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 primary health care facilities to deliver life saving emergency health services integrated with nutrition services in Fangak county of Jonglei State		
Allocation Type Category :			
OPS Details			
Project Code :		**Fund Project Code :**	SSD-16/HSS10/SA1/H/INGO/775
Cluster :		**Project Budget in US$:**	199,999.91
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 objective of this project is to reverse the rising mortality rate and reduce morbidity caused by malaria, diarrhea and pneumonia of children <5 years, epidemic prone vaccine preventable diseases, medically complicated cases of severe acute malnutrition, kala azar, unsafe child deliveries, including referrals for HIV/AIDS/TB patients and victims of sexual and gender based violence and trauma. Priority will be reaching the most vulnerable children <5 years, but also focus on adolescent girls, PLW women of IDP, women headed households, and elderly and disabled persons. The overall objective will be achieved by: (1) Improving access to, and scaling-up responsiveness to, essential emergency health care, emergency obstetric and new born care services including services for SGBV response, and treatment for children < 5 suffering medical complications from SAM; (2) Preventing, detecting and responding to epidemic prone disease outbreaks by enhancing immunization services and increasing capacity to detect and respond to disease outbreaks.

Four locations in Fangak where large IDP populations have settled will be prioritized - Phom, Nyadin, Keew, and Juiabor. These locations will receive assistance under both objectives noted above dude to large IDP populations. This project will provide COs, nurses, CHWs and EPI workers to address the rising rate of deaths in the current crisis. CHF funding will add to funding from RRHP and UNICEF to scale-up lifesaving services, serve unreached populations and fill critical humanitarian gaps. A high priority will be given to the situation of Phom since the New Fangak County Hospital was destroyed in 2014. In Phom, access to health services has only been available through short medical outreaches provided by CMA and medical evacuation services provided by MSF-H. This project will help fill this health service gap at Phom. From the base of strengthened PHCCs, CMA will employ a robust outreach approach to reach unserved IDP and host populations located in PHCU catchment areas.

Direct beneficiaries :

Men	Women	Boys	Girls	Total
26,165	21,933	25,011	23,087	96,196

Other Beneficiaries :

Beneficiary name	Men	Women	Boys	Girls	Total
Children under 5	0	0	9,697	10,505	20,202
Internally Displaced People	14,391	12,063	13,756	12,698	52,908
People in Host Communities	11,774	9,870	11,255	10,389	43,288
Pregnant and Lactating Women	0	7,696	0	0	7,696

Indirect Beneficiaries :

Catchment Population:

Link with allocation strategy :

In terms of location and populations that are most vulnerable and most in need, this project fits the HRP 2016 strategy and Health Cluster strategy for January to June 2016 in the following ways: (1) this project will cover areas of Fangak County of Jonglei listed as high priority being severely affected by the conflict, flooding and displacement; (2) this project will deliver lifesaving health services to populations that are currently unserved due collapsed facilities and departure of health personnel or are inadequately served due to insufficient personnel and failing facilities. Most recent data from Fangak County shows 95,658 IDPs (ROSS Coordinator 22 October 2015). 36% of the population of target counties is IDPs. CMA's data shows that only 3 of 20 health facilities (15%) are functioning as they are expected to. The remaining 17 facilities (85%) have either been destroyed (Fangak County Hospital) or are in various states of collapse due to lack of maintenance since the crisis erupted and departure of skilled personnel.

In terms of saving lives, and alleviating suffering through safe access to services with dignity (HRP 2016 SO1) and Health Cluster objective 1, this project will focus services on treating <5 children for the major causes of mortality (malaria, diarrhea and pneumonia) and SAM with medical complications. 85% of project activity will deliver on this SO1. The project will also address the need for scaled-up EmONC services, including psychosocial support and services for victims of SGBV. To take advantage of the dry season and address the ongoing emergency, the project will scale-up reach by delivering lifesaving medical and SAM case-finding outreaches, and mobile services to provide quality health care to unserved and underserved PHCU locations, including the Phom area (previously the location of the New Fangak County Hospital). To ensure gender equality in access to health, BEmONC and SGBV services, communities will be organized to protect vulnerable women, adolescent girls and children of IDP and host communities. In this manner the project will deliver on the "dignity" aspect of SO1.

In relation to ensuring communities are capable and prepared to cope with significant threats (HRP 2016 SO2) and Health Cluster objective 2, this project will take full advantage of the dry season to scale-up immunizations through routine facility-based services, regular vaccination outreaches and through NID campaigns and respond to outbreaks when they arise. These services will be integrated with delivery of health promotion, IYCF and WASH messages thereby achieve a highly cost-effective program. 15% of project activity will deliver on this SO2.

Even though IDPs are estimated to make up about 36% of the population, it is estimated that 55% of the direct and indirect beneficiaries will be IDPs. This is because of the high burden of morbidity and malnutrition suffered by IDPs owing to the stress and trauma of displacement, their overcrowded and poor quality living arrangement and exceptionally high level of food insecurity. These factors combined create a high level of need. In addition, the project will employ an approach that emphasizes mobile medical and immunization outreaches to reach the locations where IDPs are concentrated, and to reach those IDPs in transit.

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	20,000.00
	20,000.00

Organization focal point :

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BACKGROUND

1. Humanitarian context analysis

Fangak is in opposition held areas where access interruptions and service disruption is common. Conflict in neighboring counties has forced a large number of IDPs into Fangak. Data shows 95,658 IDPs and host population of 169,102 (ROSS Coordinator 22 Oct 2015). The economic crisis adds a high risk to humanitarian service delivery into opposition held areas. 36% of the population of Fangak is IDPs.

The Jan-Mar 2016 IPC rate is 4 (Emergency) for Fangak (Food Security Outlook FEWS NET Dec 2015) and average GAM rate is 21.5 (20151027 Nutrition Cluster Case Load 2016). Reports from personnel on ground indicate that on average households planted less than 40% of normal acreage in 2015 (Choul Thompson - CHD Officer Phom, Abraham Lilly - Clinical Officer Juiabor, Terisia Masila - Nurse Keew, 06 Nov 2015). Reasons cited were insecurity, consumption of seeds, lack of male labor, lack of access to land for IDPs and the need for IDP families to take time to gather wild foods or search for food aid which took time away from planting. Among IDP families, it is common for children to bring children to health facilities. Their mothers have left them for days to search for food aid, income or wild foods (Abraham Lilly - Clinical Officer Juiabor, Terisia Masila - Nurse Keew, 06 Nov 2015).

MEDAIR and CMA assessments in Juaibor, Nyadin and Keew May-Jun 2015 indicate: (1) most IDPs have integrated with host community, but some are only sheltered by trees; (2) 65%-75% of adult IDPs are women; (3) host populations and IDPs have subsisted on wild foods for long periods; (4) influx of IDPs has overwhelmed available health services. Weakened natural immunity caused by malnutrition, exposure stress, lack of sanitation and crowded living spaces has caused an increase in disease occurrence. Of 20 health facilities, 4 require reconstruction and 16 require rehabilitation. Phom area previously served by the New Fangak County Hospital has no continuity of health services, and remains in great need. Of 8 facilities designated for cold chains, 5 require repairs or new installation. Only 1 hospital and 2 PHCCs provide BEmONC services. In nearby Nyirol County, during a one week assessment period, 3 women experienced spontaneous abortion without skilled birth attendants (MEDAIR's Report Nov 2014). In the period Mar to Sep 2015, there were 16 maternal deaths due to complicated delivery without skilled birth attendants (CMA's Report on Chuil 28 Oct 2015). The situation of maternal mortality in Fangak is similar.

While the need for health services has increased, delivery capacity has declined. Skilled health workers have fled and facilities have been destroyed and/or closed (CRP 2014 pg 49). Salaries of MOH health workers in Fangak have not been paid since the crisis began in 2013. The tally of non-functional facilities shows the County Hospital has been destroyed and 15 of 18 facilities do not function well, clearly reducing access to health services, contributing the overwhelming demand on the few functioning facilities and consuming capacity needed for medical and EPI outreaches.

Conflict, insecurity and floods affect women and men, and boys and girls differently. Men maintained mobility, but IDPs, children U5, and women have restricted movement (HNO 2015 pg 5). Men are capable of protect themselves, but vulnerable women, girls and boys, elderly and disabled need protection to access health facilities. Pregnant women find that insecurity and flooding restrict access to facilities with skilled birth attendants (HNO 2015 pg 5). IDP women and girls are vulnerable to SGBV. In the current context, and with great distances between facilities, women face daunting challenges accessing health services. In conflict-affected Jonglei State, outpatient consultations data showed that only 37% were female, indicating lower access of the most vulnerable women and girls to health services (HRP MYR 2015 pg. 25).

2. Needs assessment

The 2016 Health Cluster Strategy lists four priority needs to be addressed: (1) limited access and coverage - 45% of health facilities are non-functional in the conflict affected states, due to destruction, damage and closure; (2) increased risk of epidemic prone, endemic, vaccine preventable and other diseases as a result of conflict and displacement; (3) shortage and inadequate health workers - insecurity and displacement has caused severe shortage of health workers for frontline needs, especially for maternal obstetric complications; and (4) shortages of essential medicines and supplies. The result is that malaria, TB/HIV/AIDS, malnutrition, pneumonia and perinatal deaths have become the major causes of mortality among IDPs.

CMA's own needs analysis shows the need for health services has sharply increased in Fangak County while delivery capacity has declined. The specific needs are: (1) treatment for common communicable diseases including ARI/pneumonia, AWD, malaria, and SAM with medical complications especially among < 5 children; (2) reduction of the maternal mortality and treatment for victims of SGBV; (3) reduction in outbreaks of preventable and epidemic prone diseases (measles and polio).

Presently, the decline in number of properly functioning health facilities has clearly reduced access to health services. CMA's report to RRHP/IMA Oct 2015 shows that of 20 health facilities, 4 facilities require complete reconstruction and 16 require rehabilitation to scale up services. Phom area previously served by the New Fangak County Hospital has no continuity of health services, and remains in great need. Of 8 facilities designated for cold chains, 5 cold chains require repairs or new installation. Only 3 facilities (1 hospital, 2 PHCCs) provide BEmONC of the 6 designated to provide these services. In Nyirol County, during a one week health assessment period, 3 women experienced spontaneous abortion without skilled birth attendants (MEDAIR's Assessment Report Nov 2014). In the period Mar to Sep 2015, there were 16 maternal deaths due to complicated delivery without the assistance of skilled birth attendants (CMA's Report on Chuil 28 Oct 2015). The situation of maternal mortality in Fangak is similar.

One of the main drivers of increased demand for health services is the high number of IDPs coping with malnutrition, survival on wild foods, poor hygiene/sanitation and crowded living spaces. Displacement stresses have caused weakened immunity while being exposed to multiple disease burdens (CRP 2014 pg 47). Data from Fangak shows 95,658 IDPs (ROSS Coordinator 22 Oct 2015). 36% of the population of Fangak is IDPs.

Conflict, insecurity and floods affect women and men, and boys and girls differently. Men have been able to sustain their mobility, but IDPs, children U5, women and girls have restricted movement (HNO 2015 pg 5). While men are capable of protecting themselves, vulnerable women, girls and boys, elderly and disabled people need protection so they can access health facilities. PLW find that insecurity and flooding restrict access to facilities with skilled birth attendants (HNO 2015 pg 5). IDP women and adolescent girls are particularly vulnerable, as they are targets of SGBV.

Priority needs are: (1) services for <5 children to prevent and treat malaria, water borne diseases, ARI, treatment of SAM with medical complications, EPI and measles vaccinations; (2) EmONC services, including services for victims of SGBV; (3) medical and SAM case finding outreaches to PHCU locations where IDP are concentrated: and (4) protection measures to ensure that vulnerable populations have access to healthcare. Delivering on these needs will require facility rehabilitation, equipment and personnel to bring non-functioning facilities back into sustained service, and to take advantage of the dry season by utilizing a robust mobile and outreach approach to ensure health services reach IDP populations.

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 communities that are hosting concentrations of IDPs 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, collaboration with CHDs and other humanitarian actors operating in these counties, CMA has identified the locations (Nyadin, Phom, Keew and Juaibor) most in need of this project's assistance. The most vulnerable and at-risk populations within these target areas have been identified through IRNAs (conducted by MEDAIR) and CMA's monitoring surveys. The primary target beneficiaries of the project will be the IDPs and those households that are hosting IDPs. The target populations have been displaced by either conflict/insecurity or floods, or both floods and conflict. The target populations within these households are the vulnerable <5 children, adolescent girls, the elderly, and pregnant and lactating mothers. CMA ensures its programs are accessible to all regardless of race, tribe, gender or religious belief. Services are available to combatants not uniformed and not carrying arms of any kind.

Even in non-crisis situations, this population has experienced the ravages of common communicable diseases caused by poor nutrition, poor water and sanitation standards, and lack of knowledge on preventions and management of common diseases. IDP and IDP hosting households are seriously affected by poor nutrition and crowded conditions - a significant direct cause of their increased morbidity. Men have joined the armed forces (HNO 2015 pg 3) leaving women to maintain households. CMA's personnel estimate that community-wide 50% of households are now women headed, and among IDP households 70% are women headed. Targeted locations are experiencing food insecurity - IPC emergency (4) and crisis (3) due to displacement, insufficient acreage planted in 2015 (Choul Thompson - CHD Officer Phom, Abraham Lilly - Clinical Officer Juiabor, Terisia Masila - Nurse Keew, 06 Nov 2015). Populations of IDP and women headed households experience weakened immunity while being exposed to multiple disease burdens (HRP - HNO 2015 pg 13). CMA's on-ground experience provides the same evidence provided in the HRP - HNO 2015. Common threats are acute respiratory infections, acute watery diarrhea, malaria, malnutrition and measles. In Fangak County, the estimated IDP population of 95,658 (ROSS Coordinator 22 October 2015) which adds to the estimated base host community population of 169,102 (IMA Adjusted Populations by County 2015) resulting in a total population of 264,760. The project will employ a mobile and outreach approach to reach areas where services have been disrupted by the conflict and where the health facilities need support in order to provide the services demanded by the concentration of the IDP population, and where facility structures, equipment, cold-chain and skilled health workers are inadequate for essential and emergency health services. Total direct beneficiaries will be 96,196 (female – 44,618 and male – 36,504) of which 52,908 (55%) will be IDPs. The total children U5 direct beneficiaries will be 20,202 (girls 10,505 and boys 9,697) and total pregnant and lactating women direct beneficiaries will be 7,696.

4. Grant Request Justification

The reduced availability, quality and access to lifesaving health services are the critical humanitarian gaps that this project will fill. Justification for the project arises from the crisis and the humanitarian need of targeted populations, specifically in locations hosting large IDP populations. CMA lead agent for RRHP and expects RRHP will be continued through to June 2016, but no contract has been issued yet. RRHP funding covers CHD services, and is spread thinly over the private hospital in Old Fangak and all PHCCs and PHCUs. There is no scope within RRHP to target a specific need (e.g. EPI), or a location of great need (e.g. where IDPs are concentrated). CHF funding will be targeted to address critical humanitarian gaps, and will serve as an important complement to RRHP funding. CHF assistance will be used to rehabilitate facilities, provide medical equipment, repair cold-chains and provide health workers in locations where MOH has ceased salary payments for health facility personnel since the crisis began in 2013. These measures will bring non-functioning facilities back into service, and scale-up services at functioning facilities in order to meet the increased demand resulting from influx of IDPs and increased disease burden.

This project will take advantage of the dry season to scale-up immunization services, and to conduct mobile medical and health promotion outreaches to areas not accessible in the wet season, and to reach all locations hosting large IDP populations. Dry season offers the best opportunity for rehabilitating health facilities that have collapsed due to lack of maintenance since the crisis began in 2013. The project will provide critical maintenance materials to ensure facilities stand for one more rain season.

CMA has worked in Fangak County since 2000 and acquired experience and capacity to sustain services in the context of the current crisis will ensure effective project delivery. In relation to BEmONC, CMA has established units for safe child delivery, and for a comprehensive program covering reproductive health, nutrition monitoring of children <5 years and therapeutic feeding programs in Keew and Juaibor. This experience will be utilized to scale-up delivery of BEmONC in PHCCs namely Nyadin, Keew and Juaibor. CMA has experience delivering health services in a gender sensitive approach, including gender training for health workers, conducting awareness on sexual and reproductive rights and mobilizing communities to address SGBV and enabling women, girls and boys to access health services in the context of conflict and insecurity. Utilizing a robust mobile outreach approach, CMA has experience delivering programs that include IDPs without excluding host communities. CMA understands the high risk of delivering projects in opposition held areas. CMA has a designated security focal point, and evacuation plans and protocols and clear ground rules to ensure a "do-no-harm' approach to service delivery. Most importantly, CMA is known and trusted as a competent health service provider by community leaders, local authorities and the county and payam health departments. With this experience, CMA is best placed to manage the risks of delivering health services in opposition held areas.

CMA's strategy is to secure the capacity of PHCCs in delivery of health services in all seasons, and to take advantage of the dry season to employ a robust outreach approach to reach unserved IDP and host populations located in PHCU catchment areas. Priority will be to reach the most vulnerable children <5 years, adolescent girls, PLW women of IDP, women headed households, and elderly and disabled persons. The relevant experience and the presence of CMA in the targeted counties place it in the best position to deliver the proposed project. The humanitarian crisis requires urgent response. This project will provide this response in locations where it is most needed.

5. Complementarity

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

CMA is currently the lead agent for RRHP in Fangak. RRHP funding provides for basic services but does not have the mandate or funding capacity to direct assistance to locations of IDP concentration, nor to special needs services like kala-azar treatment, emergency obstetric services and SAM cases with medical complications. CMA also has SSFA with UNICEF and is preparing a proposal for a longer-term PCA for nutrition and health sector interventions. The health component will focus on expanding < 5 immunization coverage. CMA will combine the resources of CHF with the RRHP and UNICEF to provide the resources required to fill critical gaps and meet the service demands where IDPs have concentrated (including in Phom area), were kala-azar treatments are needed most and where BEmONC services are presently inadequate or non-existent. Further, CMA will integrate WASH messages and IYCF messages into medical and health promotion outreaches that will include reaching schools, churches and community groups. In this manner, the CHF funded project has been designed and will complement RRHP in targeted locations, and build on CMA past work by raising up the quality health service delivery employing a robust medical and health promotion outreach approach to take advantage of the dry season.

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

LOGICAL FRAMEWORK

Overall project objective

The urgent needs in Fangak are: (1) treatment for common communicable diseases (pneumonia, AWD, malaria, and SAM with medical complications); (2) reduction of the maternal mortality; (3) reduction in outbreaks of preventable and epidemic prone diseases (measles and polio). To address these needs, the overall objective of this project is to reverse the rising mortality rate and reduce morbidity caused by malaria, diarrhea and pneumonia of children <5 years, epidemic prone vaccine preventable diseases, medically complicated cases of SAM, kala azar, unsafe child deliveries, including referrals for HIV/AIDS/TB patients and victims of SGBV, abuse and trauma. The overall objective will be achieved by: (1) Improving access to, and scaling-up responsiveness to, essential emergency health care, emergency obstetric and new born care services including SGBV services, and treatment for children < 5 suffering medical complications from SAM; (2) Preventing, detecting and responding to epidemic prone disease outbreaks by enhancing immunization services and increasing capacity to monitor and report malnutrition rates and to detect and respond to kala azar, measles and other disease outbreaks.

To address the decline in number of properly functioning health facilities and address access restrictions experienced by vulnerable people, the project will implement two strategies: (1) through a strong approach of medical and SAM case finding outreaches, the project will ensure that the most vulnerable single parent and women headed households of unreached IDPs and affected host populations have access to high quality emergency health services, and direct referrals to health facility linked nutrition services; (2) understanding that insecurity creates a situation of vulnerability for PLW, adolescent girls, children < 5 and elderly and disabled people, the project will help communities implement appropriate protection practices to enable these vulnerable groups to access health services and facility-based nutrition services.

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

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

HEALTH

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
CO1: Improve access, and scale-up responsiveness to, essential emergency health care, including addressing the major causes of mortality among U5C (malaria, diarrhea and Pneumonia), emergency obstetric care and neonate services in conflict affected and vulnerable populations	HRP 2016 SO1: Save lives and alleviate suffering through safe access to services and resources with dignity	85
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	15

Contribution to Cluster/Sector Objectives : The project will be implemented in Fangak County listed as a county in Jonglei State with greatest needs and displacements. Fangak now hosts an estimated 95,658 IDPs (Fangak ROSS Coordinator 22 Oct 2015). This project will add to RRHP to deliver outreach health services, with a focus on locations where there are large IDP populations and movements.

Project objective 1 will increase access to, and scale-up responsiveness to lifesaving emergency health care, basic EmONC services including SGBV services, integrated with WASH and nutrition services for treatment of children <5 suffering medical complications from SAM, and focused on reaching the most vulnerable children <5 years, adolescent girls, PLW of IDP, women headed HHs and the elderly and disabled. The project will provide health professionals skilled in MISP and management of SGBV from the centers targeted for BEmONC services. Training of national health workers will cover the MISP, gender sensitivity and mental health and psycho-social support for IDPs and deliver these services at 4 BEmONC centers. The project will provide additional human resources, some support to rehabilitate collapsing health facilities and materials resources and supplies to enable mobile health teams to reach and serve areas where there are no services presently. Special support will be delivered to the former site of Fangak County Hospital at Phom. The project will support delivery of emergency and routine services to increase the capacity and functionality of health facilities to deliver quality services for children < 5 years, PLW, treatments for main causes of mortality (malaria, AWD, ARI/pneumonia, kala-azar and children suffering medical complications related to SAM. An estimated 96,196 outpatient consultations will be achieve, of which about 20,202 will be children < 5 years including 128 receiving treatment for medical complications related to SAM and 7,696 will be PLW. In this manner, the project will deliver on cluster objective 1 “improve access, and scale-up responsiveness to, essential and emergency health care, including addressing the major causes of mortality among U5 (malaria, diarrhea and pneumonia), and EmONC services, including SGBV services”. Through health outreaches to PHCC/PHCU and other locations where IDPs have concentrated, a large unserved population of IDPs (estimates at 52,908 people) will be reached. In addition, a host community population of 43,288 will be reached. To ensure the project achieves gender equality in access to health services, communities will be organized to provide protection for vulnerable women, adolescent girls and children of IDP and host communities so they can access services.

Project objective 2 will increase capacity of existing health systems to prevent, detect and respond to epidemic prone disease outbreaks with enhanced immunization services and increase capacity to monitor/report malnutrition rates, and prevent malnutrition and water borne diseases. With these actions, the project will directly deliver on cluster objective 2, “to prevent, detect and respond to epidemic prone disease outbreaks in conflict affected and vulnerable states”. Key outputs from the project that support cluster objectives will be 90% of disease outbreaks verified and responded to within 48 hours, and a scaled-up immunization campaigns will reach at least 4,976 children to protect them from epidemic prone diseases. In addition, at least 1,548 children will receive pentavalent vaccine and 22 workers will be trained in disease surveillance and reporting. Further, about 130,780 people will be reached with health promotion, WASH and IYCF education messages, and 22 national health workers will be trained in MISP, communicable diseases, IMCI and mental health and psycho-social support for IDPs.

Outcome 1

Increased access to, and scaled-up responsiveness to, lifesaving essential and emergency health care, basic EmONC services including SGBV services, integrated with WASH and nutrition services for treatment of children <5 suffering medical complications from SAM, and focused on reaching the most vulnerable children <5 years, adolescent girls, PLW of IDP, women headed HHs and the elderly and disabled

Output 1.1

Description

Inadequate and damaged non-functional heath facilities addressed

Assumptions & Risks

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

Activities

Activity 1.1.1

Provide basic/minor rehabilitation of damaged health facilities, engage leaders to maintain/protect facilities, medicines and equipment

Activity 1.1.2

Provide equipment and supplies to enable health teams to deliver mobile outreach and rapid response for scale-up and swift interventions where HFs have been destroyed

Activity 1.1.3

Provide mobile teams of health workers to scale-up delivery of primary health care services

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 1.1.1	HEALTH	Frontline # Number of functional health facilities in conflict -affected and other vulnerable states					6
Means of Verification : CMA quarterly project reports.							
Indicator 1.1.2	HEALTH	Number of mobile outreach and rapid response interventions completed.					12
Means of Verification : CMA quarterly project reports							
Indicator 1.1.3	HEALTH	Number of additional health workers provided.					22
Means of Verification : CMA quarterly project reports.							

Output 1.2

Description

Manage and treat common life-threatening illness in emergency settings

Assumptions & Risks

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

Activities

Activity 1.2.1

Provide life saving treatment of common communicable diseases (malaria, URI/pneumonia and diarrhea) including outbreaks of measles and kala-azar, and record deaths of U5 children, and record total deaths

Activity 1.2.2

Provide life saving BEmONC services and outreaches to ensure vulnerable women, adolescent girls, men and community leaders are aware of services and support women to access services

Activity 1.2.3

Train health workers trained on safe deliveries, HIV transmission prevention, safe disposal of medical waste, gender sensitivity, and importance of gender disaggregated data

Activity 1.2.4

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

Activity 1.2.5

Provide basic package of treatment and management of SGBV

Activity 1.2.6

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

Activity 1.2.7

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

Activity 1.2.8

Procure from MoH and distribute life saving medicines and medical supplies to health facilities

Activity 1.2.9

Ensure men, youth and women leaders provide protection for children, adolescent girls and women, elderly and disabled people so they can access life saving health services

Activity 1.2.10

Provide reports and up dates, and engage communities to provide feedback on health and nutrition services to ensure accountability to affected populations

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.2.1	HEALTH	Number of outpatient consultations in conflict-affected and other vulnerable states					96,197
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.10	HEALTH	Number of medicine kits delivered to health facilities.					12
Means of Verification : CMA quarterly project reports							
Indicator 1.2.11	HEALTH	Number of communities organize to protect patients seeking health services					4
Means of Verification : CMA quarterly project reports							
Indicator 1.2.12	HEALTH	Number of meetings to report and engage affected populations in feedback					12
Means of Verification : CMA quarterly project reports							
Indicator 1.2.2	HEALTH	Frontline Total number of deaths recorded within the facility	23	15	6	4	48
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.3	HEALTH	Frontline # of births attended by skilled birth attendants in conflict-affected and other vulnerable states		832			832
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.4	HEALTH	Frontline # of health workers trained on safe deliveries	2	8			10
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.5	HEALTH	Frontline # Number of facilities providing BEmONC services					4
Means of Verification : CMA monthly HMIS reports							
Indicator 1.2.6	HEALTH	Frontline # of children under 5 with severe acute malnutrition with medical complications, who are clinically managed in stabilization centers			60	68	128
Means of Verification : CMA quarterly project reports							
Indicator 1.2.7	HEALTH	Frontline # of health facilities providing SGBV services					4
Means of Verification : CMA monthly health reports							
Indicator 1.2.8	HEALTH	Frontline Number of health personnel trained on MHPSS in conflict affected states	2	8			10
Means of Verification : CMA quarterly project reports							
Indicator 1.2.9	HEALTH	Frontline # of staffs trained on Clinical Management of Rape (CMR)	2	8			10
Means of Verification : CMA quarterly project reports							

Outcome 2

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

Output 2.1

Description

Scaled-up delivery of routine and emergency vaccinations, Vitamin A and de-worming treatments and promotion of health messages

Assumptions & Risks

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

Activities

Activity 2.1.1

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

Activity 2.1.2

Deliver mass vaccination campaigns (NIDs) against measles and polio

Activity 2.1.3

Provide mosquito nets (ITNs) to mothers of children <5 years

Activity 2.1.4

Provide Vitamin A supplementation to children < 5 years through routine facility based immunizations and through NIDs and dry season mass immunization campaigns

Activity 2.1.5

Provide de worming treatment to children 12 59 months through routine facility based immunizations and through NIDs and dry season mass immunization campaigns

Activity 2.1.6

Provide awareness to educate men and women leaders, schools and churches on WASH messages (water purification, sanitation, hygiene promotion), IYCF practices, reproductive health, HIV/AIDS and STI prevention and gender awareness

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 2.1.1	HEALTH	Frontline # of children with 3 doses of pentavalent vaccine			446	483	929
Means of Verification : CMA monthly HMIS reports							
Indicator 2.1.2	HEALTH	Frontline # of children 6 to 59 months receiving measles vaccinations in emergency or returnee situation			1,645	1,783	3,428
Means of Verification : CMA monthly HMIS reports							
Indicator 2.1.3	HEALTH	Number of ITNs issued					3,006
Means of Verification : CMA monthly HMIS reports							
Indicator 2.1.4	HEALTH	Number of children < 5 years received Vitamin A supplementation					3,756
Means of Verification : CMA monthly HMIS reports							
Indicator 2.1.5	HEALTH	Number of children 12 59 months received deworming					2,179
Means of Verification : CMA's monthly HMIS reports							
Indicator 2.1.6	HEALTH	Frontline # of people reached by health education and promotion before and during outbreaks	52,312	78,468	0	0	130,780
Means of Verification : CMA's monthly HMIS reports							

Output 2.2

Description

Strengthened capacity to detect and respond to disease outbreaks in emergency settings

Assumptions & Risks

Assumption: CMA can deploy, train and maintain health workers and community-based health promoters in the context of the complex emergency. 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 this program.

Activities

Activity 2.2.1

Conduct weekly surveillance, monitoring and reporting disease trends and detect outbreaks

Activity 2.2.2

Train health workers on disease surveillance and reporting on gender and age dis-aggregated basis

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 2.2.1	HEALTH	Frontline # of epidemic prone disease alerts verified and responded to within 48 hours					90
Means of Verification : CMA monthly HMIS reports							

Indicator 2.2.2	HEALTH	Frontline # of staff trained on disease surveillance and outbreak response	14	8			22

Means of Verification : CMA quarterly project reports

Additional Targets :

M & R

Monitoring & Reporting plan

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

Project reports will provide assessment of planned versus actual outcome and output results using the indicators identified in the logical framework. To monitor output achievement, health facilities will collect data on outpatient and inpatient treatments, mothers and children served in the MCH and BEmONC services, the number of participants in outreaches, HIV/AIDS and hygiene education activities and the number of patients treated for non-communicable disease conditions, SAM with medical complications, mortality data and other data as required. To monitor the outcome of health services, the M and E Specialist attached to this project will maintain monitoring systems to gather data on changes in health seeking behavior, and change in disease prevalence, morbidity and mortality. For output monitoring, the primary data gathered from the outpatient/inpatient services and outreach health services will be analyzed at the PHCC level, and worsening trends in disease incidence, outbreak and malnutrition will be investigated, and IDSR reports prepared weekly. This analysis will be used to respond any outbreaks of diseases, including kala-azar, measles, and malnutrition. In relation to outcome monitoring, the M and E Specialist will lead the analysis of information gathered through the HMIS, community surveys and consultations with VHCs, local authorities, etc. Results of this analysis will be used by CMA for review of strategies and approaches to primary health care services in the current crisis.

CMA will constantly monitor changes in local conditions that may affect the implementation of health activities (movement of IDPs, malaria, measles, kala-azar infections, flooding and conflict and security etc.) in order to plan appropriate and timely responses to any emerging health emergencies. If an unusual trend or crisis is detected, CMA is well placed to inform MOH and other agencies, so that complementary, consistent and coordinated responses can be carried out.

CMA will use HMIS for monthly reporting of health sector data. This system serves both as an internal monitoring tool as well as reporting into the MOH and allows CMA to share and compare health data with other partners and NGOs. At the output level, the CMA County Health Coordinators will work with CHD personnel to collect data, analyze and report it, including health emergency and crisis analysis. With assistance from the Medical Program Manager and M and E Specialist, the County Health Coordinators will analyze this data and prepare monthly reports. The Medical Program Manager will compile quarterly reports, and the final report will be compiled to close the project. When results are unsatisfactory, the Medical Program Manager will ensure that measures are taken to improve performance. At the outcome level, the M and E Specialist will work with the Medical Program Manager and County Health Coordinators to analyze and report data on the community-level effects of the program ensuring this data is applied both in future planning and for application at the county level the ongoing delivery of services

Workplan

Activitydescription	Year	1	2	3	4	5	6	7	8	9	10	11	12
Activity 1.1.1: Provide basic/minor rehabilitation of damaged health facilities, engage leaders to maintain/protect facilities, medicines and equipment	2016		X	X	X	X	X						
Activity 1.1.2: Provide equipment and supplies to enable health teams to deliver mobile outreach and rapid response for scale-up and swift interventions where HFs have been destroyed	2016	X	X	X	X	X	X						
Activity 1.1.3: Provide mobile teams of health workers to scale-up delivery of primary health care services	2016		X	X	X	X	X						
Activity 1.2.1: Provide life saving treatment of common communicable diseases (malaria, URI/pneumonia and diarrhea) including outbreaks of measles and kala-azar, and record deaths of U5 children, and record total deaths	2016	X	X	X	X	X	X						
Activity 1.2.10: Provide reports and up dates, and engage communities to provide feedback on health and nutrition services to ensure accountability to affected populations	2016	X	X	X	X	X	X						
Activity 1.2.2: Provide life saving BEmONC services and outreaches to ensure vulnerable women, adolescent girls, men and community leaders are aware of services and support women to access services	2016	X	X	X	X	X	X						
Activity 1.2.3: Train health workers trained on safe deliveries, HIV transmission prevention, safe disposal of medical waste, gender sensitivity, and importance of gender disaggregated data	2016		X		X		X						
Activity 1.2.4: Screen and provide care for children with life-threatening medical complications as a result of SAM, and refer children with MAM and SAM to nutrition facilities for treatment	2016	X	X	X	X	X	X						

Activity 1.2.5: Provide basic package of treatment and management of SGBV	2016	X	X	X	X	X	X						
Activity 1.2.6: Raise gender awareness with men and women, the sexual and reproductive rights of adolescent girls and women and HIV/AIDS awareness of SGBV victims	2016		X	X	X	X	X						
Activity 1.2.7: 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	2016		X	X	X	X	X						
Activity 1.2.8: Procure from MoH and distribute life saving medicines and medical supplies to health facilities	2016		X		X		X						
Activity 1.2.9: Ensure men, youth and women leaders provide protection for children, adolescent girls and women, elderly and disabled people so they can access life saving health services	2016		X	X	X	X	X						
Activity 2.1.1: Provide routine EPI service from health facilities and through outreaches to serve IDPs and other vulnerable groups	2016	X	X	X	X	X	X						
Activity 2.1.2: Deliver mass vaccination campaigns (NIDs) against measles and polio	2016		X		X		X						
Activity 2.1.3: Provide mosquito nets (ITNs) to mothers of children <5 years	2016	X	X	X	X	X	X						
Activity 2.1.4: Provide Vitamin A supplementation to children < 5 years through routine facility based immunizations and through NIDs and dry season mass immunization campaigns	2016	X	X	X	X	X	X						
Activity 2.1.5: Provide de worming treatment to children 12 59 months through routine facility based immunizations and through NIDs and dry season mass immunization campaigns	2016	X	X	X	X	X	X						
Activity 2.1.6: Provide awareness to educate men and women leaders, schools and churches on WASH messages (water purification, sanitation, hygiene promotion), IYCF practices, reproductive health, HIV/AIDS and STI prevention and gender awareness	2016		X	X	X	X	X						
Activity 2.2.1: Conduct weekly surveillance, monitoring and reporting disease trends and detect outbreaks	2016		X	X	X	X	X						
Activity 2.2.2: Train health workers on disease surveillance and reporting on gender and age dis-aggregated basis	2016		X		X		X						

OTHER INFO

Accountability to Affected Populations

The project will be implemented in collaboration with CHDs, payam health departments, local authorities and payam health committees. These structures will participate in planning, implementing and monitoring the delivery of all primary health care services. CMA will work actively to engage the payam and boma health committees conducting monthly meetings to report on health issues and to obtain feedback from local populations. Specific outreach to IDP populations and women headed households will be conducted throughout the duration of the project to ensure that these populations are included in planning health services and in accessing health facilities. Additional promotion and awareness on sexual and reproductive health rights and 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 services. The structures noted above will be engaged for the purpose of ensuring accountability for project delivery and improving health outcomes. Further, the project will promote community-based strategies and practices to provide protection for the most vulnerable community members (children, adolescent girls and women, especially IDPs) so they can access health facilities. The project will engage men and women leaders of affected populations to take responsibility for the maintenance and protection of facilities, medicines, medical equipment and supplies, and for mobilizing protection so that disadvantaged and vulnerable populations have access to health services.

The Clinical Officer (or his/her equivalent) as leader of the health facility, will be responsible for organizing and coordinating the engagement of the target communities. This person will report to CMA's County Coordinator and Medical Program Manager on each monthly meeting or more frequently if required so that community feedback is available for management decision making. Further, the Program Manager and County Coordinators will regularly (at least once per quarter) visit and supervise health facilities, and during these supervisory visits, the managers will conduct meetings with local leaders of host and IDP communities, health committees and local authorities to ensure accountability to the populations being serviced.

To adhere to the principles of "Do-No-Harm", the project will strive to deliver services in a balanced manner so that IDP and host community populations and all persons regardless of ethnicity will have equal access to health services. To achieve this balance, CMA will implement a strong program of promotion and awareness raising so that as far as feasible all who need health services will have access to them.

Implementation Plan

As the contracted agent to implement RRHP in Fangak County, CMA will implement the CHF funded activities in full collaboration with CHDs, and with the participation of local community-based groups and local authorities. No other NGOs or contractors will be involved in the delivery of this project.

CMA's structure for delivering the this project will be headed by the Country Director and a Medical Program Manager, experienced in delivering health services in the context of conflict in South Sudan. The Medical Program Manager will hold the responsibility for overseeing the field teams and lead in collaboration with CHDs and MOH. The Medical Program Manager will work with County Field Coordinators (one person for each county) to deliver field activities. The Medical Program Manager will control the locations where personnel are assigned in order to ensure sufficient personnel gender-balanced will be located where most needed and ensure that they are provided with the requisite drugs, medical supplies, equipment etc.

Each health facility team will be comprised of Clinical Officers, Midwives and Certified Nurses. Where ever possible, the Clinical Officer and Midwife / Nurse positions will be filled by South Sudanese nationals. This team of skilled personnel will supervise support personnel of the health facilities. Where qualified and skilled women national personnel are not available to achieve gender balance on the health services delivery teams, CMA will ensure that appropriately qualified international personnel are placed on these field teams. Each team will work under the supervision of the CHD and CMA's County Field Coordinator. Where required, CMA will ensure health teams are mobilized so they have capacity to reach IDPs in locations cut-off by floods and/or conflict.

A Supply Chain Manager will be responsible for procuring and delivering all supplies necessary to maintain program operation. The Supply Chain Manager will ensure that required building materials and supplies are procured and delivered to the sites where required in order to complete the repairs and maintenance of damaged health facilities.

CMA is experienced working in the health sector in collaboration with MOH and to operate in respect of the protocols, policies, strategies and practices directed by government. The features that are important for coordination with MOH will be:
(1) Ensuring that emergency health, basic HIV and HIV referral services of the project reach the populations most vulnerable in the current emergency, and to implement the outreach services to special at-risk populations unable to access health services because of insecurity or other reasons;
(2) Ensuring this project is delivering services in complement to other state and national level health services providers, and to make focused effort to reach populations not otherwise served;
(3) Ensuring the pharmaceuticals are pre-positioned and available throughout the emergency;
(4) Ensuring that pharmaceuticals used in treating patients are either sourced through the MOH or approved by MOH and that MOH approved treatment protocols are followed, and to monitor drug supplies in order to be prepared to act in a timely manner and secure drugs supplies for the health facilities.

At the national level, CMA will coordinate with other health service stakeholders ensuring an adequate exchange of knowledge and information on present and emerging health emergencies with peer organizations and networking bodies specifically, the Health cluster, UN agencies (UNICEF, WFP, UNOCHA, UNDP) and donor agencies (CHF, the Pooled Fund, USAID, IMA/World Bank) through meetings, participating in committees and sharing of annual reports and lessons learned. Similarly, the project will endeavor to link the described basic services with emergency preparedness and response through effective utilization of IDSR reporting and EWARN

Coordination with other Organizations in project area

Name of the organization	Areas/activities of collaboration and rationale
County Health department	Supervision of health facilities using Quantitative Supervisory checklist. Coordinating health care provision activities such as planning for routine and episodic mass EPI campaigns. Other areas of coordination include disease surveillance, planning, sourcing and distribution of medical supplies.

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 is 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 in their approach to health service delivery. CMA's needs analysis with the participation of men and women of IDP and host communities has enabled gender to be mainstreamed into 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 collect data disaggregated on the basis of gender; (2) engaging men and women leaders to take responsibility for mobilizing vulnerable populations (IDPs, children, adolescent girls, women, elderly, disabled) to seek services, and to protect these populations so they have equal opportunity to access health facilities; (3) providing health services to men, women, girls and boys without gender bias and conduct outreach to IDP and women headed households to ensure the most vulnerable men, women, boys and girls receive available services; (4) providing IEC to men and women of IDP and host communities to raise gender awareness, awareness on the vulnerability of children, girls and women and promote reproductive health services; (5) and engage men and women leaders of host communities and IDPs in planning interventions, monitoring impacts and revising service delivery as required.

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

Protection Mainstreaming

In the current context of the project areas, the main threats to personal safety are the conflict between the armed forces of the government and opposition force (rebels), conflict between host community members and IDPs, and sexual and gender based violence most often targeting women and adolescent girls. Households headed by women, especially IDP households head by women are particularly vulnerable to SGBV. These threats to personal safety are a direct restriction to accessing health facilities. The specific measures planned in this project to mainstream protection are:
(1) raising awareness among men, women, boys and girls on sexual and reproductive rights and the prevalence of SGBV;
(2) promoting community-based approaches and practices encouraging communities to organize committees empowered to assist vulnerable persons to access health facilities whenever needed;
(3) balancing the delivery of health services so that host communities and IDPs have equal access to the benefits of health services as a measure to reduce/eliminate conflict between IDPs and host communities;
(4) engage community leaders, and local authorities to organize themselves to protect community assets like health facilities from destruction by armed forces, and to advocate for peace between the armed forces.

The project will provide the basic package of services for the management and dignified treatment of sexual assault and violence that will include counseling as measures to support victims of SGBV and also to encourage abused women and girls to report exploitation, abuse and SGBV as the first necessary step to stemming SGBV.

Country Specific Information

Safety and Security

CMA has established safety and security plans for each site where re-locatable personnel are assigned. These plans are based on UNDSS recommendations as well as InterAction's Minimum Operating Security Standards. The purpose of CMA's safety and security plans are to:
(1) Guide the activities and behavior of employees working in South Sudan and as far as possible help them avoid security and safety risks;
(2) Protect employees in the event of conflict, and as far as possible, define the conditions, responsibilities and operating procedures for safely while working in South Sudan and when required safe evacuation from locations in conflict.

CMA has an officer located in the field who holds primary responsibility for the development and update of security and evacuation plans for each site. 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.

All sites have a common security handbook to guide employees on personal safety, and which provides standard operating procedures for employees and the officers responsible for implementing security practices and executing evacuations. CMA has established county and site specific security and evacuation plans which give details on specific procedures, required practice and priority secure destinations for the protection and safe evacuation of personnel. These plans are designed to take into account the seasonal changes in plausible escape routes, and site specific variables that impose upon evacuation plan. These plans are reviewed and updated annually or more frequently if factors change substantially. The designated officer is also responsible for verifying that all personnel are trained and prepared for both personal safety and security while working in the field and for evacuation in the case of insecurity and conflict.

Access

CMA has delivered health services in both Fangak County since 2000. CMA is well known in the community, by the local authorities, and by the CHD personnel. When security challenges do arise, local authorities have been able to intervene so that CMA could continue service delivery. CMA intends to sustain these good relationships recognizing that these relationships are critical to enabling continued operation in the targeted county. Access to all parts of the County is by charter air carriers only. CMA has longstanding good partnerships with critical air service providers, specifically AIM Air, MAF and Samaritan's Purse. Delivering this project requires that CMA sustains good operating relationships with these air service providers

BUDGET

Code	Budget Line Description	D / S	Quantity	Unit cost	Duration Recurrance	% charged to CHF	Total Cost
Staff and Other Personnel Costs							
1.1	Medical Program Coordinator	S	1	2,950.00	6	15%	2,655.00
	Medical Program Coordinator, South Sudan [Supervise field planning and implementation, supervise field personnel performance, monitor budget utilization, output achievements and compile reports] [fte 15% 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) accommodation and subsistence upkeep while working in the field]						
1.2	County Health Coordinator	S	1	2,250.00	6	30%	4,050.00
	County Health Coordinator, [Conduct field planning and coordination & delivery of health services, supervise personnel performance, monitor budget utilization, output achievements and compile reports] [fte 30% 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) accommodation and subsistence upkeep while working in the field]						
1.3	Clinical Officers/Nurses	D	2	1,950.00	6	100%	23,400.00
	Clinical Officers/Nurses (National) Lead in the delivery of project field activities & outreaches to IDPs, including supervision of CHWs, compile weekly HMIS reports, and other reports as required] [Working full-time on project activities] [Monthly salary rate inclusive of social security benefits, medical cover and upkeep while working in the field] (2 Fangak -1 Phom & 1 for one PHCC)						
1.4	Certified Midwives/Nurses	D	2	2,250.00	6	100%	27,000.00
	Certified Midwives/Nurses (International) [Lead in the delivery of project field activities, including training of National Personnel as required, compile weekly HMIS reports, and other reports as required] [Working full-time on project activities] [Monthly salary rate inclusive of social security benefits, medical cover and upkeep while working in the field] (2 Fangak - 1 Phom & 1 for one PHCCs)						
1.5	CHWs/MCHWs	D	5	850.00	6	50%	12,750.00
	CHWs/MCHWs (National) [Deliver project field activities & outreaches to IDPs,, maintain clinical records and compile reports] [Working full-time on project activities] [Monthly salary rate includes social security benefits & upkeep while working outside of duty station] (5 Fangak- 3 Nyadin PHCC & 2 Phom))						
1.6	EPI Workers & Health Promoters	D	9	350.00	6	50%	9,450.00
	EPI Workers & Health Promoters [Deliver community-based EPI, health promotion activities & outreaches to IDPs] [Working full-time on project activities] [Monthly salary rate includes social security benefits and upkeep while working outside of duty station] (Fangak - 3 for Phom & 2 each at 3 PHCCs = 9)						
1.7	Support Personnel (Clerks, Cleaners, Guards etc.)	D	7	250.00	6	15%	1,575.00
	Support Personnel (Clerks, Cleaners, Guards) [Support delivery of clinic and outreach activities, maintain and protect PHC facilities, equipment and supplies] [Working full-time on project activities] [Monthly salary inclusive of social security benefits] (Fangak - 4 for Phom & 1 each for 3 PHCCs = 7)						
1.8	Country Director, South Sudan	S	1	5,040.00	6	10%	3,024.00
	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 10% 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) accommodation and subsistence upkeep while working in the field]						
1.9	Administrative Manager	S	1	2,580.00	6	10%	1,548.00
	Support planning project budgets and preparation of financial reports, monitor and control budget utilization, ensure cash-flow meets the needs of project field activities (fte 10% 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) accommodation and subsistence upkeep while working in the field]						
1.10	Medical Manager	S	1	3,920.00	6	15%	3,528.00
	Medical Manager, South Sudan [Provide technical direction in planning and delivery of the project, overall supervision of personnel and quality of project services, budget utilization, output achievements and reports] [fte 15% is based on proportion of this project's 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) and subsistence upkeep while working in the field]						

1.11	Supply Chain Manager & Senior Logistician	S	2	2,580.00	6	10%	3,096.00
	Procure and deliver supplies, monitor shipments & verify application of supplies, manage the transportation of personnel & delivery of supplies to HF, maintain financial records of procurement & transport of supplies] [fte 10% of actual time working on this project in a 6 month period - 48 days of work [cost based on monthly salary and benefits (social security, medical & life insurance cover) & upkeep while working in the field]						
1.12	Finance Director	S	1	3,480.00	6	10%	2,088.00
	Supervise financial planning, administration and reporting to donors and monitor project budget utilization, fte 10% 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) accommodation and subsistence upkeep while working in the field]						
1.13	Accounts Personnel (Senior Accountant & Project Accountant)	S	2	2,140.00	6	10%	2,568.00
	Maintain monthly financial records on incomes and expenditures of the project and compile reports for review and approval of Finance Manager and Country Director] [fte 10% 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) accommodation and subsistence upkeep while working in the field]						
1.14	Office Support Personnel & Driver	S	4	520.00	6	10%	1,248.00
	Receptionist, Cleaner, Guard, Driver support senior personnel complete project management and administrative duties, protect and maintain office equipment and supplies, support delivery of field programs] [fte 10% 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)						
1.15	Incentives for Community-Based EPI & Health Promoters	D	9	50.00	1	100%	450.00
	Incentives for Community-Based EPI workers & Health Promoters to incentivize outreach activities to PHCUs and locations where IDPs are concentrated (kits of t-shirts, boots & gear for caring water etc. @ $50 per worker / volunteer)						
	Section Total						**98,430.00**
Supplies, Commodities, Materials							
2.1	Tents for Accommodation of Mobile Health Teams	D	2	2,245.00	1	100%	4,490.00
	Tents for use by 4 senior health personnel (2 teams of 2 persons each for Phom & Nyadin) Tent Length: 4m, Width: 4m, Center Height: 2.4m, Side Height: 1.6m suitable for 1 persons + gear inclusive of procurement and transport to the field						
2.2	Accommodation amenities for 10 senior health personnel	D	6	735.00	1	100%	4,410.00
	Accommodation amenities for 6 senior health personnel, 1 kit / person (kit comprised of bed w mattress, net & pillow $345, 3 sheets $45, 1 blanket at $25, 1 mirror at $15, 2 chairs at $40, metal trunks $65, solar lamps w/accessories @ $200)						
2.3	Rehabilitation of HF Structures	D	3	1,700.00	1	100%	5,100.00
	Basic repairs, maintenance and refurbishing existing HF structures, cost based on a per unit cost of $1,900 / unit and for 2 units per health facility, 3 sites identified for this assistance (Juiabor, Keew, Nyadin,)						
2.4	Essential drugs, Medical Materials & Supplies	D	4	2,150.00	1	100%	8,600.00
	Essential drugs, Medical materials and supplies not provided by RRHP etc. (per unit) - emergency kits of needles, syringes, lab regents, bandages, gloves, kerosene, etc.)						
2.5	Materials for EmONC Services	D	4	1,340.00	1	100%	5,360.00
	Materials for EmONC services, 4 sites identified for this assistance - Nyadin, Phom, Keew, Juaibor (hospital beds $220/bed 2 beds/unit, bedsheets $30/unit, delivery coach $600 1/unit, examination table $210/table 1/unit, plastic sheets $60/unit)						
2.6	Transportation of Materials & Supplies	D	3	4,000.00	1	100%	12,000.00
	Transportation of materials & supplies Juba - field locations 4 sites (1 cargo flight shared cost 25% / site, $12,000 / flight, overland transport 1 trip shared 25% / site $6,000 / trip)						
	Section Total						**39,960.00**
Equipment							
3.1	Equipment for EmONC Services	D	2	1,600.00	1	100%	3,200.00

	Equipment for EmONC services 2 units (drip stand $65/stand 2 pc/unit, foetal stethoscope $110/scope 4 scopes/unit, baby scale $55/scale 2 scales/unit, blood pressure machine $55/machine 2 pc/unit, adult stethoscope $90/pc 2 pc/unit, delivery sets $75/set 2 sets/unit, autoclave $300/pc 1 pc/unit, manual vacuum aspirator $90/pc 2 pc/unit)						
3.2	Equipment for emergency & security communication 2 sites	D	2	1,220.00	1	100%	2,440.00
	Equipment for emergency & security communication 2 sites Phom and Nyadin (Computer & Thuraya,) 1 set/site)						
	Section Total						**5,640.00**
Travel							
5.1	Charter Travel (Juba-HF) for Health Personnel	D	9	1,480.00	2	100%	26,640.00
	Charters (Juba-HF) & ground transport for eligible health personnel - Program Coordinator, 2 County Coordinators & 9 HF personnel (per person cost per rtrip, 1 round trip/person/quarter at 100%)						
5.2	Charter Travel (Juba-HF) for Technical Support Personnel	S	1	1,480.00	1	100%	1,480.00
	Charters (Juba-HF) & ground transport for M&E Specialist for disease trend monitoring surveys & Supply Chain Manager for monitoring HF rehabilitation and installation & security monitoring (per person cost per rtrip, 1 round trip/person at 100%)						
5.3	Accommodation & Upkeep for In-Transit Health Personnel	D	9	300.00	2	100%	5,400.00
	Accommodation & Upkeep for In-Transit Health Personnel per rtrip for Health Program Coordinator, 2 County Coordinators & 9 HF personnel (per person cost per rtrip, 1 round trip/person/quarter @ $100 per day & 3 days per rtrip at 100%)						
5.4	Accommodation & Upkeep for In-Transit Technical Support Personnel	S	1	300.00	1	100%	300.00
	Accommodation & Upkeep for In-Transit Management Personnel per rtrip for M&E Specialist & Supply Chain Manager (per person cost per rtrip, 1 round trip/person@ $100/day and 3 days / rtrip at 100%)						
5.5	Travel Visas & Permits for Technical Support Personnel	S	1	250.00	1	100%	250.00
	Visa's, Alien Permits for Management Support Personnel per person / rtrip (1 personnel 1 trip / person)						
	Section Total						**34,070.00**
General Operating and Other Direct Costs							
7.1	Communications Juba Office	S	1	750.00	6	10%	450.00
	monthly cost prorated @ 10% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.2	Communications County Offices & project field sites monthly cost	D	1	1,800.00	6	10%	1,080.00
	monthly cost prorated @ 10% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.3	Supplies & Equipment: office, & stationaries Juba Office monthly cost	S	1	980.00	6	10%	588.00
	monthly cost prorated @ 10% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.4	Supplies & Equipment: office, & stationaries County &project field sites monthly cost	D	1	1,020.00	6	10%	612.00
	monthly cost prorated @ 10% 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	350.00	6	10%	210.00
	monthly cost prorated @ 10% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.6	Office Rent: Juba Offices monthly cost	S	1	5,040.00	6	10%	3,024.00
	monthly cost prorated @ 10% 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	220.00	6	10%	132.00

	monthly cost prorated @ 10% 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	750.00	6	10%	450.00
	monthly cost prorated @ 10% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.9	Vehicle Running Costs: County monthly cost	D	1	1,083.00	6	10%	649.80
	monthly cost prorated @ 10% 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	600.00	6	10%	360.00
	monthly cost prorated @ 10% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
7.11	Licence/insurances - vehicles & property Juba Office, monthly cost	S	1	470.00	6	10%	282.00
	monthly cost prorated @ 10% 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 & project field sites monthly cost	D	1	650.00	6	10%	390.00
	monthly cost prorated @ 10% 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	980.00	6	10%	588.00
	monthly cost prorated @ 10% based on proportion of this project's budget of the total estimated South Sudan program budget for this period						
	Section Total						**8,815.80**
SubTotal			108.00				**186,915.80**
Direct							154,996.80
Support							31,919.00
PSC Cost							
PSC Cost Percent							7%
PSC Amount							13,084.11
Total Cost							**199,999.91**
Grand Total CHF Cost							**199,999.91**

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						Activity 1.1.1 : Provide basic/minor rehabilitation of damaged health facilities, engage leaders to maintain/protect facilities, medicines and equipment Activity 1.1.2 : Provide equipment and supplies to enable health teams to deliver mobile outreach and rapid response for scale-up and swift interventions where HFs have been destroyed Activity 1.1.3 : Provide mobile teams of health workers to scale-up delivery of primary health care services Activity 1.2.1 : Provide life saving treatment of

							common communicable diseases (malaria, URI/pneumonia and diarrhea) including outbreaks of measles and kala-azar, and record deaths of U5 children, and record total deaths Activity 1.2.10 : Provide reports and up dates, and engage communities to provide feedback on health and nutrition services to ensure accountability to affected populations Activity 1.2.2 : Provide life saving BEmONC services and outreaches to ensure vulnerable women, adolescent girls, men and community leaders are aware of services and support women to access services Activity 1.2.3 : Train health workers trained on safe deliveries, HIV transmission prevention, safe disposal of medical waste, gender sensitivity, and importance of gender disaggregated data Activity 1.2.4 : Screen and provide care for children with life-threatening medical complications as a result of SAM, and refer children with MAM and SAM to nutrition facilities for treatment Activity 1.2.5 : Provide basic package of treatment and management of SGBV Activity 1.2.6 : Raise gender awareness with men and women, the sexual and reproductive rights of adolescent girls and women and HIV/AIDS awareness of SGBV victims Activity 1.2.7 : 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 Activity 1.2.8 : Procure from MoH and distribute life saving medicines and medical supplies to health facilities Activity 1.2.9 : Ensure men, youth and women leaders provide protection for children, adolescent girls and women, elderly and disabled people so they can access life saving health services Activity 2.1.1 : Provide routine EPI service from health facilities and through outreaches to serve IDPs and other vulnerable groups Activity 2.1.2 : Deliver mass vaccination campaigns (NIDs) against measles and polio Activity 2.1.3 : Provide mosquito nets (ITNs) to mothers of children <5 years Activity 2.1.4 : Provide Vitamin A supplementation to children < 5 years through routine facility based immunizations and through NIDs and dry season mass immunization campaigns Activity 2.1.5 : Provide de worming treatment to children 12 59 months through routine facility based immunizations and through NIDs and dry season mass immunization campaigns Activity 2.1.6 : Provide awareness to educate men and women leaders, schools and churches on WASH messages (water purification, sanitation, hygiene promotion), IYCF practices, reproductive health, HIV/AIDS and STI prevention and gender awareness Activity 2.2.1 : Conduct weekly surveillance, monitoring and reporting disease trends and detect outbreaks

Documents

Category Name	Document Description
Project Supporting Documents	CMA RESPONSE TO CHF 2016 FIRST TR REVIEW 28.01.2016 (3).docx
Budget Documents	CHF 2016 EMONC EQUIPMENT.xls
Budget Documents	FANGAK COUNTY PHARM PHCC SUPPLIES.xls