OCHA Coordination Saves Lives

Project Proposal

Requesting Organization :	Comitato Collaborazione Medica
Allocation Type :	1st Round Standard Allocation

Primary Cluster	Sub Cluster	Percentage
HEALTH		100.00
		100

Project Title :	Improve the quality of essential health service delivery (safety nets) and strengthen the emergency response to the humanitarian needs, including obstetric services and supportive care to GBV victims in Mingkamann and underserved area of selected counties of Lakes.
Allocation Type Category :	

OPS Details

Project Code :		**Fund Project Code :**	SSD-16/HSS10/SA1/H/INGO/817
Cluster :		**Project Budget in US$:**	199,562.52
Planned project duration :	6 months	**Priority:**	
Planned Start Date :	01/01/2016	**Planned End Date :**	30/06/2016
Actual Start Date:	01/01/2016	**Actual End Date:**	30/06/2016

Project Summary :

The overall goal of the project is to reduce the morbidity and mortality of children U5 (boys and girls), PLW, victims of GBV, elderly and other vulnerable groups (HIV/TB people, IDPs/returnees) in Mingkamann (Awerial County) by combining health emergency response (reduce the risk of epidemic prone, endemic diseases, vaccine preventable and other diseases as a result of conflict and displacement) and institutional/community preparedness.
CCM engagement in Awerial has been strengthened after the conflict erupted in December 2013 which has led to a serious impact on the already vulnerable health system due to the high influx of displaced people, especially in Mingkamann. According to last figures available in Mingkamann live 71.361 IDPs, out of which 28.3% are children U5, 37.6% are aged 6-17 and 23.5% women, hailing from Bor, Twic East, Duk and Awerial. New arrivals (around 30.000 IDPs) have been registered in November 2015 (IRNA). The health service delivery of both counties is at risk due to HPF reduced the scope of the work from January to March and uncertainty on future plans and programs. The situation is particularly critical in Mingkamann where the governmental facility support is limited to quarter one of 2016 and the new stabilization center - recently inaugurated by CCM - risks to remain close before becoming operational. In line with the Health Cluster Strategy for CHF First Standard Allocation, this project will mainly focus Mingkamann to cover the following gaps:

1. Scale up emergency primary health services among displaced people in Mingkamann and in areas with limited or no access to health services (as effect of HPF reduced scope of work) especially women and children (72% of target population);
2. Enhance health emergency response and outbreak control in Mingkamann including health promotion;
3. Provision of medical supplies and commodities, including essential medicine and basic health and reproductive health kits;
4. Strengthen the referral system and access to emergency care for children and women, boys and girls (including adolescents) and elderly;
5. Improve the community participation in the health services management and promotion, supporting their ownership and involving them in the planning of outreaches and campaign.

CCM has never left the area. CHF funds will integrate the resources availed by HPF which party cover the needs from January 2016.

Direct beneficiaries :

Men	Women	Boys	Girls	Total
19,059	30,023	9,923	10,243	69,248

Other Beneficiaries :

Beneficiary name	Men	Women	Boys	Girls	Total
Internally Displaced People	4,765	18,014	5,954	6,146	34,879
People in Host Communities	14,294	12,009	3,969	4,097	34,369
Pregnant and Lactating Women	0	6,305	0	0	6,305
Children under 5	0	0	9,923	10,243	20,166

Indirect Beneficiaries :

The indirect beneficiaries of the program are 100,000 people (caretakers, household, etc..). The entire population will benefit from the project since without CHF support the institutional health system will be completely disrupted.

Catchment Population:

Geographical focus of the present action is Mingkamann but the catchment population is extended to Awerial county especially outside the PoC through community mobilization activities, mobile clinics in remote area, awareness raisingrising in underserved communities and IDPs settlements.

Link with allocation strategy :

According to the Health Cluster priorities, the project is aimed to prevent, detect and respond to disease outbreaks and immunizations of U5 in Mingkamann and remote underserved area of Awerial county and to increase basic life-saving health and nutrition services in the target areas. The project will contribute to the procurement of medical supplies and commodities, including essential medicines, basic health and RHC kits through the core pipeline, ensuring the effective provision of frontline services and complementing the stock of kits and supplies that are necessary for outbreak response and mobile activities (i.e. syringes, gloves, cannulas, masks, giving sets, rapid response tests, tetracycline capsules).
Access to emergency primary health care (PHC), targeting the main causes of mortality amongst vulnerable populations, particularly women and children with limited or no access to health services is improved. Essential Basic Care (EPI, IMCI, general consultation) and RH services is provided in Mingkamann Site 0 (MCH, FP, ANC, PNC, STI, GBV follow up, counseling and referral) both at facility level and through regular outreaches and mobile clinics in underserved and remote area, such as Khaltok, Abuyong, Awerial and Bunagok payams and cattle camps along the River Nile, Abot Bae, Wunukum and Hoor. The integration of HIV/AIDS (VCT, PMTCT) and TB preventive care within the existing PHC services is also promoted. On-the-job training on emergency response, IMCI, MISP, trauma management, disease outbreak response will improve the provision and access to health care services. Finally, VHC and women groups involvement in the health services management and promotion will ensure the spread of health education messages and the increase of health services demand especially in underserved area.

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
Health Pooled Funds	43,126.00
	43,126.00

Organization focal point :

Name	Title	Email	Phone
Elisabetta D`Agostino	Country Representative CCM	countryrep.ssd@ccm-italia.org	+211 918 570727
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BACKGROUND

1. Humanitarian context analysis

Since December 2013, the current civil war has devastated the lives of millions of South Sudanese and displaced more than 2.2 million people. About 1.6 million of them have been displaced internally in South Sudan and over 600,000 are refugees in neighboring countries. The conflict has weakened an already challenged local health system, with infrastructure destroyed by the fighting, staff and humanitarian workers targeted or displaced, and parallel and separate delivery of basic services not making the best use of limited resources and with the risk to disrupt the institutional health system. Evidence shows that the highest cause of death in South Sudan is not the direct violence of the conflict but the consequences of the secondary impacts of war, such as disease, hunger, the destruction of markets and infrastructure and the massive disruption to livelihoods caused by people fleeing from the conflict.
Comitato Collaborazione Medica (CCM), together with its partners, worked hard to save thousands of lives by responding to high levels of food insecurity and malnutrition, preventing and responding to diseases such as cholera, vaccinating children and ensuring that people access to clean water and basic care. Despite the efforts, South Sudan county health system is actually featured by extensive financial gaps. The system, if not supported by the International Humanitarian Agencies, risks to frustrate the results achieved since the independence.
The current project proposal targets Awerial county (with particular focus Mingkmann) in Lakes State where, according to recent figures (IRNA Report, 4th December 2015), more than 71,361 IDPs and additional 29,656 IDPs mainly from Jalle and Baidit Payams (Bor Payam) and Pakeer and Ajuong Payams (Twic East) joined the the host communities. According to demographic data (SSDC, 2015), 28.3% of IDPs in Mingkmann are children U5 (14.6% female), 37.6% are aged 6-17 (12.6% female) and 23.5% woman with a small proportion of over 60 (2.1%) and male (6%). Both counties are characterized by worrisome health indicators (especially concerning reproductive and Child Health) and by relatively low rates of access to PHC, mostly due to movement constraints, poverty prevalence and limited awareness of health risks. Access to reproductive and child health service is concerned with only 11% of pregnant woman and 13% of children receiving the 3rd dose of pentavalent (DHIS/CCM county statistics, November 2015). Despite the HPF support to the County Health System from January to March 2016, Mingkamann PHCC and other 4 health facilities in Awerial County have been awarded with only 43,126 GBP which are not enough to ensure key lifesaving activities form more than a month (it was estimated that over 17,600 people may lose access to basic health services on a three-month basis of closed non-functional PHC services).. In case of not additional resources, the South Sudan healthcare system in those counties is expected to close in favor of short term intervention and parallels emergency system.

2. Needs assessment

Humanitarian health needs assessed in the target area, include:
- Continue support to primary health care in Awerial county (Mingkmann and neighboring area) where there is high demand of health care, overcrowding, and continue risk of outbreak;
- Provision of ANC/PNC and BEmONC services for the P&LW in remote areas, cattle camps or IDPs settlements. Skilled birth delivery rate is extremely low (less than 1%) in the area of intervention with few of the functional health facilities staffed with permanent SBAs;
- Comprehensive RH services (including VCT/PMTCT/STI management), for women and partners living in remote areas, in cattle camps or IDP/returnees' camps;
- Increase EPI coverage in remote areas and IDPs settings in order to increase the immunization coverage among the population;
- OPD/IPD capacities to treat medical complications and common disease, focusing on U5 (boys/girls) and P&LW. Malaria, respiratory infections and diarrhea are the top three diseases in U5 (both boys and girls) throughout the year, even though during the dry seasons the incidence of eye and skin infections (including burns) is high. Facilities located close to seasonal cattle camps also report high level of brucellosis (on average, 20 cases/month, both children and adults);
- Community sensitization on hygiene, sanitation and safe RH targeting caretakers (men and women), women in reproductive age and partners, other MARPs (prisoners, soldiers, TB patients and relatives), opinion leaders (VHCs, religious leaders, teachers, youth groups);
- Institutional EP&R capacity building;
- Communicable disease control and inter sector coordination to improve the e warn and referral system, with particular focus to the implementation of preparedness plan established in Mingkamann.
- Enabling HIV people accessing counseling and treatments.

3. Description Of Beneficiaries

Geographical focus of the present action is Mingkamann and Awerial County. The action addresses the needs of IDPs community and underserved people of Awerial county. The direct beneficiaries of the project are 69,247 people. 29% of the project target are children U5 (boys and girls equally targeted) and 43% are woman (21% P&LW) from host and IDP communities Mingkamann and neighboring areas. The beneficiaries have been identified among all patients acceding health services at facility and community level (OPD U5 and Adult, ANC/PNC, EPI, outreaches and mobile clinic), with particular attention to groups heavily affected by conflicts (mainly IDPs) and prone to natural disasters (flood, heat) and with low financial capacity and income (reduced harvest capacity, loss of livestock, unhealthy household). Community involvement will ensure the identification of people in need and of the "best" health and nutrition practices, congruent with local culture, capabilities and the physical environment. Health services will be equally accessible for people with disabilities and minorities even if the project doesn't specifically target those categories. The project beneficiaries also include CHD members of Awerial County 5 people), supported through daily technical assistance and dedicated capacity building activities, in order to take the leadership and coordination of the health resources and actors in each county. Local staff (around 30) capacity will be improved by on-job and dedicated training on IMCI, MISP, trauma management, disease outbreak response, and BEmONC.

4. Grant Request Justification

Comitato Collaborazione Medica (CCM) is an international non-governmental organization specialized in the health sector. CCM is present in Southern Sudan since 1983, with a valuable experience in the management of both health and nutrition projects founded by several donors. The presence of CCM in the project target county dates back to 2005. From November 2013, in the framework of the HPF county-wide funding approach, CCM has been selected as health provider in the project county responsible also for severe acute management of malnutrition in Awerial PHC system. The present allocation will ensure the continuation of the on-going health and nutrition program, integrating nutrition services into health facilities.
Due to lack of fund, HPF can support only minimal activities in the first quarter 2016 with an high risk to close preventive, curative and emergency services in Mingkamann, disrupting the governmental system from February. CHF resources are therefore crucial to complement secured funds, covering financial gaps and humanitarian needs.
According to the health cluster strategy, Awerial is considered a high priority area where emergency and lifesaving intervention are necessary to alleviate IDPs and decrease health related risks: provision of health emergency services and outbreak control in Mingkaman, to mitigate the risk of contamination in the target area; provision of basic saving-life health and nutrition services by reinforcing the referral and access to the existent health facility system of people with limited or no access to health services especially women and children; procurement of essential emergency medical supplies and basic health and RHC kits; access to BEmONC services.

5. Complementarity

Emergency and lifesaving interventions will be mainstreamed into the existing Awerial County Health System (2 PHCC and 3 PHCU) in order to ensure data accountability and referral of underserved people to the most appropriate level of care. 2 ambulances are available in Mingkaman and Bunagok PHCC. The final goal of CCM cooperation/integration with the local health authorities is to strengthen and improve the quality of essential services delivery, as well as to increase the demand of care and the accessibility to services. Moreover, the great attention to the communities' activities and health promotion will enable CCM to provide services even in remote areas and to support the services demand increment. Added values of the proposal:
- Integration of the emergency interventions into the County Health System;
- Integration with Nutrition program;
- Long-standing partnership with CHDs for health system strengthening, technical assistance on quality service provision and data gathering/analysis;
- Improved health service delivery for local communities and IDPs/returnees.
- Complementarily with other program (HPF, UNICEF, Italian cooperation) and multi-cluster response.

LOGICAL FRAMEWORK

Overall project objective

The overall goal of the project is to reduce the morbidity and mortality of children U5 (boys and girls), PLW, victims of GBV and older people and other vulnerable groups (HIV/TB people, IDPs/returnees) in Awerial County of Lakes State by combining health emergency response (communicable disease control, EmONC capacities and RH services) and institutional/community preparedness.

HEALTH

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
CO1: Improve access, and scale-up responsiveness to, essential emergency health care, including addressing the major causes of mortality among U5C (malaria, diarrhea and Pneumonia), emergency obstetric care and neonate services in conflict affected and vulnerable populations	HRP 2016 SO1: Save lives and alleviate suffering through safe access to services and resources with dignity	68
CO2: Prevent, detect and respond to epidemic prone disease outbreaks in conflict affected and vulnerable populations	HRP 2016 SO1: Save lives and alleviate suffering through safe access to services and resources with dignity	20
CO3: Improve access to psychosocial support and mental health services for the vulnerable population, including those services related to the SGBV response	HRP 2016 SO2: Ensure communities are protected, capable and prepared to cope with significant threats	12

Contribution to Cluster/Sector Objectives : The project will contribute to the Cluster objective 1 Improve access, and scale-up responsiveness to, essential and emergency health care, including emergency obstetric care services, guarantee the access to primary and secondary health care services to the IDPs and host community thanks to the support to the Mingkaman PHCC (and the other Awerial PHCUs) in Lakes State. The two main HFs are already warranting the access to emergency obstetric cares, while the established referral system will support the access to the emergency health care. The project will support the objective 2 of the cluster thanks to the already established cooperation with the CHDs, CCM will be in condition to work to capacitate the CHDs members and work in cooperation with the other NGOs to strengthen existing health systems to prevent, detect and respond to disease outbreaks. Finally the project will contribute to the Health Cluster objective 3, Improve access to psychosocial support and mental health services for the vulnerable population, including those services related to the GBV response, through the improvement of the HFs and CHDs staff awareness and competences on psychosocial and mental health needs (including GBV). A strong action in promoting sensitization events for the community and training for the staff on the psychosocial and mental health problems and treatment will help to increase the demand for services and facilitate the access to them.

Outcome 1

To increase access to lifesavings, essential and emergency health care services in Mingkamann (Awerial county), targeting the main causes of mortality amongst vulnerable populations, particularly women and children with limited or no access to health services, IDPs and other vulnerable groups (nomadic peoples, prisoners), including case management of severe acute malnutrition of U5.

Output 1.1

Description

- Enhanced case management of common illness in emergency settings (malaria, diarrhea and Pneumonia) and emergency obstetrics and neonatal care services, including SGBV services.
- Routine and emergency vaccinations improved
- Surveillance and response to SAM cases strengthened in Mingkamann
- Increased access to essential medicines and supplies including reproductive health commodities

Assumptions & Risks

- MoH continues supporting the development of Primary Health Care Service provision in Awerial County.
- The CHD is fully staffed and committed to improve the quality of PHC services Local communities, IDPs and returnees do acknowledge and are willing to access/utilize HFs services.
- Faith based hospital are not excluded from long term strategy.
- Security and accessibility remain stable in the area.
- Movements of people and supplies are adequate.
- Prices of raw material and supplies remain in line with worldwide market.

Activities

Activity 1.1.1

Essential basic and emergency health care in Mingkamann PHCC and underserved area (OPD/IPD services, EPI services, management of common disease) to U5, boys and girls, P&LW, victims of traumas/injuries of host and IDPs community.

Activity 1.1.2

Emergency and ordinary comprehensive RH commodities (ANC, PNC, BEmONC, FP, STI), including mobile clinics in rural area and IDPs settlement.

Activity 1.1.3

Procurement and prepositioning of essential/emergency drugs, medical/non medical supplies in the dry season and integrating the MoH provision and additional emergency drugs like anti-malaria, diarrheal and GBV kits.

Activity 1.1.4

Surveillance and response to SAM cases in children U5, including referral and case management in Mingkamann stabilization centre.

Activity 1.1.5

Integration of HIV/AIDS (VCT, PMTCT) and improvement of referral system for HIV treatment.

Activity 1.1.6

On the job training on emergency response, IMCI, MISP, trauma management, disease outbreak response, hospital waste management.

Activity 1.1.7

Capacity building and supervision of male and female health workers on (i) Focused ANC, (ii) Uncomplicated delivery, (iii) Focused PNC, (iv) FP, (iv) VCT/PMTCT and trauma management (including referral), (vi) GBV, (vii) MHPSS.

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 1.1.1	HEALTH	Frontline # Number of functional health facilities in conflict -affected and other vulnerable states					5
Means of Verification : DHIS statistics							
Indicator 1.1.10	HEALTH	Frontline # of children under 5 with severe acute malnutrition with medical complications, who are clinically managed in stabilization centers			32	28	60
Means of Verification : NIS statistics							
Indicator 1.1.2	HEALTH	Frontline # Number of facilities providing BEmONC services					2
Means of Verification : DHIS statistics							
Indicator 1.1.3	HEALTH	Number of outpatient consultations in conflict-affected and other vulnerable states. Men: 7907; Women: 14057; Boys: 7324; Girls: 8260					37,548
Means of Verification : DHIS							
Indicator 1.1.4	HEALTH	Frontline # of children 6 to 59 months receiving measles vaccinations in emergency or returnee situation			958	1,300	2,258
Means of Verification : DHIS and Outreaches reports							
Indicator 1.1.5	HEALTH	Antenatal client 1st visit					1,623
Means of Verification : DHIS							
Indicator 1.1.6	HEALTH	Antenatal client 4th visit					450
Means of Verification : DHIS							
Indicator 1.1.7	HEALTH	Frontline # Number of deliveries attended by skilled birth attendants in conflict-affected and other vulnerable states		111			111
Means of Verification : DHIS							
Indicator 1.1.8	HEALTH	Frontline # of children with 3 doses of pentavalent vaccine			347	361	708
Means of Verification : DHIS							
Indicator 1.1.9	HEALTH	Frontline # of staff trained on disease surveillance and outbreak response	20	13			33
Means of Verification : training report							

Outcome 2

To scale up coordination mechanism in Awerial County capacities to prevent, detect and respond to diseases outbreak including response mechanism

Output 2.1

Description

- Emergency outbreak vaccination system in place
- Epidemic prone disease outbreaks in conflict affected and vulnerable states are prevented
- Awareness raised among vulnerable people concerning health risks and epidemic diseases.
- EP&R system in place through the involvement of the CHD.

Assumptions & Risks

- MoH continues supporting the development of Primary Health Care Service provision in Awerial County.
- The CHD is fully staffed and committed to improve the quality of PHC services.
- Local communities, IDPs and returnees do acknowledge and will access to HFs services.
- Women's will to join the education sessions and other awareness raising activities
- Local authorities are supportive in mobilizing community members
- Accessibility in the area remain stable

Activities

Activity 2.1.1

Mobile clinics in remote and underserved area of Awerial county (such as Khaltok, Abuyong, Awerial and Bunagok payams and cattle camps along the River Nile, Abot Bae, Wunukum and Hoor) .

Activity 2.1.2

Community mobilization to promote good health, hygiene & sanitation practices (prevention of communicable diseases /STIs/ malaria, EPI, health seeking behavior, hygiene, malnutrition and HIV/AIDS related-issues), and health education and promotion before and during outbreaks.

Activity 2.1.3

Training for CHD, VHC, health staff on outbreak surveillance and emergency response teams;

Activity 2.1.4

Maintenance of Vaccine Cold Chain for ordinary and emergency EPI campaign.

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 2.1.1	HEALTH	Frontline # of children 6 to 59 months receiving measles vaccinations in emergency or returnee situation			726	824	1,550
Means of Verification : DHIS							
Indicator 2.1.2	HEALTH	Frontline # of epidemic prone disease alerts verified and responded to within 48 hours					98
Means of Verification : IDSR. The indicated value is to be intended as a %							
Indicator 2.1.3	HEALTH	Frontline # of people reached by health education and promotion before and during outbreaks	5,600	7,600	0	0	13,200
Means of Verification : Internal report							
Indicator 2.1.4	HEALTH	Frontline Number of health personnel trained on MHPSS in conflict affected states	20	13			33
Means of Verification : Training report							

Output 2.2

Description

- psychosocial health services (including GBV response) provided to face the lack of services in the projects areas.

Assumptions & Risks

- The CHD fully supports and mediates with local authorities on GBV response
- Cultural barriers and stigmatization doesn't interfere in the implementation of the activities.

Activities

Activity 2.2.1

Sensitize and train health care professionals to recognize signs of GBV

Activity 2.2.2

Provision of GBV kits in the HFs and referral services put in place

Activity 2.2.3

Inclusion of GBV within family planning/reproductive health, maternal and child health, HIV and infectious disease activities

Activity 2.2.4

Community awareness on GBV and psychosocial health problems, trough specific sensitization events, community education, women groups and VHCs involvement.

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 2.2.1	HEALTH	N. of women counseled on RH, FP and GBV					9,400
Means of Verification : DHIS, Internal report							

Indicator 2.2.2	HEALTH	N. of people sensitized on GBV and psychosocial health problems					9,400
Means of Verification : internal report							
Indicator 2.2.3	HEALTH	Frontline # of health facilities providing SGBV services					2
Means of Verification : Internal report							
Indicator 2.2.4	HEALTH	N. of staff trained to recognize signs of GBV					10
Means of Verification : Training report							
Additional Targets :							

M & R

Monitoring & Reporting plan

CCM shall ensure continuous monitoring of project activities by:
- EFFECTIVE REPORTING SYSTEM: (i) compilation of daily/weekly/monthly health and nutrition facility registers and reports, (ii) compilation of outreach reports, (iii) compilation of monthly and quarterly reports for concerned CHDs and State MoH (Nutrition Cluster reporting tools), (iv) compilation of quarterly progress report for the SC and the donors, (v) monthly and quarterly reports to HQ project department. With regard to data collection and analysis, utilization of DHIS and nutrition data system shall ensure integration of project data within the MoH reporting system. Monthly reports to the national Nutrition Cluster shall be timely submitted.
- M&E: CCM staff includes Health Advisor officer based in SS Head Office (Juba), who will be responsible of periodic visits in the project areas, to check about indicators, targets and performances. - EXTERNAL MONITORING: the implementing partner will share periodical information and data on the project implementation with Nutrition Cluster focal persons both at State and federal level, to compare views and get additional inputs and comments.
- EFFECTIVE FINANCIAL MONITORING SYSTEM: (i) CCM accounting system are based on the double-entry system, which records transactions into journals and ledgers. Daily transactions, including purchases, cash receipts, accounts receivable and accounts payable are recorded using a specific accounting software which is reconcile on a weekly/monthly basis under the supervision of HQ administrative department; budget follow-up are elaborated and approved by HQ project department together with the request for funds (ii) procurement plan is elaborated at the begin of the project and review on a quarterly basis with the support and supervision of HQ procurement officer; (iii) compilation of financial report is elaborated by CCM country administration with the support of a state administrator t and subsequently approved by HQ administrative department

Workplan

Activitydescription	Year	1	2	3	4	5	6	7	8	9	10	11	12
Activity 1.1.1: Essential basic and emergency health care in Mingkamann PHCC and underserved area (OPD/IPD services, EPI services, management of common disease) to U5, boys and girls, P&LW, victims of traumas/injuries of host and IDPs community.	2016	X	X	X	X	X	X						
Activity 1.1.2: Emergency and ordinary comprehensive RH commodities (ANC, PNC, BEmONC, FP, STI), including mobile clinics in rural area and IDPs settlement.	2016	X	X	X	X	X	X						
Activity 1.1.3: Procurement and prepositioning of essential/emergency drugs, medical/non medical supplies in the dry season and integrating the MoH provision and additional emergency drugs like anti-malaria, diarrheal and GBV kits.	2016	X	X	X	X	X	X						
Activity 1.1.4: Surveillance and response to SAM cases in children U5, including referral and case management in Mingkamann stabilization centre.	2016	X	X	X	X	X	X						
Activity 1.1.5: Integration of HIV/AIDS (VCT, PMTCT) and improvement of referral system for HIV treatment.	2016	X	X	X	X	X	X						
Activity 1.1.6: On the job training on emergency response, IMCI, MISP, trauma management, disease outbreak response, hospital waste management.	2016	X	X	X	X	X	X						
Activity 1.1.7: Capacity building and supervision of male and female health workers on (i) Focused ANC, (ii) Uncomplicated delivery, (iii) Focused PNC, (iv) FP, (iv) VCT/PMTCT and trauma management (including referral), (vi) GBV, (vii) MHPSS.	2016		X	X		X	X						
Activity 2.1.1: Mobile clinics in remote and underserved area of Awerial county (such as Khaltok, Abuyong, Awerial and Bunagok payams and cattle camps along the River Nile, Abot Bae, Wunukum and Hoor) .	2016		X	X	X	X	X						
Activity 2.1.2: Community mobilization to promote good health, hygiene & sanitation practices (prevention of communicable diseases /STIs/ malaria, EPI, health seeking behavior, hygiene, malnutrition and HIV/AIDS related-issues), and health education and promotion before and during outbreaks.	2016			X		X							
Activity 2.1.3: Training for CHD, VHC, health staff on outbreak surveillance and emergency response teams;	2016		X			X							
Activity 2.1.4: Maintenance of Vaccine Cold Chain for ordinary and emergency EPI campaign.	2016	X	X	X	X	X	X						
Activity 2.2.1: Sensitize and train health care professionals to recognize signs of GBV	2016		X	X	X	X	X						
Activity 2.2.2: Provision of GBV kits in the HFs and referral services put in place	2016			X	X								
Activity 2.2.3: Inclusion of GBV within family planning/reproductive health, maternal and child health, HIV and infectious disease activities	2016		X	X	X	X	X						

Activity 2.2.4: Community awareness on GBV and psychosocial health problems, trough specific sensitization events, community education, women groups and VHCs involvement.	2016			X		X							

OTHER INFO

Accountability to Affected Populations

In order to guarantee the beneficiaries and community accountability, CCM has developed mechanisms to share project strategies and evaluations reports with the local institutions. CHD is involved in staff recruitment, induction, trainings and performance appraisal. Partnership agreements are in place to regulate the process. When required, CCM provides accessible information on organizational procedures and processes. CCM actively seeks the views of direct beneficiaries to improve their policy and practice in programming, through regular meetings. This activity ensures that the information provided are immediately received, processed and used to respond to and to learn from. Specific issues raised are referred to the competent authorities. The most marginalized people are represented and have influence on this process. Feedback received is designed to monitor and evaluate the achievement of the program.
Due to the nature of violence that has affected the country, the project carefully considers the ethical issue and cultural point of view that may arise during the implementation. These include the need to protect the confidentiality of data relating to all parties especially people at risk as well as, for example, the way data are collected, how they are stored, who has access to them and how they are used. High attention will be addressed to the nature of questions asked, especially given the often intimate personal nature of violent relationships and suffering. The right to privacy of all parties will be promoted at any time as well as the risk of those working on the project when enter in contact with perpetrators. A human rights-based approach will be ensured during the implementation of the program.

Implementation Plan

To successfully implement the project, CCM has organized a qualified and balanced team, composed of professionals with both health, nutrition and managerial background, who shall be based in Awerial co-located/attached to the CHD. Support from CCM Juba staff will also be offered, to guarantee quality control, supervision and additional support in some key areas of Health System Strengthening. The Technical Assistance that CCM will provide the CHD with is envisaged to gradually scale down from an initial consistent and close mentoring/capacity building for each project activity, to a later increased CHD degree of autonomy and decision-making empowerment, reflecting its improved competences. The management team keeps the project logical framework and work plan as primary tools to define implementation plan and assess project performances, achieved versus expected results/targets and respect of the timeframe.
A Steering Committee will be in place to ensure supervision and technical assistance to the management team throughout the project implementation. CCM and CHDs will have weekly meeting, both internal and within the Health facility, the VHCs and other interested partner in the county, to share information, verify data and define synergies to improve referral and report systems. Data coming from project nutritionist will inform the discussion, providing the base to define further interventions to address nutrition problems or to re orientate the ones on going. Project report data will be also used to brief the State authorities on County situation, supporting a wider decision-making process on the steps to be done to improve people Health and Nutrition status.

Coordination with other Organizations in project area

Name of the organization	Areas/activities of collaboration and rationale

Environment Marker Of The Project

Gender Marker Of The Project

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

Justify Chosen Gender Marker Code

The current M&E data tools used disaggregate data by gender and age, allowing an effective data analysis used for decision-making. The gender approach in needs analysis and in project implementation, will promote an effective planning to ensure equal access to services to all groups in the communities. The disaggregated data for boys and girls will allow identifying different approach to copy with cultural believes and better address services to them. The involvement of women and men in health education will spread a better understanding of nutrition issues, reducing the impact of malnutrition on children. The women group's activities will facilitate the women awareness on nutrition and health problems and their access to the HFs. Their attitude will positively influence child survival through exclusively breastfeeding, adequate complementary feeding, hygiene and good health seeking behaviors, including early identification of common diseases. Community involvement to public awareness campaigns aimed at breaking the culture of silence on GBV will raise awareness of gender inequality, human rights, the rights of the child, and the importance of women's participation in public life. This requires the close collaboration of community and religious leaders as well as educators. In addition, they should incorporate not only mass media, but must be disseminated to remote communities through networks of partners.
HIV/AIDS activities mainstream include:
– FP (including contraceptives distribution) in comprehensive RH services,
– promote VCT and PMTCT services availed in Tonj County Hospital (priority target: prisoners, soldiers, youths, P&LWs, HIV positive persons) and other PHCCs.
– counseling and referral of HIV positive patients to facilities where ARV treatment is available,
– HIV/AIDS awareness messages in health education sessions at facility and community level,
– guarantee universal precautions and safe blood supply during direct transfusions (surgery),
– manage the consequences of sexual violence, including provision of PEP and linking with protection cluster for client follow-up.

Protection Mainstreaming

The project will ensure coordination with all competent partners and relevant stakeholders in the target area in order to:
– facilitate family tracing for the unaccompanied and separated children identified during health prevention and frontline service delivery.
– provide hygiene kits to women and girls of reproductive health age.
– provide psychosocial support to the traumatized populations especially women and children.
– advocate during health and nutrition cluster meeting for child friendly spaces to be established to bridge the gap of establishment of emergency education activities and establish normalcy.
– to promote awareness raise activities to restore sense of security to the community

Country Specific Information

Safety and Security

The program is based on the assumptions that the level of violence remains stable during the project implementation.
In the last years, after the raising up of the conflict in the country, the security conditions have been going worst and worst even in the States not directly affected by the conflicts. Then the depreciation of the SS pounds in the last months has exacerbated the already poor condition of the population and increased the local criminality. Looking to the situation, CCM is improving its security policies and defining good practices to mitigate the risk and warrantee equal services for all the communities. Bi-monthly meetings with the Commissioner Office will be organized by the CHD/CCM staff to get information about the security in the county and to consider them in the activities planning. Before each movement the staff will keep in touch with the community to be visited to get further information about the condition in the area. In case of tension in some areas, CCM/CHDs will monitor the population movement to be sure reaching the most vulnerable groups that could affect by the conflicts. A tracking system will be installed on the CCM/CHDs cars to be sure tracking them in case of problems and have quick intervention. At Central level, CCM strictly monitor the security situation through information received by VSS and NGO forum and the Italian embassy.

Access

The program is based on the assumptions that the level of violence remain stable during the project implementation. Despite the challenging context of intervention, Awerial county remained accessible in the last 6 months.

BUDGET

Code	Budget Line Description	D / S	Quantity	Unit cost	Duration Recurrance	% charged to CHF	Total Cost
Staff and Other Personnel Costs							
1.1	Project Health Coordinators	D	2	2,000.00	6	100%	24,000.00
	2 Project health coordinators at $2000 per month for 6 months. LOCATION: Mingkmann (100% on CHF)						
1.2	Local health staff Mingkamann PHCC (Nurse, EPI) + key Health workers in Awerial counties	D	1	4,500.00	6	50%	13,500.00
	Local health staff of Mingkamann PHCC. Monthly salary at 4,500$ for 6 months. LOCATION: AWERIAL, (50% charged to CHF)						
1.3	1 Community mobilizers	D	1	1,500.00	6	50%	4,500.00
	1 community mobilizer at $1,500 for 6 months each. LOCATION: 1 AW (50% on CHF)						
1.4	Country Representative	S	1	5,000.00	6	15%	4,500.00
	"1 Country Representative at $5000 per month for 6 months. LOCATION: Juba. (15% charged to CHF) Location: Juba"						
1.5	Administrator	S	1	4,500.00	6	15%	4,050.00
	1 Administrator at $4,500 per month for 6 months. LOCATION: Juba. (15% charged to CHF)						
1.6	Health Advisor	S	1	5,100.00	6	15%	4,590.00
	1 Health Advisor at $5,100per month for 6 months. LOCATION: Juba. (15 % charged to CHF)						
1.7	R&R allowance	D	4	600.00	2	50%	2,400.00
	R&R allowance for CCM staff consist of the cost of international flight to a destination outside South Sudan. LOCATION: ALL (charged: 50%)						
	Section Total						**57,540.00**
Supplies, Commodities, Materials							
2.1	Essential emergency Drugs,ACT's and Disposable items	D	1	15,805.00	1	100%	15,805.00
	Pro-quota of drugs at 15805 $. See attached list for further details. LOCATION: ALL (100% charged to CHF).						
2.2	Lab supplies	D	1	8,688.37	1	80%	6,950.70
	Lab equipment, tests kits and reagents at 8,688.37$. See attached list for further details. LOCATION: ALL (80% charged to CHF).						
2.3	Transport of drugs/materials/supplies	D	1	30,000.00	1	30%	9,000.00

	Transport of drugs, materials and supplies for Awerial health facilities. 6 tons at 30,000$. LOCATION: ALL (30% covered by CHF)						
2.4	Workshops/Training of opinion leaders (VHCs, HHPs, MHPSS, etc)	D	25	80.00	6	50%	6,000.00
	training for at least 25 opinion leaders (printing materials, food) at 80$ a day. LOCATION: ALL (50% charged to CHF)						
2.5	Training for health staff	D	1	12,900.00	1	50%	6,450.00
	training on communicable diseases, surveillance *training on IMCI and MISP* *training on GBV signs* *training on BEmONC*						
2.6	Outreaches in remote areas and IDP's camps/emergency rensponse to outbreak	D	1	11,250.00	1	60%	6,750.00
	Refreshment, small equipment during outreaches, LOCATION: ALL (60% covered by CHF)						
2.7	Community activities	D	2	800.00	6	60%	5,760.00
	Refreshment, small equipment during activities (eg soap for handwashing), TBAS fee, IEC material during awareness raising campaign (poster, t-shirts, etc). LOCATION: ALL (60% covered by CHF)						
	Section Total						**56,715.70**
Equipment							
3.1	Hospital and HF equipment / supplies and HF running costs	D	1	14,729.00	1	77%	11,341.33
	HF response and management site equipment (small) and supplies at 14,729$. LOCATION: ALL (77% charged to CHF).						
3.2	Procurement and prepositioning of outbreak investigation and response materials	D	2	500.00	1	100%	1,000.00
	Procurement of medical equipment, such as cannulas, masks, rapid response tests, giving sets and outbreak response drugs like tetracycline capsules. LOCATION. ALL (100% charged to CHF)						
	Section Total						**12,341.33**
Travel							
5.1	Road transport Direct staff (taxi, per diem, accomodation etc)	D	8	120.00	6	50%	2,880.00
	Accommodation, meals, taxi in Juba and field location for movements of project staff (8 persons, 6 times a month) at 120$ per travel. LOCATION: JUBA & ALL (50% charged to CHF)						
5.2	Flight for direct and indirect staff (UNHAS/WFP)	S	8	400.00	6	50%	9,600.00
	WPF/UNAHS flight at 400 (A/R) each travel. LOCATION: ALL (50% charged to CHF)						
5.3	Maintenance, fuel and spare parts for vehicles and Ambulance	D	2	1,500.00	6	50%	9,000.00
	Field car fuel, maintenance and insurance at 1.500 $ per month. LOCATION: ALL (50% charged to CHF)						
	Section Total						**21,480.00**
General Operating and Other Direct Costs							
7.1	Airtime/internet	D	1	800.00	6	80%	3,840.00
	Cost for airtime and internet at 500$ per month. LOCATION: all (80% charged to CHF)						
7.2	Field offices running costs and maintenance	D	1	4,000.00	6	76%	18,240.00
	Cost for field office (included food and NFI) at 4.000$ per month. LOCATION: ALL (76% charged to CHF)						
7.3	Country Office maintenance and running costs (Juba)	S	1	9,500.00	6	25%	14,250.00
	Cost for field office in Juba (included food and NFI) at 9.500$ per month. LOCATION: All (25% charged to CHF)						
7.4	Visibility/bank charges	S	1	1,000.00	6	35%	2,100.00

	Bank charges at 1.320$ per month. LOCATION: All (35% charged to CHF)			
	Section Total			**38,430.00**
SubTotal		68.00		**186,507.03**
Direct				147,417.03
Support				39,090.00
PSC Cost				
PSC Cost Percent				7%
PSC Amount				13,055.49
Total Cost				**199,562.52**
Grand Total CHF Cost				**199,562.52**

Project Locations

Location	Estimated percentage of budget for each location	Estimated number of beneficiaries for each location					Activity Name
		Men	Women	Boys	Girls	Total	
Lakes -> Awerial	100	19,059	30,023	9,923	10,243	69,248	

Documents

Category Name	Document Description
Project Supporting Documents	Drugs list.xlsx
Project Supporting Documents	Lab Supplies list.xlsx