# South Sudan
# 2012 CHF Standard Allocation Project Proposal

*Proposal for CHF funding against Consolidated Appeal*

For further CHF information please visit http://unocha.org/south-sudan/financing/common-humanitarian-fund
or contact the CHF Technical Secretariat chfsouthsudan@un.org

This proposal shall be submitted by cluster partners in two stages to the Cluster Coordinators and Co-coordinators for each project against which CHF funds are sought. In the first stage, before cluster defenses, applying partners fill sections I and II. The proposal should explain and justify the activities for which CHF funding is requested and it is intended to supplement information already available in the CAP Project Sheets. The proposals will be used by the cluster Peer Review Team in prioritizing and selecting projects for CHF funding during CHF Standard Allocation round. In the second stage projects recommended for funding by the CHF Advisory Board must complete Section III of this application and revised/update sections I and II if needed. Partners should also fill and submit to cluster coordinator/ co-coordinator the CHF Allocation Matrix (Excel template).

## SECTION I:

| **CAP Cluster** | **Health** |
|---|---|

**CHF Cluster Priorities for 2012 First Round Standard Allocation**
This section should be filled by the cluster Coordinators/Co-coordinators before sending to cluster partners. Provide a brief articulation of Cluster priority activities and geographic priorities that the cluster will recommend for funding from the CHF.

| **Cluster Priority Activities** | **Cluster Geographic Priorities** |
|---|---|
| ➢ Continuation of basic frontline services in high risk counties<br>➢ Increased emergency preparedness activities<br>➢ Continuation of support for agencies able to provide surge capacity | High risk/hotspot counties |

**Project details**
The sections from this point onwards are to be filled by the organization requesting for CHF.

**Requesting Organization**

Medair South Sudan

**Project CAP Code**

SSD-12/H/46305/5095

**CAP Project Title**

Preparedness and response to health related emergencies in South Sudan and provision of basic health care to vulnerable communities in selected states of South Sudan

**Project Location(s)** (list State, County and if possible Payam where CHF activities will be implemented)

All 10 states, with a full-time presence in Awerial County of Lakes State and Renk County of Upper Nile State.

Upper Nile – 30%
Lakes State – 20%
Jonglei – 15%
Unity – 15%
Warrap – 10%
NBeG – 10%

Medair's response is flexible based on emergency needs regardless of location. These estimates are based on where emergency needs are predicted for 2012, and where Medair's emergency teams have responded in 2011.

| **Total Project Budget in South Sudan CAP** | **Amount Requested from CHF** | **Other Resources Secured** |
|---|---|---|
| US$ 3,690,000 | US$ 500,000 | US$ 897,000 |

| **Direct Beneficiaries** | |
|---|---|
| Women: | 7,430 |
| Men: | 3,710 |
| Girls: | 7,430 |
| Boys: | 7,430 |

Total: 26,000 (CHF portion only, not CAP)

**Total Indirect Beneficiary**

50,000

**Catchment Population (if applicable)**

**Implementing Partners** (Indicate partners who will be sub-contracted if applicable and corresponding sub-grant amounts)

**Project Duration** (max. of 12 months, starting from allocation date)

**Start Date (mm/dd/yy):** 03/10/12

**End Date (mm/dd/yy):** 03/09/13

| Address of Country Office | Address of HQ |
|---|---|
| Project Focal Person: Sonja Nieuwenhuis/Trina Helderman<br>Email & Tel: medical-southsudan@medair.org & +211917158914 or +211920433585<br>e-mail country director: cd-southsudan@medair.org<br><br>e-mail finance officer: finance-southsudan@medair.org<br>Address: Hai Matar, Airport View, Juba, South Sudan | e-mail desk officer: Helen.Fielding@medair.org<br>e-mail finance officer: Angela.Rey-Baltar@medair.org<br>Address: Chemin du Croset 9<br>CH-1024 Ecublens, Switzerland |

## SECTION II

### A. Humanitarian Context Analysis

Briefly describe (in no more than 500 words) the current humanitarian situation in the specific locations where CHF supported activities will be implemented. Provide evidence of needs by referencing assessments and key data, including the number and type of the affected population[1]

In 2012, South Sudan remains severely impacted by the legacy of two long civil wars and continued inter-tribal conflict. According to the OCHA South Sudan Weekly Humanitarian Bulletin from February 17th, it stated that the humanitarian community continues to contend with multiple emergencies, with responses to help 136,500 people affected by inter-communal fighting in Jonglei State, over 120,000 refugees in Upper Nile and Unity states are fleeing fighting in Sudan with on-going bombardments on the border. Changes in status of the South Sudanese in Sudan are predicting to lead to an additional mass influx of 500,000 returnees. These factors have compounded existing health system vulnerabilities with poor staffing resources and frequent drug stock outs, putting thousands of South Sudanese at risk during the first year of statehood.

There is limited local capacity to respond to health emergency needs and deliver basic services therefore, its paramount that front-line health services are maintained particularly in potential hotspot areas for returnees. Humanitarian organizations are currently providing more than 80% of all emergency health services in South Sudan and are expected to continue in 2012.

South Sudan continues to have some of the worst health parameters in the world. The Sudan Household Health Survey (SHHS) in 2006 indicated an infant mortality rate of 102/1000 live births and under-five mortality at 135/1000 live births. Childbirth also poses grave dangers with a Maternal Mortality Ratio (MMR) of 2054/100,000 live births (SHHS 2006). Few women deliver in health facilities and only 16.4% of women attend at least one antenatal care visit (SHHS 2006). Health seeking behaviors of families are also minimal and at any given time, 45.5% of children have a fever, but only 3.4% receive treatment (SHHS 2006).

An ongoing need for emergency health care continued to be evident in 2011. Cases of acute watery diarrhoea were reported among men and women in different age groups, specifically in populations of IDPs and returnees. The MoH noted that 1243 cases of measles had been reported by September 16th reaching all 10 states of the republic (Measles update, Health Cluster, Sept 2011). This outbreak could have been expected, with only 10% of the children under 5 years having access to routine immunizations (SHHS 2006). Further outbreaks can be anticipated for 2012 with continued large population influxes from the north and IDPs due to conflicts moving in the south; however, prevention is possible with improved vaccination coverage for all boys and girls under the age of 5 years.

Common diseases such as diarrhoea, respiratory tract infections, and malaria remain prevalent throughout the country, but facility utilization rates have intensified due to forced people migration with conflicts and the influx of returnees. In late 2011, health workers observed unprecedented caseloads of malaria felt to be due to normal fluctuations in malaria epidemiology normal outbreak curves, but also increases in less immune returnee and refugee populations. Though malaria is common in South Sudan, limited training of clinical staff and drug stock outs have led to prolonged outbreak as well as higher than desired case fatality rates. Neglected tropical diseases also run rampant in South Sudan including visceral leishmaniasis. Over 5,000 people were treated for kala azar last year in the peak of the outbreak. It is anticipated that cases will continue into the next biting season and may be higher than expected as the parasite continues to move westward into less immune areas.

Case management of common diseases continues to need strengthening; for example, in Renk (Upper Nile) and Awerial (Lakes), boys and girls under 5 presenting with diarrhoea were given oral rehydration salts only 50.2% and 56% of the time respectively. Supervision and direct clinical training of health staff in the proper management of diseases would improve quality of care and lead to diminished morbidity and mortality. Many communities remain with limited health care access averaging 14,000 people to a single primary health care unit, generally staffed by only a community health worker (SHHS 2006). When facilities are present, often drug stocks and supplies are minimal due to logistical difficulties and remote locations. Assisting facilities to establish base line services through provision of equipment, supplies, and training of staff in proper record keeping and data collection will strengthen the health system and provide patients access to basic and essential services including antenatal care for pregnant women, preventive care with immunizations for boys and girls under 5 years, and curative care for men, women, and children.

[1] To the extent possible reference needs assessment findings and include key data such as mortality and morbidity rates and nutritional status, and how the data differs among specific groups and/or geographic regions. Refer situation/data/indicators to national and/or global standards.

**B. Grant Request Justification**
Briefly describe (in no more than 500 words) how proposed activities support the agreed cluster priorities and the value added by your organization

Medair implements an on-going emergency health preparedness and response programme in South Sudan that provides life-saving services in areas at high-risk and with high number of displaced, refugees and returnees. Medair works to provide access to health services to the most vulnerable people affected by emergencies such as conflict, displacement, disease and malnutrition.

In 2011 and early 2012, health emergency responses have been conducted in response to influxes of refugees and returnees in Yida and Rubkona counties in Unity State, returnees in Renk County in Upper Nile State, and IDPs due to intertribal violence in Pibor County, Jonglei State. Medair's rapid health response has provided life-saving health services in each of these emergencies. In 2012, Medair will be able to respond to emergencies in any of the health cluster priority "hot spots" in South Sudan experiencing acute health emergencies including the control and spread of communicable diseases, outbreak response, and disease surveillance.

Medair also works to support the Government of South Sudan and other relevant authorities in emergency response capacity at all levels. Medair works to build the capacity of fragile primary health care units and MoH staff to prepare and respond to health emergencies and will conduct training in disease surveillance, outbreak response, case management and reporting systems. Medair is running year-long programmes in areas with existing poor health status – and potential for influxes of returnees and IDPs. This is in accordance with the strategic aims of the health cluster as stated in the CAP health objectives for 2012 – " to maintain the existing safety net by providing basic health packages and emergency referral services".

Medair's primary health care programme supports fragile health facilities in Renk, Upper Nile State and Awerial, Lakes State with a focus on assisting the facilities to establish base line services through provision of equipment, supplies, and training of staff in proper record keeping, data collection, disease surveillance and outbreak response. This is in line with the second health cluster CAP objective - to strengthen the health system and their capacity to respond to potential emergencies and provide patients access to basic and essential services including antenatal care for pregnant women, preventive care with immunizations for boys and girls under 5 years, and curative care for men, women, and children. Medair will look to add new programming in acutely vulnerable communities in 2012 – also supported in part by CHF funds.

Medair desires to work in conjunction with local partners and specifically the Ministry of Health to ensure longer-term sustainability. Indirect costs are minimized by supporting existing facilities and staff and empowering them to respond to emergencies in the future. The Medair emergency response team works with minimal mobile base needs and often partners with other NGOs to share bases and transport costs such as in Pibor county. Medair's health teams are comprised mostly of national staff with few ex-patriate supervisors limiting costs for salaries, flights, and other overhead expenses.

Medair emergency interventions demonstrate 'value for money' and good benefit-cost returns because the emergency health responses are prioritized to areas with large population needs. Temporary and mobile clinics will be established in locations to cover the largest catchment area and coverage for the population limiting the need for additional facilities. The implementation of vaccination campaigns in response to outbreaks or large influxes of the population require small staffing costs, but directly benefit thousands of beneficiaries within a short period of time.

**C. Project Description (For CHF Component only)**

**i) Purpose of the grant**
Briefly describe how CHF funding will be used to support core humanitarian activities

The overall purpose of the grant is to support Medair's health activities. The specific purpose is to assess and respond to health related emergencies and communicable diseases; implement rapid emergency response activities in prioritized states in South Sudan and provide support for communities at risk of acute emergency situations.

**ii) Objective**
State the objective/s of the project. Objective/s should be specific, measurable, achievable, relevant and time-bound (SMART)

Assess and respond to health-related emergencies across South Sudan including communicable disease outbreaks, population movements and disasters and provide basic primary health care to vulnerable populations in selected states for 2012.

**iii) Proposed Activities**
List the main activities to be implemented with CHF funding. As much as possible link activities to the exact location of the operation and the corresponding number of direct beneficiaries.

The following health emergency preparedness and response activities will be implemented using CHF funding:

1. Investigate two to four health emergencies in South Sudan through meeting with community representatives (men/women/youth), health staff, direct observations and from medical records analysis (disaggregated by sex and age).
2. Respond to three or more health emergencies which could include disease outbreaks or provision of health care in areas of large people displacements providing diagnostic and curative care to men, women, boys, and girls in South Sudan.
3. Provide 23 male and 10 female health staff with emergency preparedness and emergency response training in areas of large people movements or outbreaks in South Sudan.
4. Provide integrated disease surveillance and outbreak response training to health staff within Medair-supported facilities.
5. Ensure rapid access to essential drugs and supplies required to respond to the common health emergencies in South Sudan paying specific attention to the needs of men, women, and children.
6. Deliver health promotion messages to both men and women in dealing with (immediate) health threat
7. Contribute weekly and monthly reports on IDSR, EWARN, and DHIS at Medair facilities.
8. Partner with the Ministry of Health within the EP&R task force to monitor outbreak prone diseases and participate in response planning.
9. Appoint a UN-OCHA secondee to facilitate emergency response within South Sudan as a health cluster focal point in the organization.

The above 1-8 activities take place in Renk County, Upper Nile State and Ayod County, Jonglei state and any of the 10 states in the case of an acute health emergency, expected to be primarily in health cluster "hot spots" states. CHF funds will cover approximately 14,000 beneficiaries though the above activities.

Basic primary health care support to acutely vulnerable communities and in areas at high risk with high number of displaced, refugees and returnees (Renk, Awerial, and new vulnerable communities to be determined):

1. Support implementation of the basic health package in selected counties, including health facility rehabilitation, provision of basic medical equipment, drugs, EPI, reproductive health, medical supplies and disease surveillance,
2. Establish reproductive health services at all supported primary health care facilities, including antenatal and postnatal services, distribution of clean delivery kits to pregnant women attending antenatal care,
3. Establish EPI services, including training of vaccinators and establishing outreach services, in selected health facilities,
4. Provide bi-annual training for male and female health care providers in supported health facilities, including IECHC/IMCI training,
5. Provide a basic training to reproductive health staff , including danger signs in pregnancy, clean delivery practices and referrals,
6. Distribute LLINs to all pregnant women attending antenatal care and boys and girls completing DPT3.
7. Provide monthly supervision visits to all supported health facilities,
8. Provide trainings on integrated disease surveillance (IDSR) for health care, involve county health department (CHD) in the selection process to include men and women.

The above activities take place in Renk County, Upper Nile State (50,000 direct beneficiaries – calculated separately from emergency response programme beneficiaries expected in Renk town) Awerial County, Lakes (25,000 direct beneficiaries), and a yet to be determined new project site (estimated 21,000 direct beneficiaries). The new project site will target vulnerable areas in border states or high-risk communities. CHF funds will cover approximately 12,000 of these beneficiaries.

### iv). Cross Cutting Issues

Briefly describe how cross-cutting issues are taken into consideration (i.e. gender, environment, HIV/AIDS)

**Gender**

During assessments of health related emergencies, the special needs of men, women, girls and boys will be identified. Men and women will be consulted in the design, implementation and evaluation of the programmes to ensure their needs are taken into account. Medair will utilize both men and women from the local communities to staff health facilities and implement emergency interventions.

**Environment**

Medair strives to implement activities which have as little detrimental impact on the natural environment as possible. During health related interventions Medair trains health workers in appropriate medical waste management. Health promotion is also directed at environmental issues, Medair strongly promotes the use of clean water and proper sanitation habits, through health and hygiene promotion activities at all levels in the community.

**HIV/AIDS**

During interventions, Medair trains relevant staff in universal precautions. 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.

### v) Expected Result/s

List below the results you expect to have at the end of the CHF grant period, and provide no more than five indicators you will use to measure the extent to which those results will have been achieved. At least three of the indicators should be out of the cluster defined Standard Output Indicators.

• Effective and timely response delivered for health related emergencies including disease outbreaks, people displacements and disasters involving women, men, girls and boys,
• Trainings (including emergency preparedness and response and IDSR trainings) are provided to a selected health cadre of men and women on disease surveillance, appropriate management of common illnesses, and reproductive health.
• Health and hygiene promotion and capacity building activities are delivered to men and women to prevent deterioration of existing and potential emergencies,
• Health workers are trained in a manner that promotes on-going programming and sustainability of services after Medair's exit.
• Men, women, boys and girls have access to quality preventive and curative Primary Health Care services in line with the basic health care package in locations where services are otherwise not available.

| | Indicator | Target (indicate numbers or percentages) |
|---|---|---|
| 1 | Number of health emergencies responded to | 3 |
| 2 | Number of direct beneficiaries of health interventions (including patients and trainees) | Women- 7,430<br>Men- 3,710<br>Girls- 7,430<br>Boys- 7,430 |
| 3 | Number of <5 consultations (male and female) | Girls- 4,458<br>Boys- 4,458 |
| 4 | Number of health workers trained in MISP / communicable diseases / outbreaks / IMCI / CMR | No. of trainees:<br>18 health care workers trained in MISP/communicable diseases / outbreaks / IMCI / CMR<br>10 TBAs trained |
| 5 | | |

**vi) Implementation Mechanism**

Describe planned mechanisms for implementation of the project. Explain if it is implemented through implementing partners such as NGOs, government actors, or other outside contractors.

Medair directly implements the program activities and strives to build capacity of local partners and link programming with longer term sustainability. Medair has established bases, staff and resources in place to successfully implement the activities, given adequate funding. Medair has an emergency response team of Health Managers, Nutritionist, logisticians and Community Liaison Officers. Medair ctively participates in OCHA's regular emergency response meetings, Health cluster meetings and conducts assessments on which it bases the decision to respond.

In Renk and Awerial counties, CHF-supported activities will contribute to the ongoing Medair projects which, support MoH delivery of primary health care services in line with the Basic Package of Health Services. Medair staff will work in collaboration and coordination with Renk and Awerial County Health Departments to provide: supportive supervision of health facilities, in-service and formal training for health facility staff and community volunteers; medicines to supplement the MoH supply; and maintenance of health facilities as required.

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.

**vii) Monitoring Plan**

Describe how you will monitor progress and achievements of the project.

Progress towards project objectives are monitored internally through supervision visits, and regular collection & analysis of essential health data varying from daily outbreak line listing reports to monthly clinic morbidity and mortality data. Medair also utilises monthly situation reports by Medair management including Medair's Country Director and Monitoring & Evaluation Officer. Medair will conduct a minimum of two post-intervention assessments. This may include qualitative or quantitative follow-ups such as focus groups or household surveys. Interventions targeted for follow-up will be determined by the Monitoring and Evaluation Officer and managers, based on accessibility of project sites and the ability to measure impact of activities. A summary report will be written and disseminated for each post-intervention assessment.

Follow-up assessments for health may include measuring immunization coverage rates or qualitative and quantitative evaluations of supported health facilities. For health 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.

Medair will use Lot Quality Assurance Sampling (LQAS) methodology to conduct household surveys to guide or evaluate interventions at the discretion of the Monitoring and Evaluation Officer and management. This methodology has been successfully used in other programmes in South Sudan and will be introduced in the emergency response programme when appropriate.

Project Managers and team leaders are responsible for monitoring of activities 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 Project Coordinators are responsible for ensuring quality of interventions, through oversight of the Programme Managers and field visits. In addition, the Medair Medical Advisor provides technical input and quality assurance for project activities. The Monitoring and Evaluation Officer assumes responsibility for tracking all required indicators and for survey design, in consultation with the Health & Nutrition Advisors at country and HQ levels.

**E. Committed funding**

Please add details of committed funds for the project from other sources including in-kind supports in monetary terms (USD)

| **Source/donor and date (month, year)** | **Amount** (USD) |
|---|---|
| ECHO | 174,000 |
| OFDA | 495,000 |
| SIDA | 228,000 |

## SECTION III:

**This section is NOT required at the first submission of a proposal to the cluster coordinator/co-coordinator. However it is required to be filled for proposals recommended for funding by the Advisory Board.**

| **LOGFRAME** | | | |
|---|---|---|---|
| **CHF ref. Code: SSD-12/H/46305/5095** | **Project title: Preparedness and response to health related emergencies in South Sudan and provision of basic health care to vulnerable communities in selected states of South Sudan** | **Organisation: Medair** | |

| | | | |
|---|---|---|---|
| • To reduce morbidity and mortality in communities affected by emergencies and acutely vulnerable communities in South Sudan. | | | |
| **Specific Project Objective/s:**<br>• To assess and respond to health related emergencies and communicable diseases; implement rapid emergency response activities in prioritized states in South Sudan and provide support for communities at risk of acute emergency situations. | **Indicators of progress:**<br>• Number of Emergency Assessments Completed<br>• Number of Emergency Interventions Completed<br>• Number of primary health care facilities supported in communities at-risk for acute emergencies supported | **How indicators will be measured:**<br>• Assessment Reports<br>• Intervention Reports<br>• Health facility records/HMIS | **Assumptions & risks:**<br>• Medair is able to secure co-funding needed to meet all targets<br>• Cooperation among relevant RoSS Ministries (Central, State and County), local authorities, UN agencies and NGOs<br>• No major changes in logistical conditions in South Sudan or surrounding countries.<br>• Staff are able to obtain work and travel permits and visas<br>• Poor localised security and/or infrastructure which impair air, road and river access to actual and/or potential project sites. |
| **Results - Outputs (tangible) and Outcomes (intangible):**<br>• Potential emergencies are assessed for health needs and responded to effectively<br>• Access to quality preventive and curative Primary Health Care services provided to emergency-affected and vulnerable populations | **Indicators of progress:**<br>• 80% of emergency assessments started within 3 working days of the decision to assess<br>• 80% of emergency interventions started within 5 working days of the decision to intervene<br>• Number of direct beneficiaries of health | **How indicators will be measured:**<br>• Health facility records/HMIS<br>• Health facility consultation records<br>• Assessment Reports<br>• Intervention Reports<br>• Training attendance sheets<br>• Health facility registers | **Assumptions & risks:**<br>• Timely and adequate provision of drugs and supplies by partners, including MoH, WHO, UNICEF, UNFPA and WFP<br>• There is good provision of accurate and timely |

| | | | |
|---|---|---|---|
| • Medical staff are trained to respond to critical issues in emergency-affected and at-risk communities | interventions (including patients and trainees)<br>• Number of <5 consultations (male and female)<br>• Number of health workers trained in MISP / communicable diseases / outbreaks / IMCI / CMR | • Pre- and post-intervention data | information by counterparts and partners on the ground to facilitate interventions. |
| **Activities:**<br>• Carry out health assessments<br>• Respond to health emergencies which could relate to disease outbreaks, mass displacement or returnees<br>• Support implementation of the basic package of health services in targeted primary healthcare facilities<br>• Establish reproductive health services at supported primary health care facilities, including antenatal and postnatal services,<br>• Establish EPI services in selected health facilities<br>• Contribute weekly and monthly reports to national reporting mechanisms - IDSR, EWARN, and DHIS<br>• Deliver health promotion messages to both men and women in dealing with acute health concerns<br>• Distribute LLINs to all pregnant women attending antenatal care and boys and girls completing DPT3<br>• Train local health staff in emergency preparedness and response<br>• Train local health staff in integrated disease surveillance and outbreak response<br>• Train local health care providers in IECHC/IMCI<br>• Train reproductive health staff, including danger signs in pregnancy, clean delivery practices and referrals | **Inputs:**<br>• Transport; accommodation and food; training fees<br>• Incentives for health facility staff<br>• Training materials, equipment, and venue; transport; accommodation and food for participants.<br>• Rehabilitation materials and labour costs<br>• LLITNs (gift in kind or procured); storage and transport<br>• Clean delivery kits (gift in kind or procured); storage and transport<br>• Therapeutic and supplementary food (gift in kind or procured); storage and transport.<br>• Medicines (gift in kind or procured); inpatient food (gift in kind)<br>• Drug and medical storage, cold chain and transport.<br>• Project Staff – Health Managers, Project Managers, team leaders, PHC supervisors, etc | | |

## PROJECT WORK PLAN

This section must include a workplan with clear indication of the specific timeline for each main activity and sub-activity (if applicable).
The workplan must be outlined with reference to the quarters of the calendar year.

| ***Activity*** | **Q1 / 2012** | | | **Q2 / 2012** | | | **Q3 / 2012** | | | **Q4 / 2012** | | | **Q1. / 2013** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
| **Result 1 - Potential emergencies are assessed for health needs and responded to effectively** | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Activity (1.1) Carry out health assessments | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Activity (1.2) Respond to health emergencies – relating to disease outbreaks, mass displacement or returnees | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| | | | | | | | | | | | | | | | |
| **Result 2 – Access to quality preventive and curative Primary Health Care services provided to emergency-affected and vulnerable populations** | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Activity (2.1) Support implementation of the basic health package in targeted primary healthcare facilities | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Activity (2.2) Establish reproductive health services at supported primary health care facilities, including antenatal and postnatal services, and distribution of clean delivery kits to pregnant women attending antenatal care | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Activity (2.3) Establish EPI services in selected health facilities | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Activity (2.4) Contribute weekly and monthly reports to national reporting mechanisms - IDSR, EWARN, and DHIS | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Activity (2.5) Deliver health promotion messages to both men and women in dealing with acute health concerns | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Activity (2.6) Distribute LLINs to all pregnant women attending antenatal care and boys and girls completing DPT3 | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| | | | | | | | | | | | | | | | |
| **Result 3 – Medical staff are trained to respond to critical issues in emergency-affected and at-risk communities** | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Activity (3.1) Train local health staff in emergency preparedness and response | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Activity (3.2) Train local health staff in integrated disease surveillance and outbreak response | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Activity (3.3) Train local health care providers in IECHC/IMCI | | | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Activity (3.4) Train local reproductive health staff, including danger signs in pregnancy, clean delivery practices and referrals | | | x | x | x | x | x | x | x | x | x | x | x | x | x |

*: TIMELINE FOR EACH SPECIFIC ACTIVITY MUST BE MARKED WITH AN X AND SHADED GREY 15%