.

Outcome 1

Increased access and scale-up in emergency responsiveness to an integrated primary healthcare package focusing on the major causes of mortality among U5 children (malaria, diarrhea, pneumonia, measles) and SAM with medical complications, and emergency HIV/AIDS, TB referrals and BEmONC focused on PLW.

Output 1.1

Description

Damaged and non-functional heath facilities made operational and delivering an integrated essential primary healthcare package in emergency context including as bases for delivering mobile medical outreach responses.

Assumptions & Risks

Assumptions: that CMA can sustain functional health facilities as bases for mobilizing outreach health teams, that these facilities can serve as bases for delivering mobile services and that CMA 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.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	HEALTH	Number of functional health facilities in conflict affected and other vulnerable states.					5
Means of Verification : CMA quarterly project reports							
Indicator 1.1.2	HEALTH	[Frontline services] Number of facilities providing BEmONC services					5
Means of Verification : CMA quarterly project reports							
Indicator 1.1.3	HEALTH	Total number of skilled workers (Clinical Officers, Certified Nurses, Certified Midwives, CHWs/MCHWs and Laboratory and Pharmacy workers) providing an integrated essential primary healthcare package including outreach personnel – total 31(10 women, 21 men					31
Means of Verification : CMA quarterly project reports							
Indicator 1.1.4	HEALTH	Number of skilled workers (Certified Nurses/Midwives and CHWs/MCHWs) providing medical outreach services with an integrated essential primary healthcare package – total 15 (5 women, 10 men).					15
Means of Verification : CMA quarterly project reports							
Indicator 1.1.5	HEALTH	Number of health personnel trained on HIV transmission prevention, safe disposal of medical waste, gender sensitivity, and importance of gender disaggregated data – total 9 (4 women, 5 men).					9
Means of Verification : CMA quarterly project reports.							

Activities

Activity 1.1.1

rehabilitate damaged facilities and equip PHCCs to improve emergency response services including mobile medical outreaches

Activity 1.1.2

equip PHCCs to provide quality BEmONC services

Activity 1.1.3

provide skilled personnel (Clinical Officers, Certified Nurses, Certified Midwives, CHWs/MCHWs and Laboratory and Pharmacy workers) to put non-functional facilities into operation and undertake medical outreaches delivering an integrated emergency primary healthcare package including HIV transmission prevention

Activity 1.1.4

equip and mobilize for medical outreaches skilled health workers (Certified Nurses/Midwives and CHWs/MCHWs) with medical bag-pack for basic curative consultations and provide health education and promotion and active case search on diseases of public health concern

Activity 1.1.5

provide health workers and provide in-service training on HIV transmission prevention, safe disposal of medical waste, gender sensitivity, and importance of gender disaggregated data.

Output 1.2

Description

Lifesaving primary healthcare services and mobile medical outreaches deliver treatments of common life-threatening illnesses

Assumptions & Risks

Assumptions: that CMA can access areas and IDP populations where health services are most needed, populations can access services, especially survivors of SGBV, PLW, U5 children and elderly, and CMA can access sufficient of drugs and medical supplies.
Risks: Food scarcity and hunger may force populations to migrate in search of food and out of the reach of the project; localized insecurity could disrupt project delivery of outreach services; 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.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.2.1	HEALTH	[Frontline services] Number of outpatient consultations in conflict and other vulnerable states	18,154	20,823	7,097	7,688	53,762
Means of Verification : CMA monthly HMIS reports							

Indicator 1.2.2	HEALTH	Number of U5 outpatient consultations in conflict affected and other vulnerable states – total 14785, (girls 7688, boys 7097);					14,785
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.3	HEALTH	Total number of outpatient consultations of persons over 5 years in conflict affected and other vulnerable states total 38977, (females 20823, males 18154);					38,977
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.4	HEALTH	[Frontline services] Total number of deaths recorded within the facility	49	47	0	0	96
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.5	HEALTH	[Frontline services] Total number of U5 deaths recorded within the facility			21	24	45
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.6	HEALTH	[Frontline services] Number of health workers trained on safe deliveries	5	4			9
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.7	HEALTH	[Frontline services] Number of deliveries attended by skilled birth attendants in conflict-affected and other vulnerable states					116
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.8	HEALTH	[Frontline services] Number of children under 5 with severe acute malnutrition with medical complications, who are clinically managed in stabilization centers			67	69	136
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.9	HEALTH	Number of the affected population that are aware of the rights to health services, their reproductive health rights and the complaints mechanism for feeding back complaints on health program performance and issues.					22,470
Means of Verification : CMA quarterly project reports							

Activities

Activity 1.2.1

deliver static and mobile medical outreaches for life saving treatment of common communicable diseases (malaria, diarrhea, pneumonia and other common diseases), and outbreaks of measles, kala-azar, cholera;

Activity 1.2.2

provide reproductive health services to WCBA and adolescent girls, and provide life saving BEmONC to vulnerable women through static and outreach services;

Activity 1.2.3

receive referrals and provide clinical management of SAM cases with medical complications;

Activity 1.2.4

engage affected populations in planning health interventions and deliver information sessions to ensure affected populations are aware of their rights and entitlements with respect to health services, men and women are aware of their reproductive health rights, and aware of the complaints mechanism with respect to their rights, and ensure men, youth and women leaders of affected populations provide protection for children, adolescent girls and women at risk of SGBV so they can access lifesaving health services.

Output 1.3

Description

Scaled-up delivery of vaccinations, Vitamin A and ITNs and promotion of health messages through static health services and medical outreaches to serve IDPs and other vulnerable groups.

Assumptions & Risks

that 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, and that CMA can access adequate supplies of vaccines, micronutrients, vitamins and ITNs for successful delivery of EPI and health promotion activities, and the PCA with UNICEF will be extended.
Risks: Localized conflict could prevent implementation of outreaches intended to deliver routine and emergency vaccinations. Vaccine stock-outs could impede EPI delivery. To mitigate these risks, 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, and make application for vaccines from UNICEF in advance of planned immunization activities.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.3.1	HEALTH	[Frontline services] Number of facilities with functioning Cold chain in conflict states					5
Means of Verification : CMA quarterly project reports							
Indicator 1.3.2	HEALTH	[Frontline services] Number of children with 3 doses of pentavalent vaccine			1,135	1,231	2,366
Means of Verification : CMA quarterly project reports							
Indicator 1.3.3	HEALTH	Number of ITNs issued – total 2366 (girls 1231, boys 1135)					2,366
Means of Verification : CMA monthly HMIS reports							
Indicator 1.3.4	HEALTH	[Frontline services] Number of of children (under -5) supplemented with Vitamin A			5,382	4,968	10,350
Means of Verification : CMA monthly HMIS reports							
Indicator 1.3.5	HEALTH	[Frontline services] Number of children 6 to 59 months receiving measles vaccinations in emergency or returnee situation			2,129	2,306	4,435
Means of Verification : CMA monthly HMIS reports							
Indicator 1.3.6	HEALTH	[Frontline services] Number of people reached by health education /promotion	8,009	14,461	0	0	22,470
Means of Verification : CMA monthly HMIS reports							

Activities

Activity 1.3.1

provide cold chains and cold chain maintenance;

Activity 1.3.2

provide routine EPI service through outreaches and conduct vaccination campaigns (NIDs) to serve IDPs and other vulnerable groups;

Activity 1.3.3

provide mosquito nets (ITNs) to mothers of children U5 years through outreaches to serve IDPs and other vulnerable groups;

Activity 1.3.4

provide Vitamin A supplementation to children U5 years through outreaches to serve IDPs and other vulnerable groups;

Activity 1.3.5

deliver routine and emergency outreach EPI services against measles and polio

Activity 1.3.6

provide health promotion and awareness to educate men and women leaders, schools and churches on protection, WASH messages (water purification, sanitation, hygiene promotion), acute malnutrition prevention, reproductive health, HIV/AIDS and STI prevention and gender awareness.

Outcome 2

Emergency response to epidemic prone disease outbreaks increased which targets kala-azar, measles and cholera.

Output 2.1

Description

Detect disease outbreaks and respond within 48 hours through outreaches to serve IDPs and other vulnerable groups in emergency settings

Assumptions & Risks

Assumptions: that for disease surveillance work, CMA can deploy, train and maintain outreach health workers and community-based health promoters in the context of the complex emergency, and that these personnel can effectively deliver needed response.
Risk: Localized conflict could prevent implementation of surveillance and monitoring outreach efforts. To mitigate this risk, CMA will engage community leaders and focus recruitment and training on skilled South Sudanese personnel to deliver surveillance, detection and effective responses.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 2.1.1	HEALTH	[Frontline services] Number of staff trained on disease surveillance and outbreak response	5	4			9
Means of Verification : CMA quarterly project reports							

Indicator 2.1.2	HEALTH	[Frontline services] Proportion of epidemic prone disease alerts verified and responded to within 48 hours					90
Means of Verification : CMA monthly HMIS reports							
Indicator 2.1.3	HEALTH	[Frontline services] Number of children 6 to 59 months receiving measles vaccinations in emergency or returnee situation			1,064	1,154	2,218
Means of Verification : CMA monthly HMIS reports							
Indicator 2.1.4	HEALTH	total number of patients treated for measles, kala-azar and cholera in emergency or returnee situation - total 76, (women 20, men 18, girls 20, boys 18).					76
Means of Verification : CMA monthly HMIS reports.							

Activities

Activity 2.1.1

conduct in-service training of health workers on disease surveillance and reporting;

Activity 2.1.2

conduct weekly surveillance and reporting disease trends and detect and report outbreaks

Activity 2.1.3

conduct emergency response actions to arrest disease outbreaks and deliver measles vaccinations

Activity 2.1.4

conduct emergency response actions to treat disease outbreaks including treatments/referrals for measles, kala-azar and cholera.

Outcome 3

Improved access to essential clinical health services that are inclusive and implemented with dignity and targeted to the specific needs of vulnerable populations (women and adolescents).

Output 3.1

Description

Essential SGBV and clinical management of rape delivered.

Assumptions & Risks

Assumptions: CMA can deploy and maintain qualified health workers and access needed PEP kits for static services and mobile outreaches that can effectively deliver needed services for SGBV and clinical management of rape in the context of the complex emergency, and that communities will support victims of SGBV and rape to seek services.
Risks: Localized conflict could prevent implementation of services, and cultural factors could prevent survivors of SGBV and rape from presenting their situations to health facilities for treatment. To mitigate these risks, CMA will engage community leaders to support victims of SGBV to access available clinical management of rape services.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 3.1.1	HEALTH	[Frontline services] Number of staffs trained on Clinical Management of Rape (CMR)	5	4			9
Means of Verification : CMA quarterly project reports							
Indicator 3.1.2	HEALTH	[Frontline services] Number of health facilities providing SGBV services					5
Means of Verification : MOH - CMA quarterly project reports							
Indicator 3.1.3	HEALTH	Number of rape survivors who receive appropriate post-rape treatment at health facilities within 72 hours – total 50					50
Means of Verification : MOH - CMA monthly HMIS reports							

Activities

Activity 3.1.1

conduct in-service training of health personnel on clinical management of rape including techniques of applying the MISP and best practices for clinical care of survivors of SGBV and rape and provide GBV services from PHCCs

Activity 3.1.2

equip facilities with the supplies needed to provide care for GBV including MISP kits (emergency contraceptive pills, and post-exposure prophylaxis (PEP) and STI presumptive treatment within 72 hours);

Activity 3.1.3

conduct treatment for the victims of rape with MISP and best practices for clinical care of survivors of SGBV.

Outcome 4

Access to mental health and psychosocial support services (MHPSS) for the vulnerable people increased

Output 4.1

Description

Psychosocial support and mental health services for the highly vulnerable population (adolescent girls, and women of IDP and women headed households) delivered

Assumptions & Risks

Assumptions: CMA can deploy and maintain qualified health workers for static services and mobile outreaches that can effectively deliver needed services for MHPSS for victims of SGBV and rape in the context of the complex emergency, and that communities will support victims of SGBV and rape to seek services.
Risks: Localized conflict could prevent implementation of services, and cultural factors could prevent survivors of SGBV and rape from seeking mental health treatment for SGBV and rape. To mitigate these risks, CMA will engage community leaders to support victims of SGBV to access available mental health services.

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 4.1.1	HEALTH	[Frontline services] Number of health personnel trained on MHPSS in conflict affected states	5	4			9
Means of Verification : CMA quarterly project reports							
Indicator 4.1.2	HEALTH	Number of SGBV survivors receiving MHPSS services – total 50					50
Means of Verification : CMA monthly HMIS reports.							
Indicator 4.1.3	HEALTH	Number of health facilities providing MHPSS services in IDP settings 5.					5
Means of Verification : CMA quarterly project reports							

Activities

Activity 4.1.1

conduct in-service training of health personnel on techniques of providing MHPSS, the referral pathway, laws and practices including survivor consent governing reporting cases of GBV

Activity 4.1.2

provide MHPSS for management of SGBV, and referrals for those needing specialized post-rape treatment;

Activity 4.1.3

raise gender awareness with men and women on the sexual and reproductive rights of adolescent girls and women, and victims of SGBV and ensure vulnerable women and adolescent girls, and men and women community leaders are aware of SGBV services and men and women leaders support victims to access services.

Additional Targets :

M & R

Monitoring & Reporting plan

The baseline data for this project has already been established in the DHIS, and program monthly and quarterly reports of CMA's ongoing health programming. CMA will use the following tools to monitor project activities: (1) Focused community surveys to monitor protection, impacts of awareness outreaches and IDP access to health facilities; (2) Regular consultations with affected populations (host community, IDP, vulnerable women, girls and boys) to ensure participation in planning and monitoring the program, access to services, implementation of a complaints mechanism and raise awareness on its process, and ensure a system of representation of affected populations is in place; (3) Monthly HMIS, weekly IDSR reports and immunization campaign reports from health facilities; (4) Monthly activity reports from health facilities providing data not icluded in the HMIS reports; (5) Quarterly project reports to donors; (6) 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, outbreaks and malnutrition will be investigated. IDSR reports will be prepared weekly. This analysis will be used to respond to any outbreaks of diseases, including kala-azar, measles, cholera 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 affected populations, communities and 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, cholera and conflict 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. At the output level, the CMA County Health Coordinator 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 Coordinator 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 Coordinator 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: rehabilitate damaged facilities and equip PHCCs to improve emergency response services including mobile medical outreaches	2017				X	X							
Activity 1.1.2: equip PHCCs to provide quality BEmONC services	2017				X	X							
Activity 1.1.3: provide skilled personnel (Clinical Officers, Certified Nurses, Certified Midwives, CHWs/MCHWs and Laboratory and Pharmacy workers) to put non-functional facilities into operation and undertake medical outreaches delivering an integrated emergency primary healthcare package including HIV transmission prevention	2017			X	X	X	X	X	X				
Activity 1.1.4: equip and mobilize for medical outreaches skilled health workers (Certified Nurses/Midwives and CHWs/MCHWs) with medical bag-pack for basic curative consultations and provide health education and promotion and active case search on diseases of public health concern	2017				X	X							
Activity 1.1.5: provide health workers and provide in-service training on HIV transmission prevention, safe disposal of medical waste, gender sensitivity, and importance of gender disaggregated data.	2017			X	X	X	X	X	X				
Activity 1.2.1: deliver static and mobile medical outreaches for life saving treatment of common communicable diseases (malaria, diarrhea, pneumonia and other common diseases), and outbreaks of measles, kala-azar, cholera;	2017			X	X	X	X	X	X				
Activity 1.2.2: provide reproductive health services to WCBA and adolescent girls, and provide life saving BEmONC to vulnerable women through static and outreach services;	2017			X	X	X	X	X	X				
Activity 1.2.3: receive referrals and provide clinical management of SAM cases with medical complications;	2017			X	X	X	X	X	X				
Activity 1.2.4: engage affected populations in planning health interventions and deliver information sessions to ensure affected populations are aware of their rights and entitlements with respect to health services, men and women are aware of their reproductive health rights, and aware of the complaints mechanism with respect to their rights, and ensure men, youth and women leaders of affected populations provide protection for children, adolescent girls and women at risk of SGBV so they can access lifesaving health services.	2017			X	X	X	X	X	X				
Activity 1.3.1: provide cold chains and cold chain maintenance;	2017				X	X							

Activity 1.3.2: provide routine EPI service through outreaches and conduct vaccination campaigns (NIDs) to serve IDPs and other vulnerable groups;	2017			X	X	X	X	X	X			
Activity 1.3.3: provide mosquito nets (ITNs) to mothers of children U5 years through outreaches to serve IDPs and other vulnerable groups;	2017			X	X	X	X	X	X			
Activity 1.3.4: provide Vitamin A supplementation to children U5 years through outreaches to serve IDPs and other vulnerable groups;	2017			X	X	X	X	X	X			
Activity 1.3.5: deliver routine and emergency outreach EPI services against measles and polio	2017			X	X	X	X	X	X			
Activity 1.3.6: provide health promotion and awareness to educate men and women leaders, schools and churches on protection, WASH messages (water purification, sanitation, hygiene promotion), acute malnutrition prevention, reproductive health, HIV/AIDS and STI prevention and gender awareness.	2017			X	X	X	X	X	X			
Activity 2.1.1: conduct in-service training of health workers on disease surveillance and reporting;	2017			X	X							
Activity 2.1.2: conduct weekly surveillance and reporting disease trends and detect and report outbreaks	2017			X	X	X	X	X	X			
Activity 2.1.3: conduct emergency response actions to arrest disease outbreaks and deliver measles vaccinations	2017			X	X	X	X	X	X			
Activity 2.1.4: conduct emergency response actions to treat disease outbreaks including treatments/referrals for measles, kala-azar and cholera.	2017			X	X	X	X	X	X			
Activity 3.1.1: conduct in-service training of health personnel on clinical management of rape including techniques of applying the MISP and best practices for clinical care of survivors of SGBV and rape and provide GBV services from PHCCs	2017			X	X							
Activity 3.1.2: equip facilities with the supplies needed to provide care for GBV including MISP kits (emergency contraceptive pills, and post-exposure prophylaxis (PEP) and STI presumptive treatment within 72 hours);	2017				X	X						
Activity 3.1.3: conduct treatment for the victims of rape with MISP and best practices for clinical care of survivors of SGBV.	2017			X	X	X	X	X	X			
Activity 4.1.1: conduct in-service training of health personnel on techniques of providing MHPSS, the referral pathway, laws and practices including survivor consent governing reporting cases of GBV	2017			X	X							
Activity 4.1.2: provide MHPSS for management of SGBV, and referrals for those needing specialized post-rape treatment;	2017			X	X	X	X	X	X			
Activity 4.1.3: raise gender awareness with men and women on the sexual and reproductive rights of adolescent girls and women, and victims of SGBV and ensure vulnerable women and adolescent girls, and men and women community leaders are aware of SGBV services and men and women leaders support victims to access services.	2017			X	X	X	X	X	X			

OTHER INFO

Accountability to Affected Populations

The project will be implemented in collaboration with CHDs, local authorities, payam health committees, and the leaders of IDPs to ensure their inclusion in program decision-making. These structures will participate in planning, implementing and monitoring the delivery of all emergency health care services. CMA will work actively to engage the local health committees, to mobilize communities to receive health services and engage groups of IDPs by 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 the 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 among affected populations 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, 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 targeted 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 Coordinator 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 robust monitoring, effective implementation of the complaints mechanism so as to achieve effective accountability to the populations being served.

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

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 the County Coordinator to deliver field activities and control the locations where personnel are assigned in order to ensure sufficient personnel that are 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 and support personnel. Where ever possible, the Clinical Officer and Midwife / Nurse positions will be filled by South Sudanese nationals. This team of skilled personnel will lead in delivery of static and medical outreach services, and supervise community health workers and support personnel of static facilities and those implementing medical 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 the program and 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 county and state 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, UNICEF, IMA/World Bank). This will be achieved through meetings, participating in committees and sharing 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	Overall supervision of health facilities and delivery of health and nutrition services. Linking agencies delivering health services in Fangak County and 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, detecting and filling gaps in coverage and components of primary health care services.
UNICEF	Funding partner for cold-chain rehabilitation and installation, and delivery of immunizations, Vitamin A and deworming, and iCCM and maternal and child health services.

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 County dates back to 2000. Presently, CMA has been the lead agent for RRHP. CMA's analysis shows that the drivers of the humanitarian crisis are conflict, insecurity and seasonal flooding. These crisis drivers affect women and men, and 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 particularly vulnerable. CMA has designed health delivery strategies and activities to ensure equality of opportunity to access health services. CMA has also ensured that health personnel are sensitized to gender issues and skilled to apply gender equity principles and practices in their approach to health service delivery with dignity toward patients both male and female. CMA's needs analysis with the participation of men and women of IDP and host communities has enabled gender to be mainstreamed into the planning of project objectives, outcomes, outputs and activities.

Specific measures to identify different needs of men, women, boys and girls and integrate gender into ongoing planning, implementation and monitoring of health service delivery include: (1) training of gender balanced teams of health workers to deliver services with gender sensitivity and always with dignity toward patients; (2) collecting of data always disaggregated on the basis of gender; (3) engaging men and women leaders to take responsibility for mobilizing vulnerable populations (IDPs, children, adolescent girls, women, elderly, disabled) to seek services, and to protect these populations so they have equal opportunity to access health facilities; (4) 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; (5) 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 promote reproductive health services; (6) and engaging 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 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 and training health workers on provision of MISP and MHPSS services at all PHCCs, and ensuring all health personnel know the treatment referral pathway for victims of SCBV;
(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) raising awareness among men and women leaders of host and IDP communities on the vulnerability of boys targeted for conscription into armed forces;
(5) engaging community leaders, IDP leaders and local authorities to organize themselves to protect community assets like health facilities from destruction or looting by armed forces, and to advocate for peace between the armed forces and the community.
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-relocatable 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 safety while working in South Sudan and when required, to safely evacuate 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 potential 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 and 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 plans. 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

Currently, there are no access restrictions on the targeted project locations in Fangak County. CMA has delivered health services in Fangak County 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 or boat only. CMA has longstanding good partnerships with critical air service providers, specifically AIM Air, MAF and Samaritan's Purse, as well as UNHAS. 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	4,234.23	6	25.00	6,351.35
	Medical Program Manager, South Sudan [Supervise field planning and implementation, supervise field personnel performance, monitor budget utilization, output achievements and compile reports] [fte 25% is based on proportion of this project budget of the total estimated country program budget for this period] [cost based on monthly salary and benefits (social security, medical and life insurance cover)]						
1.2	Health Coordinator	D	1	3,480.55	6	40.00	8,353.32
	Health Coordinator, [Conduct field planning and coordination and delivery of health services, supervise personnel performance, monitor output achievements and compile draft reports] [fte 40% 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	County Field Coordinator-Fangak	D	1	1,216.22	6	40.00	2,918.93
	County Field Coordinators, [Conduct coordination and delivery of health services in the County, supervise personnel performance, monitor output achievements and compile data for draft reports] [fte 40% on this project budget for this period] [cost based on monthly salary and benefits (social security, medical and life insurance cover)] (1 for Fangak County)						
1.4	Clinical Officers (National)	D	4	1,322.00	6	40.00	12,691.20
	Clinical Officers (National) Lead in the delivery of static services and outreaches to IDPs, including supervision of CHWs, compile weekly HMIS reports, and other reports as required] [based on 40% fte on project activities] [Monthly salary rate inclusive of social security benefits] (4 Fangak PHCCs)						
1.5	Certified Midwives/Nurses (International)	D	4	1,177.98	6	40.00	11,308.61
	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 40% fte on project activities] [Monthly salary rate inclusive of social security benefits] (4 Fangak)						
1.6	Certified Midwives/Nurses (National)	D	1	909.00	6	40.00	2,181.60
	Certified Midwives/Nurses (National) [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 40% fte on project activities] [Monthly salary rate inclusive of social security benefits] (1 Fangak,)						
1.7	Laboratory Technicians (National)	D	2	739.00	6	40.00	3,547.20
	Laboratory Technicians (National) [Deliver laboratory services at PHCCs, maintain records and compile reports] [Working 40% fte on project activities] [Monthly salary rate includes social security benefits] (2 Fangak)						
1.8	Pharmacy and Laboratory Assistants (National)	D	5	182.00	6	40.00	2,184.00
	Pharmacy and Laboratory Assistants (National) [Deliver pharmacy and laboratory services at PHCCs, maintain records and compile reports] [Working 40% fte on project activities] [Monthly salary rate includes social security benefits] (5 Fangak - 1 each for 5 PHCCs)						
1.9	Senior CHWs/MCHWs	D	5	329.00	6	40.00	3,948.00
	Senior CHWs/MCHWs (National) [Deliver project static services and outreaches to IDPs, maintain clinical records and compile reports] [Working 40% fte on project activities] [Monthly salary rate includes social security benefits] (5 Fangak)						
1.10	CHWs/MCHWs	D	10	249.00	6	40.00	5,976.00
	CHWs/MCHWs (National) [Deliver project static services and outreaches to IDPs, maintain clinical records and compile reports] [Working 40% fte on project activities] [Monthly salary rate includes social security benefits] (10 Fangak)						

1.11	Support Personnel and Casuals (Cooks, Guards, Cleaners, Porters)	D	15	182.00	6	40.00	6,552.00
	Support Personnel and Casuals (Cooks, Guards, Cleaners, Porters) Support delivery of static services and outreach activities. [Working 40% fte on project activities] [Monthly salary inclusive of any applicable benefits] (Fangak - 15, 3 support personnel for each PHCC)						
1.12	Country Director, South Sudan	S	1	3,476.55	6	20.00	4,171.86
	Country Director, South Sudan [Provide overall direction in planning and delivery of the project and supervision of performance in budget utilization and output achievements] [fte 20% is based on proportion of this project's budget of the total estimated South Sudan program budget for this period] [cost based on monthly salary and benefits (social security, medical and life insurance cover)]						
1.13	M&E Specialist	D	1	2,568.72	6	20.00	3,082.46
	Support Health Program Coordinator designing and implementing surveys and data collection and analysis to monitor disease trends and report outcome results achieved at beneficiary level] [fte 20% of actual time working on this project in a 6 month period - planned 24 days of work] [cost based on monthly salary and benefits (social security, medical and life insurance cover)]						
1.14	Supply Chain Manager	S	2	1,648.19	6	20.00	3,955.66
	Procure and deliver supplies, monitor shipments and verify application of supplies, manage the transportation of personnel and delivery of supplies to HF, maintain financial records of procurement and transport of supplies] [fte 20% of actual time working on this project in a 6 month period [cost based on monthly salary and benefits (social security, medical and life insurance cover)]						
1.15	Senior Logistician	S	1	1,316.70	6	20.00	1,580.04
	Deliver supplies to the field sites, monitor shipments and verify application of supplies, coordinate the transportation of personnel and delivery of supplies to HF, maintain financial records of procurement and transport of supplies] [fte 20% is based on proportion of this project's budget of the total estimated South Sudan program budget for this period] [cost based on monthly salary and benefits (social security, medical and life insurance cover)]						
1.16	Administrator and Senior Accountant	S	2	1,091.50	6	20.00	2,619.60
	Coordinate and manage administration of the project, maintain financial planning and monitoring, deliver payroll and monthly financial records on incomes and expenditures, and compile reports for review and approval of Finance Manager and Country Director] [fte 20% is based on proportion of this project's budget of the total estimated South Sudan program budget for this period] [cost based on monthly salary and benefits (social security, medical insurance cover)]						
1.17	Project Accountant	S	0	0.00	0	25.00	0.00
	CHWs/MCHWs (National) [Deliver project static services and outreaches to IDPs, maintain clinical records and compile reports] [Working 40% fte on project activities] [Monthly salary rate includes social security benefits] (10 Fangak)						
1.18	Office Support Personnel and Driver	S	4	485.00	6	20.00	2,328.00
	Receptionist, Cleaner, Driver support senior personnel complete project management and administrative duties, protect and maintain office equipment and supplies, support delivery of field programs] [fte 20% is based on proportion of this project's budget of the total estimated South Sudan program budget for this period] [cost based on monthly salary and benefits (social security, medical and life insurance cover)						
1.19	Accomodation and Upkeep For Eligible (Relocatable) Field Personnel	D	10	15.00	90	40.00	5,400.00
	Upkeep ($5/day), medical, hardship and accommodation expenses and allowances ($10/day) for eligible relocatable personnel working in the County and PHCCs based on rate of $15 / day and a per person average of 90 days in the field during a 6 month period						
1.20	Accommodation and Upkeep for Eligible Management Personnel	D	5	80.00	25	40.00	4,000.00
	Upkeep ($30/day), and accommodation expenses and allowances ($50/day) for eligible management personnel while on field monitoring and work assignments the County and PHCCs based on rate of a total $80 / day and average of 25 days in the field per eligible manager during a 6 month period.						
1.21	Incentives for CHWs/MCHWs, EPI and Community-Based Health Promoters	D	36	125.00	1	40.00	1,800.00
	Outreach Incentives for CHWs/MCHWs, EPI Vaccinators and Community-Based Health Promoters to incentivize outreach activities to PHCUs and locations where IDPs are concentrated (kits of food, t-shirts, boots, gear for caring water, cash etc. @ $125 per worker / volunteer) [36 Fangak]						
	Section Total						**94,949.83**
Supplies, Commodities, Materials							
2.1	Basic PHCC Facility Maintenance	D	5	3,000.00	1	40.00	6,000.00

	Basic maintenance of HF structures, cost based on a per structure cost of $3,000 / unit and for 1 structure per PHCC facility, total of 10 structures for maintenance						
2.2	Medical Materials and Supplies	D	3	1,550.00	1	40.00	1,860.00
	Medical materials and supplies for outreaches and static clinics (per unit) - kits of needles, syringes, lab regents, bandages, gloves, kerosene, etc.) [total of 3 PHCCs, 1 kit per PHCC) total 3 kits						
2.3	Materials for BEmONC Services	D	3	1,670.00	1	40.00	2,004.00
	Materials for BEmONC services, 3 sites identified for this assistance - Nyadin, Pakan, Kuernyang (hospital beds $240/bed 2 beds/unit, bedsheets $40/unit, delivery couch $800 1/unit, examination table $250/table 1/unit, plastic sheets $100/unit)						
2.4	Air Transportation of materials and Supplies	D	5	4,500.00	1	40.00	9,000.00
	Transportation of maintenance materials and medical supplies Juba - field locations 5 PHCCs (1 caravan flights / PHCC, $4,800 / flight)						
2.5	Overland Transportation of materials and Supplies	D	1	4,500.00	1	40.00	1,800.00
	Overland transportation of maintenance materials and medical supplies Juba - field locations 7 PHCCs (overland transport 2 trips shared for all site $7,000 / trip)						
	Section Total						**20,664.00**
Equipment							
3.1	Equipment for emergency and security communication 2 sites	D	2	1,650.00	1	40.00	1,320.00
	Equipment for emergency and security communication for County Coordination centers 2 sites (Thruway, Began, Quack) 1 set/site)						
3.2	Equipment for BEmONC Services	D	2	3,410.00	1	40.00	2,728.00
	Equipment for BEmONC services 3 PHCCs (Nyadin, Kuernyang, Pakan) (drip stand $70/stand 4 pc/unit, foetal stethoscope $120/scope 4 scopes/unit, baby scale $65/scale 2 scales/unit, blood pressure machine $65/machine 2 pc/unit, adult stethoscope $105/pc 4 pc/unit, delivery sets $85/set 4 sets/unit, autoclave $350/pc 1 pc/unit, manual vacuum aspirator $100/pc 4 pc/unit, delivery beds 2/unit @ $220/pc, recovery beds 4/unit @ $110/pc)						
3.3	Equipment for PHCC Inpatient Services	D	2	2,680.00	1	40.00	2,144.00
	Equipment for PHCC Inpatient services 3 PHCCs (Nyadin, Kuernyang, Pakan) (drip stand $70/stand 4 pc/unit, blood pressure machine $65/machine 2 pc/unit, adult stethoscope $105/pc 4 pc/unit, autoclave $350/pc 1 pc/unit, manual vacuum aspirator $100/pc 4 pc/unit, recovery beds 10/unit @ $110/pc)						
3.4	Air Transportation of Medical Equipment	D	2	4,500.00	1	40.00	3,600.00
	Transportation of medical equipment Juba - field locations 3 PHCCs (1 caravan flights / PHCC, $4,800 / flight)						
	Section Total						**9,792.00**
Contractual Services							
4.1	In-service Training of CHWs/MCHWs/Home Health Promoters	D	27	60.00	2	40.00	1,296.00
	Training CHWs/MCHWs/Home Health Promoters on promotion of home health interventions, prevention of SGBV, training on reproductive rights, malaria prevention and neonatal care training expenses including training supplies, subsistence, transportation allowance (@ $120/trainee/training session - $100 for transport and accom, $20 for supplies).						
	Section Total						**1,296.00**
Travel							
5.1	Charter Travel (Juba-HF) for Coordinators and Health Facility Personnel	D	10	1,100.00	2	40.00	8,800.00
	Charters (Juba-HF) and ground transport for eligible relocatable health personnel - County Coordinator (1), 9 Midwives/Nurses and 5 Clinical Officers personnel (unit cost - per person cost per rtrip, based on 1 round trip/person/quarter at 50%)						
5.2	Charter Travel (Juba-HF) for Technical and Management Support Personnel	S	1	1,100.00	1	20.00	220.00

	Charters (Juba-HF)and ground transport for Supply Chain Manager and M and E Specialist for supplies delivery monitoring and disease trend monitoring surveys respectively (unit cost-per person cost per rtrip, 2 round trips/person) @25%						
5.3	Ground and Boat Transportation for Outreaches	D	2	2,180.00	6	50.00	13,080.00
	Ground/boat transport, accom and supplies for delivery of distant/extended health outreaches (18 outreaches. 1/mth to 3 PHCUs @ $2,280/outreach @ 50%)						
5.4	Accommodation and Upkeep for In-Transit Health Personnel	D	10	300.00	2	50.00	3,000.00
	Accommodation and Upkeep for In-Transit Health Field Personnel per rtrip for County Coordinator (1), 9 Midwives/Nurses and 5 Clinical Officers personnel (per person cost per rtrip, based on 1 round trip/person/quarter @ $100 per day and 3 days per rtrip at 50%)						
5.5	Accommodation and Upkeep for In-Transit Technical Support Personnel	S	1	300.00	1	20.00	60.00
	Accommodation and Upkeep for In-Transit Management Personnel per rtrip for Supply Chain Manager and M&E Specialist (per person cost per rtrip, 2 round trips/person@ $100/day and 3 days / rtrip at 25%)						
5.6	Travel Visas and Permits for International Health Personnel and Technical Support Personnel	D	7	250.00	1	40.00	700.00
	Visa's, Alien Permits for International Health and Technical Support Personnel per person (7 personnel) @50%						
	Section Total						**25,860.00**
General Operating and Other Direct Costs							
7.1	Communications Juba Office	S	1	400.00	6	20.00	480.00
	monthly cost prorated @ 40% 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	1,110.00	6	40.00	2,664.00
	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	420.00	6	20.00	504.00
	monthly cost for supplies and equipment repairs prorated @ 40% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.4	Supplies, Stationery and Equipment Replacement: County offices and project sites	D	1	2,129.00	6	40.00	5,109.60
	monthly cost for supplies and equipment replacement, maintenance and repair 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	1	285.00	6	20.00	342.00
	monthly cost prorated @ 40% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.6	Office and Stores Rents: Juba Offices and Stores monthly cost	S	2	2,400.00	6	20.00	5,760.00
	monthly cost for rents and maintenance prorated @ 40% 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	1	370.00	6	20.00	444.00
	monthly cost prorated @ 40% 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	1	754.00	6	20.00	904.80
	monthly cost prorated @ 40% 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	750.00	6	40.00	1,800.00
	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	1	360.00	6	20.00	432.00
	monthly cost prorated @ 40% 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	1	210.00	6	20.00	252.00
	monthly cost prorated @ 40% 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	220.00	6	40.00	528.00
	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	1	150.00	6	20.00	180.00
	monthly cost prorated @ 40% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
	Section Total						**19,400.40**
SubTotal			208.00				**171,962.23**
Direct							147,728.27
Support							24,233.96
PSC Cost							
PSC Cost Percent							7.00
PSC Amount							12,037.36
Total Cost							**183,999.59**

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	100	3,077	4,936	6,387	6,919	21,319	Activity 1.1.1 : rehabilitate damaged facilities and equip PHCCs to improve emergency response services including mobile medical outreaches Activity 1.1.2 : equip PHCCs to provide quality BEmONC services Activity 1.1.3 : provide skilled personnel (Clinical Officers, Certified Nurses, Certified Midwives, CHWs/MCHWs and Laboratory and Pharmacy workers) to put non-functional facilities into operation and undertake medical outreaches delivering an integrated emergency primary healthcare package including HIV transmission prevention Activity 1.1.4 : equip and mobilize for medical outreaches skilled health workers (Certified Nurses/Midwives and CHWs/MCHWs) with medical bag-pack for basic curative consultations and provide health education and promotion and active case search on diseases of public health concern Activity 1.1.5 : provide health workers and provide in-service training on HIV transmission prevention, safe disposal of medical waste, gender sensitivity, and importance of gender disaggregated data. Activity 1.2.1 : deliver static and mobile medical outreaches for life saving treatment of common communicable diseases (malaria, diarrhea, pneumonia and other common diseases), and outbreaks of measles, kala-azar, cholera; Activity 1.2.2 : provide reproductive health services to WCBA and adolescent girls, and provide life saving BEmONC to vulnerable women through static and outreach services; Activity 1.2.3 : receive referrals and provide clinical management of SAM cases with medical complications; Activity 1.2.4 : engage affected populations in planning health interventions and deliver information sessions to ensure affected populations are aware of their rights and entitlements with respect to health services, men and women are aware of their reproductive health rights, and aware of the complaints mechanism with respect to their rights, and ensure men, youth and women leaders of affected populations provide protection for children, adolescent girls and women at risk of SGBV so they can access lifesaving health services. Activity 1.3.1 : provide cold chains and cold chain maintenance; Activity 1.3.2 : provide routine EPI service through outreaches and conduct vaccination campaigns (NIDs) to serve IDPs and other vulnerable groups; Activity 1.3.3 : provide mosquito nets (ITNs) to mothers of children U5 years through outreaches to serve IDPs and other vulnerable groups; Activity 1.3.4 : provide Vitamin A supplementation to children U5 years through outreaches to serve IDPs and other vulnerable groups; Activity 1.3.5 : deliver routine and emergency outreach EPI services against measles and polio Activity 1.3.6 : provide health promotion and awareness to educate men and women leaders, schools and churches on protection, WASH messages (water purification, sanitation, hygiene promotion), acute malnutrition prevention, reproductive health, HIV/AIDS and STI prevention and gender awareness. Activity 2.1.1 : conduct in-service training of health workers on disease surveillance and reporting;

Documents

Category Name	Document Description
Project Supporting Documents	Health Full Proposal TR1 Comments and CMA Responses (29 Mar 17).docx