Project Proposal

Organization	MEDAIR (MEDAIR)			
Project Title	Emergency response to acute and chronic complex health emergencies and increased access to health care for vulnerable populations in South Sudan			
Fund Code	SSD-15/HSS10/SA2/H/INGO/643			
Cluster	**Primary cluster**: HEALTH; **Sub cluster**: None			
Project Allocation	2nd Round Standard Allocation		Allocation Category Type	Frontline services
Project budget in US$	220,000.00		Planned project duration	6 months
Planned Start Date	01/08/2015		Planned End Date	31/01/2016
OPS Details	OPS Code		OPS Budget	0.00
	OPS Project Ranking		OPS Gender Marker	

Project Summary

Through this project Medair will respond to prioritized, assessed, unmet health needs or gaps in primary health service provision, to reduce morbidity and mortality of vulnerable girls, boys, women and men in conflict affected and other vulnerable states. This project aims to improve access to quality preventative and curative primary health care services, including reproductive health. Due to the underlying vulnerabilities of the population, high maternal and under 5 mortality rates, this project will focus on improving access of quality life-saving services to pregnant and lactating women and children under 5 years. This project will maintain provision of essential primary health care services to IDPs and the host community in Renk County where the health system has been dysfunctional as a result of the conflict.
The project will also maintain Medair's health mobile response capacity to act as "First Responders" in an emergency location following a needs assessment, as well as to scale-up this first response in the absence of other partners. Medair's health emergency response team forms part of a well-established multi-sector emergency response team that has been responding to acute emergencies across South Sudan for more than 10 years. Medair deploys health personnel and life-saving assistance at short notice, to assess or respond to needs triggered by acute health emergencies in the country. Medair's mobile teams propose to respond to the needs of communities affected by outbreak disease or other public health emergencies and to communities displaced or impacted by the ongoing conflict. This project also aims to support the Ministry of Health and other relevant authorities in emergency response capacity, training local male and female health workers to respond to health emergencies and providing training in disease surveillance, outbreak response, case management, reporting systems, and awareness of various health gender needs based on current disease trends.

Direct beneficiaries

	Men	Women	Boys	Girls	Total
Beneficiary Summary	10551	15825	13187	13187	**52,750**
Total beneficiaries include the following:					

Indirect Beneficiaries		Catchment Population	

Link with the Allocation Strategy

This project will contribute to the overall objective of the CHF allocation strategy to address life-threatening health needs for displaced populations, returnees and vulnerable host communities in South Sudan. In line with the first health sector objective, Medair will improve access to essential primary health care where there is a critical service gap to a vulnerable population. In locations where Medair supports Primary Health Care, Medair will continue to provide patient consultation, essential PHC drugs, routine EPI and provision of antenatal care while working towards implementation of MISP and establishing effective referral systems for emergency obstetric care in project locations. Medair will provide Primary Health Care services for IDPs in Renk County and the Juba-based health mobile response team will respond to new displacements or vulnerable groups to increase access to essential preventative and curative health care, targeting the most at risk groups. In locations, such as Renk County, where Medair is supporting provision of essential basic and preventive health care for a longer period, the project is designed to impact community behaviour change through a participatory cascade model using mothers groups.
This project supports the second health sector objective through enhancing surveillance using IDSR in PHC supported locations and facilitating timely reporting. This project maintains Medair's emergency health mobile response team capacity to assess reported outbreaks and act as "First Responders" in a location requiring emergency response following a needs assessment. The emergency health team will also have capacity to scale-up initial responses in the absence of other partners. Medair will procure drugs to facilitate timely response to disease outbreaks and train local health care workers in prevention, diagnosis and case management of disease outbreaks according to South Sudan MoH guidelines. Through this project, Medair's emergency response team will have capacity to implement community mobilization to spread targeted health education and promotion messages related to public health emergencies and implement mass vaccination campaigns against disease outbreaks. Medair's emergency response team will coordinate with the MoH and health cluster to assess and respond in any of the 10 states in South Sudan to provide lifesaving services to girls, boys, women and men vulnerable to or directly affected by public health emergencies. This project will aim to improve the detection and management of SGBV through increasing access to services through PHC facilities and training for midwives and clinical staff. Where mother's groups are established, issues and concerns around utilizing services for SGBV will be addressed. Where possible, Medair will work with organisations in the protection sector to increase utilization of services and provide appropriate referral of cases.

Sub-Grants to Implementing Partners

Other funding Secured For the Same Project (to date)

Source	US$
ECHO	418,000.00
EOMET	975,000.00
OFDA	640,000.00
	2,033,000.00

Organization focal point contact details

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BACKGROUND INFORMATION

1. Humanitarian context analysis.. Humanitarian context: Describe the current humanitarian situation in the specific locations where this project will be implemented

As of mid-2015, more than 2.1 million South Sudanese people have been displaced from their homes by the conflict (HRP, July 2015). This includes 1.5 million people who are either living amongst host communities or who have sought refuge in Protection of Civilian (PoC) sites, and over 600,000 people who have crossed into neighbouring countries (OCHA, July 2015).

This project will be implemented in locations with displaced or conflict affected communities in Upper Nile, Jonglei and Unity State. Medair will maintain flexibility to implement emergency response across the 3 affected states as well as current locations of operation which include Renk County in Upper Nile State and Leer in Unity State.

The conflict has caused a public health crisis, exacerbating underlying health vulnerabilities, high maternal and <5 mortality rates and weak infrastructure. The disruption of essential services, disruption in drug supplies and lack of qualified health care workers has inhibited surveillance for disease outbreaks, preventative and curative healthcare, integrated nutrition programming and reproductive health care. The most common causes of morbidity, particularly for boys and girls under 5 years continue to be acute respiratory infections, diarrhoeal disease and malaria. Lack of access to antenatal care, safe options for delivery and post natal care are primary health needs for women. The unpredictable and changing nature of the current conflict in South Sudan highlights the need for flexible and rapidly available humanitarian response.

In Renk County, the fighting between SPLA and SPLA(IO) forces has continued with near monthly clashes involving heavy mortar fire and shelling. The County

	remains in need of ongoing health emergency support as (former) returnees and IDPs have experienced multiple conflict displacement and the health system isn't functioning including the hospital, leaving the county without secondary health care services. Both Leer and Mayendit Counties have been facing violent attacks since May 2015 resulting in mass displacement of the host population taking refuge in swamps, high prevalence of sexual violence and increased mortality. In this insecure context, with all health facilities looted and very limited access, only emergency responses can currently be maintained.
2. Needs assessment. Explain the specific needs of the target group(s), explaining existing capacity and gaps. State how the needs assessment was conducted, list any baseline data and explain how the number of beneficiaries has been developed. Indicates references to assessments such as Multi-cluster/sector Initial Rapid Assessments (MIRA)	Provision of essential and emergency health care to displaced or vulnerable host populations is a significant need for the upcoming 6 months of 2015. In Renk County, reduced capacity of the CHD, multiple displacements and destruction of facilities such as the hospital, has crippled the health infrastructure. There is no civilian referral facility in the County and no doctors. PHC coverage falls well below Sphere standards. Based on an estimated 50,000 population, Renk County has 1.8 Medical Assistants and 1.8 midwives/10,000 population, whereas Sphere HR minimum standard is 22 qualified health workers/10,000 people. In the first 5 months of 2015 there has been ongoing conflict and recurrent displacement of the population, inhibiting access to health services and contributing to sporadic measles outbreaks despite an integrated measles vaccination campaign and EPI outreach in the IDP camps. A Medair SMART survey conducted in Renk amongst the host population in July 2015 highlighted the detrimental impact of conflict displacement on children <5yrs; host U5MR was 0.86/10,000/day while the CMR was 0.93/10,000/day (Female 0,57 and Male 1,32). In terms of morbidity, the above survey showed that 57,6% of children 6-59 months were sick during the previous 2 weeks with fever 31,2%, diarrhea 28% and cough 15,2%.Between January and June 2015, Medair's IDP health facilities provided 48,171 consultations, including 23,344 children <5yrs (6106 girls, 6238 boys). Diarrhea, ARI and malaria were the primary causes of morbidity among children <5 years. The large presence of military personnel, displaced population and high number of female headed households increases the risk of SGBV in Renk County. In Leer County, intense conflict in May 2015 caused disruption to all health and nutrition services. Destruction of health facilities and widespread looting of essential PHC drugs and health supplies as well as displacement of health care workers caused a crisis in health care access for vulnerable groups, particularly women and children. The presence of multiple risk factors over a prolonged period such as lack of food, displacement into swamp areas contributing to increased incidence of malaria and AWD, widespread SGBV and a high number of trauma wounds including gunshots, makes the population in Leer County among the most at risk and severely affected within South Sudan. This project will also be implemented in other locations within the 3 prioritized states, depending on needs assessments of new health emergencies. Where PHC is supported, reducing the maternal mortality rate is a programme priority. The South Sudan maternal mortality rate was estimated to be 1,989 per 100,000 live births before the current conflict. In 2015 there has been further reduction in access to basic reproductive health services including EmONC. Only 18% of women in South Sudan gave birth with a skilled birth attendant and only 15% in Upper Nile (MICS 2010). Neonatal deaths account for 34% of all the deaths in children <5 years of age in South Sudan and the neonatal mortality rate in South Sudan was estimated at 36/1000 live births pre2013. It can be expected that in 2015 this figure is significantly higher among communities within Upper Nile, Jongeli and Unity States. Through this project, Medair will respond to disease outbreaks within the three priority states. When suspected outbreaks are reported, Medair will prioritize responses in locations with multiple underlying vulnerabilities, such as displacement, malnutrition and limited healthcare access.
3. Description Of Beneficiaries	The beneficiaries of this project are girls, boys, women and men who have been internally displaced as well as vulnerable host communities, including those displaced multiple times but returning to their area of origin. In locations such as Leer, Medair beneficiaries are vulnerable whole communities who have no access to facility based care and have multiple risk factors for mortality. In locations where Medair has existing programs, staff take extra time and provide additional support for people with disabilities to access health services at the facility. Using standard, globally recognized tools, Medair carries out needs assessments before responding to emergencies. Prioritization of the assessed needs and identification of the most vulnerable groups will determine the targeted assistance provided. Where an independent needs assessment is not feasible, Medair will source assessments previously completed, contact local partners and counterparts on ground to get as much data regarding the emergency as possible. This project is designed to decrease morbidity and mortality for the main diseases among the most vulnerable groups. Therefore, children, particularly under 5 years, pregnant and lactating women, people with special needs and the elderly are usually identified as especially vulnerable and the emergency intervention will be designed accordingly. Adolescent girls are also vulnerable and a priority for the RH component of Medair's PHC, along with PLW as they are often an at risk group for complicated deliveries. Health staff who receive targeted training are also beneficiaries of this project. Medair works through existing structures such as MoH to build the capacity of local health workers, which includes supervision and on the job training of female and male local health care workers and health and hygiene promoters. Medair provides public information to the beneficiaries about their projects through local government, community outreach and facility based awareness and health promotion activities. Medair consults with local authorities, community leaders, CHD and health staff regarding decisions to intervene, adapt or complete projects. ERT assessments include key informant interviews and focus group discussions to determine vulnerable groups within the community. In Renk, Medair uses household surveys to assess programme coverage and evaluate the impact of the project on the community.
4. Grant Request Justification.	Medair has demonstrated the capacity to deliver quality emergency response in South Sudan. Since 2001, Medair's focus has been delivering health services and emergency responses in the most conflict affected states, responding to population displacement, disease outbreaks and restoring health services to vulnerable communities. Medair's health emergency response team can mobilize staff at short notice to assess and/or respond to health emergencies. Medair is responding to the cholera outbreak in Juba, which has also been confirmed in Bor and suspected cases are reported in other states. This project will enable Medair to continue supporting cholera preparedness and response activities as well as other disease outbreaks to prevent or reduce the associated increase in morbidity and mortality. Medair will continue to work closely with the MoH, health cluster and partners to coordinate, assess and respond to prioritized locations of greatest need, avoiding duplication of services. Priority areas for emergency PHC support will be where there has been new or repeated displacement in addition to underlying vulnerabilities such as high levels of malnutrition or outbreak disease. Medair will always seek to implement evidenced based packages, such as IMCI/IECHC and MISP to reduce morbidity and mortality among women and children under 5 years. Where EPI has been disrupted, Medair will seek to re-establish services and promote outreach activities to increase immunization rates. Medair provides emergency PHC in 2 IDP camps through temporary facilities in Renk County. This allocation will enable Medair to continue provision to vulnerable communities who would otherwise have no access to health care. Medair will include additional ways of reaching vulnerable communities in Renk County by restoring function to existing MoH facility serving IDPs integrated with the host community and establishing iCCM to reach remote communities who are cut off from accessing facility based services. Medair clinics are the only civilian facilities in Renk County providing comprehensive ANC and basic EmONC alongside other routine RH services such as family planning. Medair will continue to advocate for the provision of CEmONC as well as HIV testing and safe blood transfusion for Renk County. In the interim Medair will implement a referral mechanism with the military hospital for obstetric emergencies. Medair's RH program in Renk includes management of SGBV, including psychosocial support and using the Care Groups to increase community awareness and uptake of services. In locations such as Leer County, Unity State, where access is restricted due to intense conflict but health needs are most critical, Medair will adapt and continually review the emergency response strategy to provide remote support and essential targeted PHC and RH supplies and support to qualified health care staff on the ground until facility based services can be restored. Medair programs are designed to have minimal environmental impact. At PHC sites, Medair ensures an incinerator is available and clinical waste is disposed of correctly. Health Promotion at all programme levels promotes the use of clean water and sanitation in the community. Health staff are trained in universal precautions and made aware of HIV transmission and prevention. Free condoms are available from Medair supported health facilities. HIV services in the area are mapped upon arrival to new intervention areas. Where possible, patients with suspected HIV infection are referred to the nearest voluntary counselling and testing (VCT) centre. Treatment is provided for opportunistic infections during case management interventions. Medair's emergency response programme is co-funded by ECHO and EOMET and the programme in Renk County is co-funded by OFDA.
5. Complementarity. Explain how the project will complement previous or ongoing projects/activities implemented by your organization.	This project is a continuation of Medair's ongoing health support to IDPs and vulnerable host communities in Renk County and will enable Medair to continue responding to emerging health emergency response needs throughout the remainder of 2015. Medair's CHF Round 1 health allocation expires at the end of July 2015. Other donors funding Medair's health activities in 2015 include OFDA, ECHO and EOMET. Wherever possible, Medair seeks to integrate health programming with nutrition and WASH activities to strengthen the response. For example, in Renk County, Medair fill a critical gap in the provision of multi-sectoral support across the health, nutrition and WASH sectors. In fixed sites behavior change communication is implemented through the Care Group Model which address cross cutting health, nutrition and hygiene practices. The health emergency response team (ERT) is one part of a broader team which also includes nutrition, WASH and NFI. Assessments made, even if sector specific, consider the bigger picture in terms of needs and as much as possible planned responses are multi sectorial. As an example, the ongoing emergency response in Leer county includes all 4 sectors. It allows for faster decisions on agreeing what items (and quantities) need to be prioritized for the intervention as well as which staff is the most appropriate to go. Because Medair had a nutrition program in Leer when the conflict broke out, daily contact with local staff on the ground is taking place to identify priority needs, security context and potential protection issues directly linked to drawing people into one location to receive humanitarian support.
LOGICAL FRAMEWORK	
Overall project objective	To reduce morbidity and mortality of vulnerable girls, boys, women and men in emergency situations by improving access to quality preventative and curative primary health care services.

Logical Framework details for HEALTH

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
2015 SSO 1: Improve access to, and responsiveness of, essential including emergency health care, and emergency obstetric care services	SO 1: Save lives and alleviate suffering by providing multi-sector assistance to people in need	40
2015 SSO 2: Enhance existing systems to prevent, detect and respond to disease outbreaks	SO 1: Save lives and alleviate suffering by providing multi-sector assistance to people in need	40

2015 SSO 3: Improve availability, access and demand for Gender Based Violence and Mental Health and Psycho-Social Support services targeting highly vulnerable people	SO 1: Save lives and alleviate suffering by providing multi-sector assistance to people in need	20

Outcome 1	Increased access to quality lifesaving primary health services for people in conflict affected states	
Code	**Description**	**Assumptions & Risks**
Output 1.1	People, including IDPs, in the conflict affected states are provided with quality preventive and curative primary health services	

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 1.1.1	HEALTH	[Frontline services] # of <5 outpatient consultations in conflict-affected and other vulnerable states			5880	5880	11760
	Means of Verification:						
Indicator 1.1.2	HEALTH	[Frontline services] # of >5 outpatient consultations in conflict-affected and other vulnerable states	22120	22120			44240
	Means of Verification:						
Indicator 1.1.3	HEALTH	Percentage of cases diagnosed and treated per standardized case management protocols, by sex and age (Target: >95%)					95
	Means of Verification:						

Activities

Activity 1.1.1	Provide emergency primary health services including both preventive and curative care
Activity 1.1.2	Provide PHC equipment and supplies according to the MoH Basic Package of Health Services for emergency PHC facilities in IDP sites
Activity 1.1.3	Provide monthly facility based supervision for all clinic staff and conduct monthly exit interviews to assess correct diagnosis and treatment

Output 1.2	Increased provision, access and utilization of quality services for pregnant women	

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 1.2.1	HEALTH	Number and percentage of pregnant women in their third trimester who received a clean delivery kit					2000
	Means of Verification:						
Indicator 1.2.2	HEALTH	[Frontline services] Proportion of births attended by skilled birth attendants					40
	Means of Verification:						
Indicator 1.2.3	HEALTH	[Frontline services] # of health facilities providing basic package of GBV services in IDP setting					3
	Means of Verification:						

Activities

Activity 1.2.1	Provide comprehensive ANC services, including TT, LLIN, IPT, micronutrient supplementation, clean delivery kits
Activity 1.2.2	Provide skilled birth attendance in clinic locations
Activity 1.2.3	Increase community awareness of SGBV services through trained staff and Care Group implementation

Output 1.3	Increased access to emergency health care for vulnerable communities affected by communicable diseases and outbreaks in conflict affected states	

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 1.3.1	HEALTH	[Frontline services] # of health workers trained in MISP / communicable diseases / outbreaks / IMCI / CMR/trauma	47	50			97
	Means of Verification:						
Indicator 1.3.2	HEALTH	[Frontline services] # of people reached with health education and promotion messages	5000	5000	0	0	10000
	Means of Verification:						

Activities

Activity 1.3.1	Conduct rapid health assessments of suspected disease outbreaks and other reported emergencies
Activity 1.3.2	Provide case management responses to disease outbreaks
Activity 1.3.3	Carry-out mass vaccination campaigns in response to vaccine preventable outbreaks
Activity 1.3.4	Implement and supervise social mobilization to increase awareness of preventive behaviors and early health seeking in affected communities
Activity 1.3.5	Ensure submission of integrated disease surveillance reporting and promote use of EWARN system in affected locations

WORK PLAN

Project workplan for activities defined in the Logical framework

Activity Description (Month)	Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Activity 1.1.1 Provide emergency primary health services including both preventive and curative care	2015								X	X	X	X	X
	2016	X											
Activity 1.1.2 Provide PHC equipment and supplies according to the MoH Basic Package of Health Services for emergency PHC facilities in IDP sites	2015								X	X	X	X	X
	2016	X											
Activity 1.1.3 Provide monthly facility based supervision for all clinic staff and conduct monthly exit interviews to assess correct diagnosis and treatment	2015								X	X	X	X	X
	2016	X											
Activity 1.2.1 Provide comprehensive ANC services, including TT, LLIN, IPT, micronutrient supplementation, clean delivery kits	2015								X	X	X	X	X
	2016	X											
Activity 1.2.2 Provide skilled birth attendance in clinic locations	2015								X	X	X	X	X
	2016	X											
Activity 1.2.3 Increase community awareness of SGBV services through trained staff and Care Group implementation	2015								X	X	X	X	X
	2016	X											
Activity 1.3.1 Conduct rapid health assessments of suspected disease outbreaks and other reported emergencies	2015								X	X	X	X	X
	2016	X											
Activity 1.3.2 Provide case management responses to disease outbreaks	2015								X	X	X	X	X
	2016	X											
Activity 1.3.3 Carry-out mass vaccination campaigns in response to vaccine preventable outbreaks	2015								X	X	X	X	X
	2016	X											
Activity 1.3.4 Implement and supervise social mobilization to increase awareness of preventive behaviors and early health seeking in affected communities	2015								X	X	X	X	X
	2016	X											
Activity 1.3.5 Ensure submission of integrated disease surveillance reporting and promote use of EWARN system in affected locations	2015								X	X	X	X	X
	2016	X											

M & R DETAILS

Monitoring & Reporting Plan: Describe how you will monitor the implementation of each activity. Describe the tools you plan to use (checklist, photo, questionnaires, interviews, suggestion box etc.) in order to collect data and how you will store data. Explain the frequency type and protocol of reporting (how often do you report about what to whom?). State if, when and how you plan to evaluate your project .

Medair will monitor programme impact during and after interventions, depending on the health intervention. The frequency depends on the services provided. Where Medair supports PHC facilities, impact will be measured using clinic registers to monitor clinic utilization and numbers treated. Medair has also internal quality indicators such as the percentage of children correctly diagnosed and treated according to South Sudan MoH guidelines. Those are gathered through monthly exit interviews. Clinic supervisory checklists (standardised South Sudan MoH, as well as internal Medair checklists) are also maintained by the team. For the ERT interventions, Medair communicate s terms of reference before assessment/response and shares post intervention summary reports with the health cluster and partners to disseminate programme impact of the emergency health team in a location such as case fatality rates for treatment of outbreak diseases. In case of outbreak daily line listing is taking place: patients are registered upon admission with name, age, sex, village and treatment given. This information is then entered into the computer, analyzed, communicated to partners and included in donor reports. In case of clinic support, weekly and monthly reporting is taking place following the same process.

Evaluations may include qualitative or quantitative follow-ups such as focus group discussions and annual household surveys. Interventions targeted for follow-up will be determined by the monitoring and evaluation officer, technical advisors, and managers, based on accessibility of project sites and the ability to measure impact of activities. Where feasible, Medair will conduct post vaccination coverage surveys following immunization campaigns, disaggregating people reached by sex and age. Medair will contribute to all national reporting mechanisms relevant to the activities being implemented, and will build capacity of local healthcare workers to continue using those mechanisms.

All data presented in weekly and monthly reports is monitored by local project managers as well as the health advisor based in Juba to determine any areas of concern, identify vulnerable populations or gender disparities in access to health services or note preparations needed for changes in disease trends. Medair will use representative sampling methods such as Lot Quality Assurance Sampling (LQAS) or cluster sampling methodologies to conduct household surveys for interventions at the discretion of the monitoring and evaluation officer and technical advisors. These methods have been successfully used in other Medair health programmes in South Sudan and will be utilized in the emergency response programme when appropriate.

Project Managers are responsible for monitoring of activities and tracking all required indicators during implementation and upon completion of assessments and interventions. Medair disseminates summary reports for assessments and interventions to external actors, remaining accountable to government, donors, and the humanitarian community through that process. The ERT projects coordinator is responsible for ensuring quality of interventions, through oversight of the project managers and field visits. In addition, the health advisor will provide technical input and quality assurance for this program. The monitoring and evaluation officer supports the project managers and assumes responsibility for survey design, in consultation with sector advisors at country and HQ levels.

OTHER INFORMATION

Accountability to Affected Populations

As a member of HAP-I, Medair seeks to provide public information to the beneficiaries about the programmes provided through local government, community outreach and facility based awareness and health promotion activities. Medair consults with local authorities, community leaders, CHD and health staff throughout the project implementation regarding decisions to commence, adapt or complete programmes. ERT assessments include key informant interviews and focus group discussions among community groups. In static sites, Medair uses annual household surveys to assess programme coverage and post exit interviews are used at the facility level for monitoring the quality of service provision. Every staff member joining to work with Medair in South Sudan gets an orientation on the Code of Conduct and has to sign upon it, together with a “Summary of Minimum Standards for the Protection of Women and Children Against Sexual Abuse and Exploitation” which form part of the National and International Staff Guidelines.

Implementation Plan: Describe for each activity how you plan to implement it and who is carrying out what.

Medair directly implements the programme activities and strives to build capacity of local partners and link programming with longer term sustainability. Throughout the intervention, Medair works with the local community to ensure both men and women have equal access to employment with Medair as well as services. Medair has support bases, staff and resources in place to successfully implement the activities, given adequate funding. Medair has an emergency response team of Health Managers (clinical officers and nurses), nutritionists, logisticians and health and hygiene promotion officers implementing behavior change communication through the Care Group Model (CGM) in fixed sites. . Gender analysis through focus group discussions with women, men, boys and girls will continue to take place to identify roles and responsibilities of each group and adjust programing whenever it is possible.

Medair actively participates in OCHA’s regular emergency response meetings, health cluster and health EP+R meetings to support coordination for rapid assessment and response. Medair has capacity to organize rapid assessments with its own team or in collaboration with other agencies as part of an interagency assessment. Where appropriate, Medair will plan multi-sector assessments with clearly defined TORs that support rapid response if indicated. Standard tools such as the IRNA are typically used as well as context specific assessment criteria if appropriate. During assessments, Medair will consider the situations and views of females and males as well as different age groups. Medair’s decision to respond to a health emergency is based on prioritized, assessed needs. Local health workers and volunteer staff will be utilized and trained for all interventions to work alongside Medair’s emergency response team.

Medair staff will continue working in collaboration and coordination with the County Health Departments in all interventions seeking advice, informing on plans and adapting to the context, Medair also works in partnership with other national NGOs and international NGOs within the same area of emergency to ensure gaps are filled and there is no overlap of services. In all responses and activities, Medair liaises and coordinates with national, state, county and local government officials and authorities. Medair also liaises with Unicef, WHO and UNFPA to acquire health items which support our activities.

Health interventions will primarily target boys and girls under 5 as well as PLW as the most vulnerable to morbidity and mortality. Projects will provide primary health care either to fill a gap in services like in Renk, to support/capacity build partners, respond to health emergencies or conduct preventative interventions (i.e. vaccinations) In catchment areas of PHCU/C with no health services in places Medair may implement integrated community case management. Primary health services will include preventative and curative care including consultations, immunization and reproductive health services. Drugs will continue to be purchased independently especially as shortages are foreseen within the coming months. Exit criteria are established prior to project implementation (including emergencies)

	and reviewed on a yearly basis for longer term projects. Medair will maintain the flexibility to adapt time frames and activities of an intervention to fluctuating/increasing health needs in an area and will prioritise interventions based on greatest impact on morbidity and mortality for the most vulnerable. Preposition of health supplies including essential PHC drugs and supplies for the treatment of common outbreak diseases will be done in Juba for rapid deployment to support emergency interventions.

Coordination with other Organizations in project area

Name of the organization	Areas/activities of collaboration and rationale
1. CHD (all locations)	Consultation and coordination in all locations where assessment/project is implemented
2. IMA (Renk county)	MoH facilities are supported by IMA.
3. IOM (Renk county, ERT)	Health actor in the IDP camp. Mass measles vaccination campaign done in collaboration (social mobilization and immunization). Actual collaboration in support of JTH hospital in the cholera outbreak in Juba.
4. MSF, CMA, UNIDO, JDF (ERT)	Partners with whom close collaboration has been taking place in the last few months through the ERT (impossible to predict with whom next interventions will be coordinated with)
5. UNICEF, WHO, UNFPA	GIK: vaccines, mosquito nets, tent, RDTs, CDKs, PEP kits

Environmental Marker Code	
Gender Marker Code	2a-The project is designed to contribute significantly to gender equality
Justify Chosen Gender Marker Code	During assessments of health related emergencies, the needs of men, women, girls and boys will be identified, including their requirements to access health care. Where possible Medair will hold single sex, age segmented FGDs to encourage participation, particularly of women, in health service design. Both men and women from local communities will be trained and used to staff health facilities and implement emergency interventions. Interventions will be monitored through reviewing clinic data and patient exit interviews to ensure quality services and identify and resolve obstacles to equitable access. In all situations, mortality and morbidity data will lead the focus of the intervention. Interventions which are not responding to disease outbreaks, will target women more than men, particularly pregnant and lactating women as they are more vulnerable and the health and health knowledge of mothers has a direct impact on the health of their children.
Protection Mainstreaming	
Safety and Security	
Access	

BUDGET

1 **Staff and Other Personnel Costs** *(please itemize costs of staff, consultants and other personnel to be recruited directly by the implementing partner for project implementation)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015		2016	Quarterly Total
								Q3	Q4	Q1	
1.1	Programme Nat. staff	D	1	99177.47	6	8.79%	52,306.20	17,435.00	26,153.00	8,718.20	52,306.20
	58 staff (4 Care group officer/Assistant, 2 EPI Vaccinator, 2 Health Manager, 5 Logistics Officer/Assistant, 4 Medical Assistant, 2 Medical Center Health Worker, 4 Midwife, 7 Nurse, 4 Registrar/Clinic Assistant, 1 Reproductive Health Manager, 2 Translator, 2 Warehouse Officer/Assistant, 2 Community Liaison Officer, 1 Finance Officer, 1 HR Officer, 11 guards, 4 Cleaner/Cook)										
1.2	Programme Int. staff	D	1	50846.75	6	16.72%	51,009.46	17,003.00	25,505.00	8,501.46	51,009.46
	9 staff (1 Health Manager, 1 Medical Advisor, 1 ERT MD, 1 ERT Health/Nutrition Project Manager, 1 Logistics Officer/Assistant, 2 Projects Coordinator, 1 Programme Funding Manager, 1 Warehouse Manager)										
	Section Total						103,315.66	34,438.00	51,658.00	17,219.66	103,315.66

2 **Supplies, Commodities, Materials** *(please itemize direct and indirect costs of consumables to be purchased under the project, including associated transportation, freight, storage and distribution costs)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015		2016	Quarterly Total
								Q3	Q4	Q1	
2.1	Consumable supplies	D	9	2611	6	7.80%	10,997.53	3,666.00	5,499.00	1,832.53	10,997.53
	(Medicines and medical supplies, ANC cards, Vaccination cards, Stationery, charcoal, sugar, cleaning materials, OPD cards)										
2.2	Food, soap	D	2	1930.67	6	7.05%	1,633.35	544.00	817.00	272.35	1,633.35
	Direct beneficiary										
2.3	Equipment, furniture and accessories	D	11	1212.76	6	7.42%	5,939.13	1,979.46	2,969.19	990.48	5,939.13
	(Examination couches, Delivery beds, Blood pressure machine, Solar fridges, Stethoscopes, Benches, Chairs, Cabinets, Tables, Solar lamps)										
2.4	Incentives and Casual labour	D	7	3769.78	6	7.12%	11,273.15	3,755.58	5,633.38	1,884.19	11,273.15
	(Dispenser in Pharmacy, 8 Care Group Promoters, Casual repair clinic, casual labor for offloading and erecting tents and cleaning, gardening, loading offloading cargo)										
2.5	Transport for medications and medical supplies ent equipment to Field, Transport of construction supplies in Renk, Transport warehouse-airport-warehouse, Transport of Patients to referral centre	D	7	3983.17	6	7.71%	12,898.30	4,297.57	6,446.36	2,154.37	12,898.30
2.6	Promotion and training	D	23	683.96	6	7.35%	6,937.41	2,316.02	3,474.03	1,147.36	6,937.41
	(Items for demonstration of behavior, ICCM incentive, Care group promoter)										
	Section Total						49,678.86	16,558.63	24,838.96	8,281.28	49,678.87

3 **Equipment** *(please itemize costs of non-consumables to be purchased under the project)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015		2016	Quarterly Total
								Q3	Q4	Q1	
3.1	Laptop accessories	D	1	309.62	6	6.88%	127.81	43.00	64.00	20.81	127.81
3.2	Cell phone, Thuraya/sat phones	D	1	843.23	6	6.84%	346.06	115.00	173.00	58.06	346.06
	Section Total						473.87	158.00	237.00	78.87	473.87

4 **Contractual Services** *(please list works and services to be contracted under the project)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015		2016	Quarterly Total
								Q3	Q4	Q1	

4.1	Surveys & evaluations	D	2	714.46	6	8.10%	694.46	231.00	347.00	116.46	694.46
4.2	Translation	D	5	6.67	6	8.10%	16.21	5.00	8.00	3.21	16.21
4.3	Printing	D	1	75	6	8.10%	36.45	12.00	18.00	6.45	36.45
4.4	Legal fees	S	1	32.01	6	16.47%	31.63	11.00	16.00	4.63	31.63
	Section Total						778.75	259.00	389.00	130.75	778.75

5 **Travel** *(please itemize travel costs of staff, consultants and other personnel for project implementation)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015		2016	Quarterly Total
								Q3	Q4	Q1	
5.1	Ground Travel	D	3	983.3	6	7.16%	1,267.28	422.42	633.63	211.23	1,267.28
	(taxi to and from airport)										
5.2	Ground Travel	S	3	283.72	6	16.47%	841.12	280.38	420.57	140.17	841.12
	(taxi for support managers)										
5.3	Continental flights	D	16	838.3	6	7.09%	5,705.81	1,901.95	2,852.92	950.94	5,705.81
	(for programme staff)										
5.4	Continental flights	S	6	317.64	6	16.47%	1,883.35	627.79	941.69	313.87	1,883.35
	(for support managers)										
5.5	Intercontinental flights	D	5	1349.53	6	7.16%	2,898.79	965.17	1,447.76	485.86	2,898.79
	(home leave for programme staff)										
5.6	Rental of vehicle/boat, including fuel and maintenance	D	5	1581.79	6	7.17%	3,402.43	1,134.00	1,701.00	567.43	3,402.43
5.7	Rental of vehicle/boat, including fuel and maintenance	S	33	47.3	6	16.47%	1,542.48	514.00	771.00	257.48	1,542.48
	Section Total						17,541.25	5,845.71	8,768.57	2,926.98	17,541.26

6 **Transfers and Grants to Counterparts** *(please list transfers and sub-grants to project implementing partners)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015		2016	Quarterly Total
								Q3	Q4	Q1	
	Section Total						0.00	0	0	0	0.00

7 **General Operating and Other Direct Costs** *(please include general operating expenses and other direct costs for project implementation)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost	2015		2016	Quarterly Total
								Q3	Q4	Q1	
7.1	Office supplies	D	3	436.86	6	10.12%	795.78	265.00	398.00	132.78	795.78
	(cartridges, stationery, paper for the project)										
7.2	Office supplies	S	2	155.22	6	16.47%	306.78	102.00	153.00	51.78	306.78
	(cartridges, stationery, paper for the supporting staff)										
7.3	Transport for non-beneficiary goods, packaging materials linked to the project	D	2	3072.73	6	23.03%	8,491.80	2,831.00	4,246.00	1,414.80	8,491.80
7.4	Transport for non-beneficiary goods, packaging materials	S	3	333.37	6	16.47%	988.31	329.00	494.00	165.31	988.31
7.5	Communication costs	D	2	3791.29	6	6.83%	3,107.34	1,036.00	1,555.00	516.34	3,107.34
	(phone, internet, satellite communications) for the project										
7.6	Communication costs	D	5	163.97	6	16.47%	810.18	270.00	405.00	135.18	810.18
	(phone, internet, satellite communications) for the supporting staff										
7.7	Visibility material	D	5	97.2	6	100.00%	2,916.00	972.00	1,458.00	486.00	2,916.00
	(posters, sign boards)										
7.8	Facility maintenance, and supplies	D	4	2966.91	6	7.02%	4,998.65	1,666.00	2,500.00	832.65	4,998.65
	(Warehouse maintenance, supplies, generators, water for warehouse, warehouse rent)										
7.9	Facility maintenance, and supplies	S	4	158.4	6	16.47%	626.12	209.00	313.00	104.12	626.12
	(Office, house repairs, electrical repairs, gas, electricity)										
7.10	Office equipment maintenance, security supplies	D	4	560.03	6	7.31%	982.52	328.00	491.00	163.52	982.52
	(Warehouse security maintenance, computer/Thuraya repair)										
7.11	Office equipment maintenance, security supplies	S	6	322.93	6	16.47%	1,914.72	638.00	957.00	319.72	1,914.72
	(locks, batteries, fire alarms, fire extinguishers)										
7.12	Rent costs for responding sites	D	1	7517	6	6.86%	3,094.00	1,031.00	1,547.00	516.00	3,094.00
7.13	Office rent for support base	S	1	2784	6	16.47%	2,751.15	917.00	1,376.00	458.15	2,751.15

Section Total	31,783.34	10,594.00	15,893.00	5,296.35	31,783.35

Sub Total Direct Cost	203,571.76
Indirect Programme Support Cost *PSC rate (insert percentage, not to exceed 7 per cent)*	7%
Audit Cost *(For NGO, in percent)*	1%
PSC Amount	14,250.02

Quarterly Budget Details for PSC Amount

2015		**2016**	**Total**
Q3	Q4	Q1	
4,750.00	7,125.00	2,375.02	14,250.02

Total Fund Project Cost	217,821.78

Project Locations

Location	Estimated percentage of budget for each location	Beneficiary Men	Women	Boy	Girl	Total	Activity
Jonglei	20					0	
Unity	20					0	
Upper Nile	20					0	
Upper Nile -> Renk	40					0	

Project Locations (first admin location where activities will be implemented. If the project is covering more than one State please indicate percentage per State)

DOCUMENTS