OCHA Coordination Saves Lives

Project Proposal

Requesting Organization :	MEDAIR
Allocation Type :	1st Round Standard Allocation

Primary Cluster	Sub Cluster	Percentage
HEALTH		100.00
		100

Project Title :	Emergency response to acute and chronic complex health emergencies and increased access to health care for vulnerable populations in South Sudan
Allocation Type Category :	

OPS Details

Project Code :		**Fund Project Code :**	SSD-16/HSS10/SA1/H/INGO/738
Cluster :		**Project Budget in US$:**	300,000.00
Planned project duration :	6 months	**Priority:**	
Planned Start Date :	01/02/2016	**Planned End Date :**	31/07/2016
Actual Start Date:	01/02/2016	**Actual End Date:**	31/07/2016

Project Summary :

Through this project Medair will respond to prioritised, 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 of 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
21,066	42,134	8,400	8,400	80,000

Other Beneficiaries :

Beneficiary name	Men	Women	Boys	Girls	Total
Children under 5	0	0	8,400	8,400	16,800
Internally Displaced People	5,603	11,207	2,230	2,230	21,270
People in Host Communities	15,463	30,927	6,170	6,170	58,730
Pregnant and Lactating Women	0	6,400	0	0	6,400

Indirect Beneficiaries :

Catchment Population:

Link with allocation strategy :

This project is in line with the CHF allocation strategy, as project activities directly address life-threatening risks and vulnerabilities, in locations where these are most critical. This project will contribute to the overall objective of the CHF strategy, to save lives and alleviate suffering through safe access to services with dignity and links closely with the health cluster response strategy as it includes integrated health and nutrition life-saving packages, life-saving referral mechanisms and rapid response modalities including outreach response.

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
OFDA	836,000.00
	836,000.00

Organization focal point :

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BACKGROUND

1. Humanitarian context analysis

Priority locations for implementation of this project are in Upper Nile, Jonglei and Unity State where there are displaced or conflict affected communities. Medair will also maintain flexibility to assess and respond in other states affected by public health emergencies such as disease outbreaks.

In Renk County, reduced capacity of the CHD, multiple displacement and destruction of facilities such as the hospital, has crippled the health infrastructure. There is no civilian referral facility in the County. PHC coverage falls well below Sphere standards. Based on an estimated 40,000 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. Ongoing conflict and displacement of the population in 2015 inhibited access to health services and contributed to sporadic measles outbreaks despite an integrated measles vaccination campaign and EPI outreach in the IDP camps. A Medair SMART survey in August 2015 highlighted the detrimental impact of the conflict on children in Renk County; host U5MR was 0.87/10,000/day (95%CI; 0.39-1.96), GAM 17.6% (95%CI; 14.9 - 20.5) and in displaced communities U5MR 1.15/10,000/day (95%CI; 0.56-2.35), GAM 21.8% (95%CI; 18.2 - 26.0). Despite a displaced and spread out population in Renk County, Medair provided over 25,000 PHC consultations between August and November 2015 and implemented a mass measles vaccination campaign in September 2015. However due to ongoing population movement through the County and across the border, 95% coverage was not achieved, highlighting continued vulnerability to outbreak disease. Diarrhoea, 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 which continued for 7 months. Medair's emergency response team supported healthcare workers displaced with their communities through provision of emergency health backpacks to provide community case management of the main causes of morbidity and mortality. In December, humanitarian access to Leer County opened, enabling return to locations where health facilities had been destroyed or looted and staff killed or displaced. This project will enable Medair to scale up response to re-establish emergency health services. 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.

Where PHC is supported through this project, reducing the maternal mortality rate is a priority. The current South Sudan maternal mortality rate is not known, however Medair plans to support the EMMS in programme areas in 2016. There was reduced access to reproductive health services, including BEmONC and CEmONC, in 2015. Neonatal deaths account for 34% of all the deaths in children <5 years of age in South Sudan and as the neonatal mortality rate in South Sudan was estimated at 36/1000 live births pre2013, it can be expected that at the beginning of 2016 this figure is significantly higher among communities within Upper Nile, Jongeli and Unity States. Through this project, Medair will assess and respond to disease outbreaks. Measles outbreaks were confirmed in 6 counties in 2015. Other outbreak diseases in 2015 included cholera, Hepatitis E, polio, kala azar and pertussis. When suspected outbreaks are reported, Medair will prioritise responses in locations with multiple underlying vulnerabilities, such as displacement, malnutrition and limited healthcare access.

2. Needs assessment

Provision of essential and emergency health care to displaced or vulnerable host populations is a priority need for the first 6 months of 2016. In 2015 there was increased morbidity and mortality among displaced populations within formal camps, in informal settlements and in hard to reach areas. More than 1.6 million people are displaced, of which approximately185,000 are living in PoCs. In week 34 the U5MR in Bentiu PoC reached 2.131 deaths/10,000/day which breached the emergency threshold and highlights the high vulnerability of displaced populations and detrimental impact of displacement particularly on children <5yrs, who account for 45% of all deaths within the PoCs. The highest causes of morbidity and mortality for children <5yrs remain malaria, diarrhea and acute respiratory infections. U5MR among displaced groups or conflict affected host communities with reduced or no access to essential services is likely to be higher than within the PoCs where services are provided. Ongoing population displacement has been noted in early January 2016, particularly in Unity state. IOM DTM indicates that new arrivals to Bentiu PoC between 9th and 15th January came from all over Unity state; Rubkona, Leer, Mayendit, Mayom, Koch, Panijar and Guit. This highlights the ongoing insecurity that has already destroyed health infrastructure, restricted access and inhibited provision of preventive life-saving services such as EPI. Routine EPI services in the Greater Upper Nile region have been disrupted since 2014. By 2015, an estimated 34.2% children in South Sudan were fully immunized by 1year (UNICEF). However, EPI data from July 2015 showed in Unity, Upper Nile and Jonglei this is <10% and measles coverage is <20%, and in 2015 there were confirmed measles outbreaks in 6 counties. Other outbreaks in 2015 include cholera, Hep E, polio, kala azar and pertussis.

Although national MMR is not known, with a baseline of 15% (MICS 2010) pre crisis, women delivering with a skilled attendant and a critical lack of access to BEmONC and CEmONC services, improving access for maternal health is a critical need in 2016. In Leer County, intense conflict between May and December 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. The opening up of limited access in early 2016, is an opportunity to urgently scale up life-saving activities to address unmet health needs among women and children.

The IPC report in December 2015 classified the nutrition situation in Unity state as very critical and the majority of Greater Upper Nile, including Renk County, as critical. Multiple conflict displacement has depleted coping mechanisms of the population in Renk County and contributed to emergency levels of malnutrition among both host and IDP population. A Medair SMART survey in August 2015 found; host U5MR was 0.87/10,000/day (95%CI; 0.39-1.96), GAM 17.6% (95%CI; 14.9 - 20.5) and in displaced communities U5MR 1.15/10,000/day (95%CI; 0.56-2.35), GAM 21.8% (95%CI; 18.2 - 26.0). 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%, indicating a significant burden of disease. Continued provision of integrated nutrition services at health facilities, active case finding and the capacity to scale up services in hard to access locations remains a critical need i

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 programmes, such as Renk County, staff take extra time and provide additional support for people with disabilities to access health services at the facility. Using standard, globally recognised tools, Medair carries out needs assessments before responding to emergencies. Prioritisation 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 implement, 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 mobilise staff at short notice to assess and/or respond to health emergencies. In 2015 Medair responded to the cholera outbreak in Juba. This project will enable Medair to support cholera preparedness and response activities in 2016 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 prioritised 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 immunisation rates. Medair provides emergency PHC in 2 IDP sites through temporary facilities in Renk County and restoration of a MoH facility that was not functioning and where there was increased population and critical needs. 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 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 to a CEmONC facility in Sudan 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 has been 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 programmes 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 the programme in Renk County is co-funded by OFDA.

5. Complementarity

This project is a continuation of Medair's ongoing emergency PHC 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 in 2016. Medair's CHF 2015 Round 2 health allocation expires at the end of January 2016. Other donor funding secured for Medair's health activities in 2016 include OFDA. Wherever possible, Medair seeks to integrate health programming with nutrition and WASH activities to strengthen the response. For example, in Renk County, Medair fills a critical gap in the provision of multi-sector support across the health, nutrition and WASH sectors. Integration of all CMAM components through supported health facilities in Renk County, including a Stabilisation Centre in Abayok and mobile OTP/TSFP services in hard to reach locations, has increased the impact and scope of Medair's emergency health services. 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 multi-sector team, including nutrition, WASH and NFI. All ERT assessments consider the multi-sector impact of an emergency and wherever possible Medair implements multi-sector responses to have greatest impact on reducing morbidity and mortality. For example, Medair's emergency response in Leer, which commenced in 2015 and is still ongoing, provided emergency response in all 4 sectors and has adapted to developing needs to prioritize the most time critical and life-saving activities.

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.

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	50
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	50

Contribution to Cluster/Sector Objectives : Medair's project is designed to contribute to both of the health cluster objectives. In line with the first objective, Medair will improve access to essential and emergency health care with a focus on women and children, in Renk County and in emergency affected locations through the health emergency response team. In Renk County, Medair will provide PHC including Integrated Essential Child Health Care (IECHC) for the management of the main causes of morbidity and mortality among children under 5, essential PHC drugs and EPI, through both outreach and fixed facilities. Medair will continue to provide nutrition services integrated in PHC, with all components of Community Management of Acute Malnutrition (CMAM), including provision of a Stabilisation Centre for the management SAM with medical complications. This project will also enable Medair will provide antenatal care, skilled delivery, post natal care, SGBV services and continue to facilitate the only effective referral system for emergency obstetric care in Renk County. In locations with IDPs and vulnerable host communities, where PHC has collapsed or is not functioning and particularly in areas where humanitarian access has reopened following intense conflict, such as in Leer County, Medair's emergency response health team will scale up or re-establish PHC services including basic life-saving packages such as IECHC, seek to establish EPI and work towards the full implementation of the Minimal Initial Service Package (MISP), including referral of obstetric emergencies and provision of SGBV services. Where insecurity or other prevailing factors prevent continued presence on the ground, Medair will use alternative emergency response modalities to reach affected populations.

This project will also support the second cluster objective to prevent, detect and respond to epidemic prone disease outbreaks in conflict affected and vulnerable states. In all programme locations, Medair will enhance surveillance using IDSR and EWARNS in all supported locations and facilitate timely reporting. Medair's health emergency response team will have capacity to assess reported outbreaks and act as "First Responders" in a location requiring emergency response following a needs assessment. 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 mobilisation 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.

Outcome 1

People in conflict affected or vulnerable states have increased access to quality lifesaving primary health services, including reproductive health care

Output 1.1

Description

Increased provision, access and utilisation of quality PHC services, including reproductive health, for IDPs and host communities in the conflict affected or vulnerable states

Assumptions & Risks

Security situation remains stable in intervention locations and authorities allow access to locations with vulnerable population. Medair is able to hire qualified staff and to procure and transport essential supplies in a timely manner.

Activities

Activity 1.1.1

Provide emergency primary health services including both preventive and curative care in emergency settings

Activity 1.1.2

Procure and provide emergency PHC supplies and essential medicines according to the MoH Basic Package of Health Services for PHC

Activity 1.1.3

Provide monthly facility based supervision for all clinic staff and conduct monthly exit interviews to assess correct diagnosis and treatment according to IECHC and PHC guidelines

Activity 1.1.4

Provide comprehensive ANC services, including TT, LLIN, IPT, micronutrient supplementation, clean delivery kits

Activity 1.1.5

Provide skilled birth attendance in clinic locations

Activity 1.1.6

Provide RH training on MISP for midwives

Activity 1.1.7

Increase community awareness of SGBV services through trained staff and Care Group implementation

Activity 1.1.8

Provide training in Psychological First Aid for health staff

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	HEALTH	Number of outpatient consultations in conflict affected and other vulnerable states (Men: 13,166; Women: 25,334; Boys: 5,250; Girls: 5,250)					50,000
Means of Verification : Clinic registers and HMIS data							
Indicator 1.1.2	HEALTH	Percentage of cases diagnosed and treated per standardised case management protocols, by sex and age (Target: >85%)					0
Means of Verification : Exit interviews and clinic supervision reports							
Indicator 1.1.3	HEALTH	Frontline # Number of deliveries attended by skilled birth attendants in conflict-affected and other vulnerable states		1,600			1,600
Means of Verification : Clinic and RH registers							
Indicator 1.1.4	HEALTH	Frontline # of health workers trained on safe deliveries	0	20			20
Means of Verification : Clinic training records							
Indicator 1.1.5	HEALTH	Frontline Number of health personnel trained on MHPSS in conflict affected states	10	20			30
Means of Verification : Clinic training records							

Outcome 2

People affected by communicable diseases and outbreaks in conflict affected and other vulnerable states have increased access to emergency health care for vulnerable communities

Output 2.1

Description

Mitigation and response implemented for communicable diseases and outbreaks

Assumptions & Risks

Security situation remains stable in intervention locations and authorities allow access to locations with vulnerable population. Medair is able to hire qualified staff and to procure and transport essential supplies in a timely manner.

Activities

Activity 2.1.1

Conduct rapid health assessments of suspected disease outbreaks and other reported emergencies

Activity 2.1.2

Ensure submission of integrated disease surveillance reporting and promote use of EWARN system in affected locations

Activity 2.1.3

Provide case management responses to disease outbreaks

Activity 2.1.4

Carry-out mass vaccination campaigns in response to vaccine preventable outbreaks

Activity 2.1.5

Implement Behaviour Change Communication for prevention and/or control of outbreak diseases through community mobilization

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 2.1.1	HEALTH	Frontline # of staff trained on disease surveillance and outbreak response	20	20			40
Means of Verification : Clinic training records							
Indicator 2.1.2	HEALTH	Frontline # of children 6 to 59 months receiving measles vaccinations in emergency or returnee situation			5,000	5,000	10,000
Means of Verification : Vaccination tally sheets and report							
Indicator 2.1.3	HEALTH	Frontline # of people reached by health education and promotion before and during outbreaks	7,900	15,800	3,150	3,150	30,000
Means of Verification : Health Promotion and Care Group tally sheets							

Additional Targets :

M & R

Monitoring & Reporting plan

Medair will monitor health programme impact during and after interventions. 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 (using standardised South Sudan MoH, as well as internal Medair checklists) are also maintained by the team. For the ERT interventions, Medair communicates terms of reference before assessment/response and shares post intervention summary reports with the health cluster and partners to disseminate programme impact of the ERT, such as case fatality rates for treatment of outbreak diseases. In case of an outbreak response, daily line listing is provided: 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 manager, technical advisors and managers, based on accessibility of project sites and the ability to measure impact of activities. 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 manager supports the project managers and assumes responsibility for survey design, in consultation with sector advisors at country and HQ levels.

Workplan

Activitydescription	Year	1	2	3	4	5	6	7	8	9	10	11	12
Activity 1.1.1: Provide emergency primary health services including both preventive and curative care in emergency settings	2016		X	X	X	X	X	X					
Activity 1.1.2: Procure and provide emergency PHC supplies and essential medicines according to the MoH Basic Package of Health Services for PHC	2016		X	X	X	X	X	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 according to IECHC and PHC guidelines	2016		X	X	X	X	X	X					
Activity 1.1.4: Provide comprehensive ANC services, including TT, LLIN, IPT, micronutrient supplementation, clean delivery kits	2016		X	X	X	X	X	X					
Activity 1.1.5: Provide skilled birth attendance in clinic locations	2016		X	X	X	X	X	X					
Activity 1.1.6: Provide RH training on MISP for midwives	2016		X	X	X	X	X	X					
Activity 1.1.7: Increase community awareness of SGBV services through trained staff and Care Group implementation	2016		X	X	X	X	X	X					
Activity 1.1.8: Provide training in Psychological First Aid for health staff	2016		X	X	X	X	X	X					
Activity 2.1.1: Conduct rapid health assessments of suspected disease outbreaks and other reported emergencies	2016		X	X	X	X	X	X					
Activity 2.1.2: Ensure submission of integrated disease surveillance reporting and promote use of EWARN system in affected locations	2016		X	X	X	X	X	X					
Activity 2.1.3: Provide case management responses to disease outbreaks	2016		X	X	X	X	X	X					
Activity 2.1.4: Carry-out mass vaccination campaigns in response to vaccine preventable outbreaks	2016		X	X	X	X	X	X					
Activity 2.1.5: Implement Behaviour Change Communication for prevention and/or control of outbreak diseases through community mobilization	2016		X	X	X	X	X	X					

OTHER INFO

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 to be transparent regarding decisions to commence, adapt or complete programmes. ERT assessments include key informant interviews and focus group discussions among community groups to build beneficiary participation into the programme design and evaluation. 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

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 to work in collaboration 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 NNGOs and INGOs 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 access core pipelines to support programme implementation.

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 PHC to fill a critical gap in services where there are emergency health or nutrition needs such as Renk, to support/capacity build partners who are unable to meet the needs in their location, respond to health emergencies or conduct preventative interventions (i.e. vaccinations). Medair will maintain flexibility to use various modes of response according to the context. These include; remote support with emergency provisions to health staff in insecure locations, integrated community case management (iCCM) in hard to reach catchment areas and PHCU provision through temporary of mobile structures. 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 anticipated in the first quarter of 2016. 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. Prepositioning 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
CHD (all locations)	Consultation and coordination in all locations where assessment/project is implemented
IMA (Renk county)	MoH facilities are supported by IMA.
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.
UNICEF, WHO, UNFPA	GIK: vaccines, mosquito nets, tent, RDTs, CDKs, PEP kits

Environment Marker Of The Project

Gender Marker Of The Project

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

Justify Chosen Gender Marker Code

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 wherever possible. 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

Medair seeks to incorporate protection principles through emergency response programming, from assessment and prioritizing health needs to designing and implementing a response. This is done through awareness of protection risks during assessment and the impact an intervention to reduce or exacerbate those risks. Medair will increase access to services and promote safety and dignity through the activities implemented. Despite under-reporting, SGBV is widespread in the conflict affected locations in South Sudan. Medair will seek to provide SGBV services wherever possible and map service providers to enable appropriate referral to another service provider if not a component of the emergency response intervention. Medair will aim to mainstream psychosocial care through emergency health programming, through provision of PFA and to identify and reduce barriers to accessing services for vulnerable groups.

Country Specific Information

Safety and Security

Access

BUDGET

Code	Budget Line Description	D / S	Quantity	Unit cost	Duration Recurrance	% charged to CHF	Total Cost
Staff and Other Personnel Costs							
1.1	Programme Nat. staff	D	58	1,736.35	6	12%	71,724.45
	(4 Care group officer/Assistant, 2 EPI Vaccinator, 2 Health Manager, 2 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 HR Officer, 11 guards, 4 Cleaner/Cook, 2 M&E Officer, 1 Procurement Officer, 1 Admin Assistant)						
1.2	Programme Int. staff	D	17	3,494.39	6	12%	42,307.98
	17 staff (4 Health Manager, 1 Health Advisor, 2 Medical Advisor, 1 ERT MD, 2 ERT Health/Nutrition Project Manager, 2 Logistics Officer/Assistant, 2 Projects Coordinator, 1 Programme Funding Manager, 1 Warehouse Manager, 1 Monitoring & Evaluation Manager)						
1.3	Support base Nat. staff	S	10	1,522.71	6	12%	10,844.74
	10 staff-all allocated as a % to the project (Facilities Officer, Finance Officer, Fleet Manager, Flights Officer, Procurement Assistant, 2 Procurement Officer, Senior Finance Officer, Senior HR Officer, Senior Payroll Officer)						
1.4	Support base Int. staff	S	8	2,577.29	6	12%	14,684.37
	8 (Communications Officer, Country Director, 2 Deputy Country Director, Finance Manager, Human Resources Manager, ICT Officer, Logistics Manager)						
	Section Total						**139,561.54**
Supplies, Commodities, Materials							
2.1	Consumable supplies	D	16	3,492.13	6	12%	39,793.52
	Medicines and medical supplies, ANC cards, Vaccination cards, Stationery, charcoal, sugar, cleaning materials, OPD cards, Box files, Clear sleeves, Clear bags, Printing Cards, Batteries, Pens, Paper						
2.2	Food, soap	D	2	970.96	6	12%	1,383.04
	Food, soap						
2.3	Construction materials	D	2	3,451.05	6	12%	4,915.68
	Basic supplies for building simple local structures e.g. for OPD or for maintaining existing structures						
2.4	Equipment, furniture and accessories	D	14	553.14	6	12%	5,515.25
	Examination couches, Delivery beds, Blood pressure machine, Solar fridges, Stethoscopes, Benches, Chairs, Cabinets, Tables, Solar lamps, Solar Fridge, MSF Dispensary Tent, Boma Tent, Megaphones						
2.5	Incentives and Casual labour	D	17	1,004.23	6	12%	12,158.61
	Dispenser in Pharmacy, 8 Care Group Promoters, Casual repair clinic, casual labor for offloading and erecting tents and cleaning, gardening, gumboots, raincoats, t-shirts, loading offloading cargo, vaccination campaigns						
2.6	Transport	D	7	4,259.32	6	12%	21,234.41
	For medications and supplies, equipment to Field,Transport warehouse-airport-warehouse, Transport of Patients to referral centre						
2.7	Promotion and training	D	23	241.92	6	12%	3,962.79
	Items for demonstration of behavior, ICCM incentive, Care group promoters, training supplies, food for training						
	Section Total						**88,963.30**
Equipment							
3.1	Laptop accessories	D	1	133.38	6	12%	94.99
	IT equipment						
3.2	Cell phone, landline, Thuraya/sat phones	D	3	197.84	6	12%	422.70

	Project communications costs						
3.3	Household, IT, Power, and Communications equipment	S	7	106.82	6	12%	532.54
	Equipment for Medair bases						
	Section Total						**1,050.23**
Contractual Services							
4.1	Surveys & evaluations	D	2	768.90	6	12%	1,095.22
	Contribution to cost of surveys and evaluations to monitor project activities						
4.2	Legal fees	S	3	32.52	6	12%	69.48
	Standard legal fees						
	Section Total						**1,164.70**
Travel							
5.1	Ground Travel	D	5	259.84	6	12%	925.29
	(taxi to and from airport, travel to project site)						
5.2	Ground Travel	S	6	102.28	6	12%	437.06
	(taxi for support managers)						
5.3	Continental flights	D	16	819.98	6	12%	9,343.84
	(for programme staff)						
5.4	Continental flights	S	8	115.82	6	12%	659.90
	(for support managers)						
5.5	Intercontinental flights	D	8	437.84	6	12%	2,494.64
	(home leave for programme staff)						
5.6	Intercontinental flights	S	8	105.03	6	12%	598.42
	(home leave for supportstaff)						
5.7	Rental of vehicle/boat, including fuel and maintenance	D	5	899.09	6	12%	3,201.66
	Rental of vehicle/boat, including fuel and maintenance to support project activities						
5.8	Rental of vehicle/boat, including fuel and maintenance	S	8	420.06	6	12%	2,393.33
	Rental of vehicle/boat, including fuel and maintenance to support project activities						
	Section Total						**20,054.14**
General Operating and Other Direct Costs							
7.1	Office supplies	D	3	247.69	6	12%	529.21
	(cartridges, stationery, paper for the project)						
7.2	Office supplies	S	5	90.16	6	12%	321.06
	(cartridges, stationery, paper for the supporting staff, business cards, label maker)						
7.3	Transport for non-beneficiary goods, conference fees, packaging materials linked to the project, customs fees	D	4	910.33	6	12%	2,593.35
	(Transportation costs for non-beneficiary goods, contribution to conference fees, packaging materials, custom fees)						
7.4	Transport for non-beneficiary goods, conference fees, bank fees	S	3	223.40	6	12%	477.32
	(Transport for non-beneficiary goods, conference fees, bank fees)						
7.5	Communication costs for project	D	3	1,629.11	6	12%	3,480.76

	(Internet, satellite communications)						
7.6	Communication costs for supporting staff	S	3	468.72	6	12%	1,001.47
	(Phone, internet, satellite communications)						
7.7	Visibility material for project	D	5	83.36	6	12%	296.84
	(posters, sign boards, T-shirts, stamps, stickers, billboards)						
7.8	Visibility material for support	S	5	1.23	6	12%	4.38
	(posters, sign boards, T-shirts, stamps, stickers, billboards)						
7.9	Facility maintenance, and supplies	D	9	875.84	6	12%	5,613.96
	(Warehouse maintenance, supplies, generators, water for warehouse, warehouse rent, tables, chairs, beds, mattresses for ERT sites and office)						
7.10	Facility maintenance, supplies, furniture, and utilities	S	6	443.04	6	12%	1,893.20
	(Office, house repairs, electrical repairs, gas, electricity, water)						
7.11	Office equipment maintenance, security supplies, training, maintenance	D	6	290.56	6	12%	1,241.62
	(Warehouse security maintenance, computer/Thuraya repair)						
7.12	Office equipment maintenance, security supplies, training, and maintenance	S	8	164.86	6	12%	939.31
	(locks, batteries, fire alarms, fire extinguishers)						
7.13	Rent costs for responding sites	D	1	10,098.08	6	12%	7,191.85
	Cost of rent for responding sites						
7.14	Office rent for support base	S	1	5,610.21	6	12%	3,995.59
	Cost of rent for support base						
	Section Total						**29,579.92**
SubTotal			316.00				**280,373.83**
Direct							241,521.66
Support							38,852.17
PSC Cost							
PSC Cost Percent							7%
PSC Amount							19,626.17
Total Cost							**300,000.00**
Grand Total CHF Cost							**300,000.00**

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	20						
Unity	20						
Upper Nile	20						
Upper Nile -> Renk	40						

Documents

Category Name	Document Description
Project Supporting Documents	Estimated health supplies for CHF 2016.docx