Project Proposal

Organization	WHO (World Health Organization)			
Project Title	Provision of immediate lifesaving health services among vulnerable groups, and response to communicable disease outbreaks and other health related emergencies in the fronline counties			
Fund Code	SSD-15/SA1/H/UN/356			
Cluster	**Primary cluster**: HEALTH; **Sub cluster**: None			
Project Allocation	1st Round Standard Allocation		Allocation Category Type	Frontline services
Project budget in US$	300,007.24		Planned project duration	6 months
Planned Start Date	01/01/2015		Planned End Date	30/06/2015
OPS Details	OPS Code	SSD-15/H/73137	OPS Budget	0.00
	OPS Project Ranking		OPS Gender Marker	
Project Summary	This project will compliment the technical aspect of WHO response to the current emergency with focus on epidemic response and provision of other frontline services like provision of life saving surgery, emergency primary health care, support to outbreak response, mobile clinics and will further support the health cluster to perform its role as provider of last resort			

Direct beneficiaries

	Men	Women	Boys	Girls	Total
Beneficiary Summary	29355	28203	26031	25011	**108,600**
Total beneficiaries include the following:					
Children under 5	0	0	11631	11175	22806
People in Host Communities	0	0	0	0	0
Internally Displaced People	29355	28203	0	0	57558
People in Host Communities	14400	13836	0	0	28236

Indirect Beneficiaries		Catchment Population	
Link with the Allocation Strategy	The project will contribute to the three health cluster objectives by ensuring lifesaving supplies are available and easily accessed to respond to common but potential fatal illness. Communicable disease account for more 80% of the mortality and morbidity in the population and hence strengthening the capacity of the health system to control and prevent this avoidable mortality is paramount. The CHF funding will be used to enhance the emergency preparedness and response capacity at state, county levels in order to reduce morbidity and mortality associated with humanitarian emergencies and mitigate the impact of the emergencies by having a quick and prompt response. Main components to be supported through the CHF funding include support to strategically prepositioning of inter-agency emergency kits, stand alone emergency medical supplies including specialize kala azar drugs. Other activities include conducting rapid health assessments, distribution and transportation of the life saving drugs, capacity building activities for emergency preparedness and response activities, health cluster coordination activities, health information systems in emergencies, prompt deployment of trained and competent technical officers and technical support to the health cluster members in areas regarding emergency preparedness and response. These funded components will improve and increase the preparedness and response levels of the health cluster and as such will reduce the negative impact of the emergencies on the health of the affected population. Special attention will be directed towards the special needs of the elderly, children, women, disabled, and returnees, IDPs, refugees and people living with HIV/AIDS		
Sub-Grants to Implementing Partners		Other funding Secured For the Same Project (to date)	

Organization focal point contact details

Name	Title	Phone	Email
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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

Humanitarian operations in South Sudan remain precarious, complex, expensive and challenging. During the rainy season over 60% of the country is inaccessible because of either flooding or the continuing conflict, which hampers humanitarian access and increases the cost of implementing emergency operations. This is exacerbated by very fragile health systems (lack of skilled staff, supplies and equipment, leadership, etc. at all levels) that have further affected the humanitarian response. Although over 3.8 million people will need emergency health services in 2013, only 40% of the population has access to health services (MOH 2011).

Since December 2013, heavy fighting in South Sudan has driven over 1.4 Million people into displacement sites and with renewed tensions its estimated that more displacements will be realized. Tribal conflict continues to be one of the major causes of internal displacement. Over 110,000 people still remain displaced from Abyei in North Warrap and Agok areas.

Communicable diseases remain prevalent in South Sudan, and appear to be on the increase including a re emergence of vaccine preventable diseases (i.e. measles, polio, & meningitis). The high number of clinical malaria (81% of IDSR data) cases in the states of Warrap, Northern Bahergazel, Unity and remote counties is linked to poor health conditions, environmental conditions, & lack of vector control. Acute respiratory infections & bloody diarrhea are the leading causes of morbidity, especially among children under five. Over 5214 cases of Khalazar(CFR 3.1%) have been recorded to date and the trends continue to rise A cholera outbreak was declared on 15 May in Juba. It later spread to the states of Upper Nile and Eastern Equatorial State (still having active transmission). A total of 6141 cases (CFR 2.29%) were recorded and this had immense presser on the existing health services. Malaria remains a major public health problem causing high morbidity and mortality, while the acute water diarrheal and measles incidence increased since the beginning of the year to date as compared to the previous years. The current kala azar epidemic continues to threaten thousands of lives of people in the states of Upper Nile. Jonglei, Unity and Eastern Equatorial, and the cases are on the rise since 2009.

There are glaring gaps in life-saving medical and surgical interventions. From January to November 2014,over 7710 casualties of gun short wounds have been managed in health facilities with continued support of WHO. The State hospitals continue to be overburdened and are not in position to cope up with trauma surge as their capacity to handle mass casualties is in dire need to be strengthened.

The emergency health needs of the populations of humanitarian concern continue to rise due to the population explosion, coupled with malnutrition and poor sanitation conditions especially in the critical states of Lakes, Warrap, Upper Nile, Unity, Jonglei and Northern Bahr El Gazel(which bear the highest burden of IDPs, refugees, returnees and other vulnerable segments (such as children and women of childbearing age, who account for 25% of the population) . This has stretched the already fragile health system that face an enormous task of coping with the increasing need for life saving emergency health services and as such it is of utmost importance that the cluster lead for health has adequate funds to support front line services especially in time when WHO has to perform its role as a provider of last resort and hense respond to any potential emergencies.

2. Needs assessment. Explain the specific needs of the target group(s), explaining existing capacity and gaps.

The crisis in South Sudan has caused a major public health crisis with extensive disruption of essential primary and secondary health care services. As of July 2014 only 41% of health facilities in Unity were functioning, 57% in Upper Nile and 68% in Jonglei. 184 of 425 health facilities in conflict-affected states are not functioning. This also hampers preventative care including vaccination campaigns, malnutrition screening and antenatal care

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)	The Health situation in the Republic of South Sudan is fragile and the recent crisis in South Sudan has caused a major public health crisis with extensive disruption of essential primary and secondary health care services. Healthcare coverage across the country is poor with only 40% estimated able to access health care within in 5km radius; Access to health care is variable throughout the country ranging from 34,807 persons per facility (Eastern Equatoria State) to 4000 persons per facility (Western Bahr el Ghazal) and is further hindered by geographical constraints and poor transport infrastructure. Only 1 person out of 5 utilizes health care facilities per year (SPHERE standard is one consultation per person per year). The health sector budget as a proportion of the national budget has declined from 7.9% in 2006 to about 4.2% in 2014. Following the crisis , only 41% of health facilities in Unity were functioning, 57% in Upper Nile and 68% in Jonglei. 184 of 425 health facilities in conflict-affected states are not functioning. This also hampers preventative care including vaccination campaigns, malnutrition screening and antenatal care Health Cluster CAP partners provide at least 80% of countrywide services and consultations. Transition in health sector funding mechanisms which started in 2012 will continue into 2015, and until full implementation is completed gaps in support for basic health care are anticipated to continue further worsening access to health care. Infant Mortality Rate (IMR) and under-five Mortality Rate (UMR) are very high at 102 per 1000 live births and 135 per 1000 live births, respectively. South Sudan has one of the highest Maternal Mortality Rates (MMR) in the world, estimated at 2054/100,000 live births. Although close to 46.7% of pregnant women attend at least one ANC visit, only 14.7% of deliveries are attended by skilled health professionals Communicable diseases remain a concern in the country due to various predisposing factors. These include poor sanitation, shortage of water, crowded living conditions, malnutrition, and poor immunity, with young children and pregnant women particularly vulnerable. The situation is compounded by gaps in the EWARN coverage and low routine vaccine coverage (26% DPT 3 coverage according to official estimates). Outbreaks of cholera and kala-azar have affected some 6,100 and 4,100 people respectively so far in 2014. The pattern is likely to continue in 2015 given the prevalence of predisposing factors. Other common threats to people's health include acute respiratory infections, acute watery diarrhea, malaria, malnutrition and measles. The country being in the meningitis belt of Africa, the dry season may see outbreaks of meningococcal meningitis Due to weak logistic systems, poor infrastructure, and environmental access constraints, distribution of drugs to health facilities is often challenging, resulting in ruptures at facility level. During period of transition there is concern that the new drug procurement system will not be available in time to ensure a continued supply. Upsurge in malaria cases, and improved case reporting have reflected insufficient antimalarials in country, resulting in emergency procurement of anti malarial supplies to ensure treatment capacity. Health partners are often called upon to mobilize and assist during extraordinary efforts to help in procurement as well as transport and distribution.
3. Description Of Beneficiaries	This is a proprtion of the target group stipulated in the SRP.A total of 108600 beneficiaries will be targeted of which 55,386 will be of the female sex. These are a fraction of the target population form the health cluster response plan based on the estimated utilization rate of the previous years. its estimated that 40% of the vulnerable groups will attend OPD consultations and will benefit from the pipeline supplies. In addition to this 51,042 children will be targeted by the response for treatment of common illnesses, measles vaccination and other life saving interventions. All the targeted beneficiaries will, through the health partners access life saving supplies at the OPD installments in the areas hosting populations of humanitarian concern
4. Grant Request Justification.	WHO continues to play a key role in the coordination of health services and as such this will remain a critical function given the fact that a considerable number of emergencies continues to be in play. Adequate preparedness including training of health personnel on health in acute emergencies including basic surgical and trauma skills, communicable disease in emergencies, health facility preparedness and standard operating procedures is key in ensuring appropriate response and timely surge capacity. The health cluster being one of the largest in Southern Sudan requires a strong and consistent coordination mechanism both at central and state level and requires strong support and resources to ensure that the humanitarian strategy for health is rolled out Effective emergency preparedness and response is critical in mitigation and reducing the impact of humanitarian emergencies on the vulnerable population In South Sudan, the Ministry of Health has very limited capacity to manage public health risks and reduce morbidity and mortality for common epidemic prone diseases. Evidence also has it that, immediate availability of up to data and reliable information on health risks, vulnerability, morbidity, mortality and other health indicators is essential in order to assess and monitor developments in complex emergency settings, as well as to evaluate the impact of actions taken. There is therefore urgency to strengthen preparedness through prepositioning of supplies and training of the core teams to respond. Trauma and surgical kits, Diarrhea Disease Kits, Interagency Health Kits, Outbreak investigation kits, Yellow Fever vaccines and cold chain supplies, meningitis vaccines, are considered a top priority in the sector and need to be urgently procured and prepositioned. South Sudan's current surgical services do not meet the needs of the population. Considering the current humanitarian situation, there is a tremendous lack of professional health staff, most notably medical doctors and trained nurses'in the increasing tribal, ethnic and conflict related incidents; the gap for emergency surgical interventions will remain glaring. WHO remains the only agency involved in such interventions. It identifies needs in hospitals (such as training for male and female health workers) and supports training courses designed to ensure they have the knowledge and skills to perform emergency surgical care. WHO also donates emergency surgical equipment and supplies to ensure they are readily available. Contributing to the current inadequate state of providing surgical services to emergency patients is the fact that most of state hospitals are lacking the necessary equipments for operation theatres, anaesthesia and blood transfusion Most of the epidemics in South Sudan arise because the level of readiness and preparedness is not sufficient to cope up with relative hazards. The weaknesses of essential social services like health are the major causes of epidemics. Based on the statistics of the previous years, the biggest contributor of morbidity and mortality in the population is epidemic prone diseases as a result of low level of epidemic preparedness and response capacity by the government institutions at all level Since January 2014, WHO has supported the deployment of over 64 technical officers over the ten states with special emphasis on the six high risk states. This has added lot of the value to the current emergency response in terms of quality and effectiveness. With funding constraints and budgetary cuts for the MOH in place, the health partners and MOH will continue to rely heavily on WHO for emergency surge support and deployment in 2015 especially in the key technical areas Currently the funding for WHO is minimal and expires between March and June 2014 and no commitments have yet been given for continued funding for emergency health response
5. Complementarity. Explain how the project will complement previous or ongoing projects/activities implemented by your organization.	

LOGICAL FRAMEWORK

Overall project objective	To enhance epidemic and emergency surgical capacity to respond to the critical health situation in order to reduce excess mortality and morbidity among the population affected by crisis in South Sudan

Logical Framework details for HEALTH

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
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	70
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	30

Outcome 1	Improved early warning surveillance and response capacity for communicable disease control and epidemic response at state and county level	
Code	**Description**	**Assumptions & Risks**
Output 1.1	Number of suspected disease outbreak detected and responded to within 48hours after notification	well trained network of health workers are availablle,there is an existing EWARN

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator	HEALTH	[Frontline services] Proportion of communicable diseases alerts verified and responded to					80

1.1.1		within 48 hours
	Means of Verification:	Outbreak Log and outbreak investigation reports

Activities

Activity 1.1.1	Enhance health tracking and communicable disease surveillance in areas of concern by providing technical support to the detection of, response to and containment of epidemic-prone diseases
Activity 1.1.2	Provision and distirbution of technica guidelines on epidemic response
Activity 1.1.3	Operational support to outbreak field investigations and alert/ event verification

Output 1.2	200 health wokers are trained on epidemic management and mass casuality surgical management and deployed in frontt line areas with acute emergencies	security situation allows,funds are released as planned

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 1.2.1	HEALTH	[Frontline services] # of health workers trained in MISP / communicable diseases / outbreaks / IMCI / CMR/trauma	112	88			200
	Means of Verification:	Training logs,reports and attendance list					

Activities

Activity 1.2.1	Organize and conduct training courses for at least 200 health care workers (men and women) on health care in emergencies, epidemic disease outbreaks, case management for epidemic prone
Activity 1.2.2	Support the MOH and health partners with deployment of health workers ,technical staff to ensure emergency health services are covered

Output 1.3	Six state EPR committees are functional at state level and ensure have adequate and acceptable preparedness levels	SMOH provide a conducive atmosphere,funds are readliy available

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 1.3.1	HEALTH	[Frontline services] # of states with outbreak investigation materials prepositioned					10
	Means of Verification:						

Activities

Activity 1.3.1	Facilitate the refresher training of the existing EPR committees at state level on basic principles of epidemic preparedness and response
Activity 1.3.2	Operational support to the state to ensure emergency preparedness, epidemic preparedness and response capacity improved at central and state levels and timely response and containment measures implemented

Outcome 2	Enhanced emergeny response capacity as as such basic health care needs of displaced people, returnees , including treatment of common illnesses and provison of life saving surgery are met

Code	Description	Assumptions & Risks
Output 2.1	Frontline health workers and facilities have adequate supplies and 200 health workers are trained in mass causality management and epidemic response	MOH and the health cluster partners provide a critical mass of health workers to be trained,funds available in the anticipated time and security situation provides enabling enviroment for training; Risks-Security situation detoriates hence no training takes place,health workers flee the areas were they are deployed due to insecurity of persecution

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 2.1.1	HEALTH	[Frontline services] # of health workers trained in MISP / communicable diseases / outbreaks / IMCI / CMR/trauma	111	89			200
	Means of Verification:	Training Logs and reports					
Indicator 2.1.2	HEALTH	[Frontline services] # of direct beneficiaries from emergency drugs supplies (IEHK / trauma kit / RH kit / PHCU kits)	34000	31000	18000	17000	100000
	Means of Verification:	OPD registers,Mand E reports,HMIS					

Activities

Activity 2.1.1	Organize and conduct training courses for at least 200 health care workers (men and women) on health care in emergencies, emergency preparedness and response, disaster risk reduction and health cluster coordination mechanisms
Activity 2.1.2	Faciltate and ensure that NGO partners and the MOH are regularly supplied with essential medicines, and there are no shortages reported

Output 2.2	At least six key referral hospitals are identified ,equipped, staffed and mapped for surgical referrals	MOH staff available,life saving trauma kits availed,security situation allows for implementation of work

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	

Indicator 2.2.1	HEALTH	[Frontline services] # of functional health facilities in conflict-affected and other vulnerable states					6
	Means of Verification:						
Indicator 2.2.2	HEALTH	[Frontline services] # of key facilities able to perform surgery					6
	Means of Verification:	Hospital records,HMIS,supervision reports					

Activities

Activity 2.2.1	Deploy short-term emergency public health officers, epidemiologists, technical officers, surgeons and anesthesiologist to MOH establishments in acute emergencies
Activity 2.2.2	Support development of surgical mapping and 3ws for surgical capacity Identification of state hospitals and facilitating equipping of the hospitals

Output 2.3 Support the MOH to strengthen the health cluster coordination mechanisms at all levels to ensure all critical gaps are filled and not duplicated

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 2.3.1	HEALTH	[Frontline services] # of direct beneficiaries from emergency drugs supplies (IEHK / trauma kit / RH kit / PHCU kits)	120000	40000	34000	21000	215000
	Means of Verification:						
Indicator 2.3.2	HEALTH	[Frontline services] Total # of outpatient consultations in conflict-affected and other vulnerable states	120000	40000	34000	21000	215000
	Means of Verification:	OPD registers,HMIS,hospital records					

Activities

Activity 2.3.1	Support health assesments in high risk states to document and do gap analysis
Activity 2.3.2	Operational support and platform for health cluster corrdination mechanicms
Activity 2.3.3	Support the health cluster in providing last resort mechanism to areas that have no partners to perform lifesaving interventions by supporting mobile clinics, deployments, establishing treatment centers, outbreak investigations, medical referrals and surgical interventions
Activity 2.3.4	Support MOH and the health cluster with monitoring and reporting of life saving field interventions

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 1.2.1 Organize and conduct training courses for at least 200 health care workers (men and women) on health care in emergencies, epidemic disease outbreaks, case management for epidemic prone	2015		X	X	X								
Activity 2.1.1 Organize and conduct training courses for at least 200 health care workers (men and women) on health care in emergencies, emergency preparedness and response, disaster risk reduction and health cluster coordination mechanisms	2015		X	X									
Activity 2.2.1 Deploy short-term emergency public health officers, epidemiologists, technical officers, surgeons and anesthesiologist to MOH establishments in acute emergencies	2015	X	X	X	X	X	X						
Activity 2.2.2 Support development of surgical mapping and 3ws for surgical capacity Identification of state hospitals and facilitating equipping of the hospitals	2015	X	X	X									
Activity 1.3.1 Facilitate the refresher training of the existing EPR committees at state level on basic principles of epidemic preparedness and response	2015		X	X	X								
Activity 1.3.2 Operational support to the state to ensure emergency preparedness, epidemic preparedness and response capacity improved at central and state levels and timely response and containment measures implemented	2015	X	X	X	X	X	X						
Activity 2.1.2 Faciltate and ensure that NGO partners and the MOH are regularly supplied with essential medicines, and there are no shortages reported	2015		X	X	X	X							
Activity 1.1.1 Enhance health tracking and communicable disease surveillance in areas of concern by providing technical support to the detection of, response to and containment of epidemic-prone diseases	2015	X	X	X	X	X	X						
Activity 1.1.2 Provision and distirbution of technica guidelines on epidemic response	2015		X		X								
Activity 1.1.3 Operational support to outbreak field investigations and alert/ event verification	2015	X	X	X	X	X	X						
Activity 1.2.2 Support the MOH and health partners with deployment of health workers ,technical staff to ensure emergency health services are covered	2015	X	X	X	X	X	X						
Activity 2.3.1 Support health assesments in high risk states to document and do gap analysis	2015	X	X	X	X	X	X						
Activity 2.3.2 Operational support and platform for health cluster corrdination mechanicms	2015	X	X	X	X	X	X						
Activity 2.3.3 Support the health cluster in providing last resort mechanism to areas that have no partners to perform lifesaving interventions by supporting mobile clinics, deployments, establishing treatment centers, outbreak investigations, medical referrals and surgical interventions	2015	X	X	X	X	X	X						

	Activity 2.3.4 Support MOH and the health cluster with monitoring and reporting of life saving field interventions	2015	X	X	X	X	X	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 .	Monitoring and Evaluation officer from Health Cluster will support WHO in directly monitoring the implementation of the CHF project .The monitoring process will aim at tracking the implementation of planned activities. The regular (weekly, monthly) tracking of the level of implementation will be done by the WHO focal points with the technical support by the expertise from the regional and headquarter offices. The front line activities will be monitored by the technical officers and logistic assistants in the WHO sub offices in the states. The tracking will be done against the indicators through the indicated means of verification mainly weekly and monthly reports as well as some deliverables like the health cluster or epidemiological bulletin, and regular field visit of the EHA focal point, Health Cluster Coordinator and senior supervisor (WR). The tracking will be done against the set indicators and verified through HMIS,IDSR weekly reporting tool,line lists,casebased investigation forms, way bills, training reports, attendance sheets, regular cluster meetings, support supervision reports and Morbidity and mortality reports as well as routine support supervision visits by the EHA team. Based on the Monitoring and Reporting framework, the health cluster will support the monitoring process and data collection and reporting against the set and identified CHF indicators on a quarterly basis. Key reports generated will be Weekly WHO situation reports,Epidemiological bulletins on a weekly basis,health cluster bulletin,quaterly reports and surveillance reports that will be shares with health cluster partners on a periodic basis

OTHER INFORMATION

Accountability to Affected Populations	The affected population will be engaged in the needs analysis through provision of the much needed information during assessments and surveys. Key opinion holders in the community will be consulted on pertinent issues in coordination with the cluster. Existing Community structures like the surveillance systems will also be engaged in the response especially community based interventions like integrated community case management where a number of volunteers are trained to be able to handle and refer cases of most common causes of morbidity include malaria, acute respiratory tract infections and malaria. Likewise community resource persons will be involved in mitigation measures for major health hazard and also as first responders in the major humanitarian emergencies
Implementation Plan: Describe for each activity how you plan to implement it and who is carrying out what.	The duration for implementing of the CHF funded activities will be 6 months. The project will be implemented through WHO state offices, health cluster partners and local health authorities. WHO being a technical agency supports responses for health through the existing structures which are the local health authorities and members of the cluster. All distibution of the life saving emergency drugs and supplies will be undertaken by WHO through the logistics unit at both field and nationla level. Coordination, led by the Ministry of Health and WHO in close collaboration with other partners, will be optimized to ensure maximum effectiveness of assistance, avoid overlapping and reprogram activities in due time. Mobile health units will provide live-saving health services to displaced people in affected areas. Transportation of medical supplies to the states or counties will be contracted by logistic, common transport system and private transporters. The focus of the interventions will be in the high risk states of Warrap, Jonglei, Upper Nile, Unity, Northern Bahergazal and Lakes. As part of the synchronization of filling in critical gaps, WHO will continue to work with other actors including logistics cluster (IOM and WFP) , UNICEF,OCHA and NGOs to ensure a coordinated, systematic and efficient delivery of the emergency health services in need. Monitoring of the activities will be done by the WHO technical officers on a monthly basis with provision of regular situation reports with support and leadership of the representative of the World Health Organization..
Coordination with other Organizations in project area	
Environmental Marker Code	
Gender Marker Code	2a-The project is designed to contribute significantly to gender equality
Justify Chosen Gender Marker Code	
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		Quarterly Total
								Q1	Q2	
1.1	Emergency Epidemiologists for Outbreak response	D	1	18000	6	49.59%	53,557.20	0.00	0.00	
	Technical officer for emergency and humanitarian response(P3 @ 18,000 per months for 6 months)-50% of the 6 month salary for the huba of Malakal(This technical office is different from the one reflected in Round one proposal)									
1.2	Risk Comunication Specialist	D	1	13000	6	39.00%	30,420.00	0.00	0.00	
	Emergency Health Education and communication specialist(P2 @ 13000usd per months for 6 months)-50% of the 6 month salary									
1.3	Program assistants	D	2	3200	6	10.00%	3,840.00	0.00	0.00	
	Programe ssistant to support the emergency programs on project proposals,budget controll for the CHF funding and procurement follow up. Two assistants @3200usd permonth for six months as support to WHO and health cluster response-80|5of the salary as contibution									
1.4	Consultants to support L3 health emergency	D	2	13000	4	30.00%	31,200.00	0.00	0.00	
	Three months consultants to support the techincal areas at subnational level in areas of health cordiation,mental health,HIV, Life saving surgeries and mass casuality management at p3 level@ 13000usd per month for four months									
	Section Total						119,017.20	0.00	0.00	0.00

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		Quarterly Total
								Q1	Q2	
2.1	Rapid Diagnostic tests for outbreak response	D	100	2500	1	10.00%	25,000.00	0.00	0.00	
	RDTS for cholera,kalazar,paracheks,hepatitis E unit cost is 2500 per kit based on the local market analysisi									
	Section Total						25,000.00	0.00	0.00	0.00

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		Quarterly Total
								Q1	Q2	
	Section Total						0.00	0	0	0.00

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		Quarterly Total
								Q1	Q2	

4.1	Private charters for rapid response	D	1	14000	6	16.99%	14,271.60	0.00	0.00	
	MAF charters at a rate of 3500 per charter,4 charters per month for six month for delivery of supplies,support to health parthers,medvacs,outbreak investigations; 4x3500x6 months=84,000									
	Section Total						14,271.60	0.00	0.00	0.00

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		Quarterly Total
								Q1	Q2	
5.1	Internationla Travel	D	2	1800	3	50.00%	5,400.00	0.00	0.00	
	International travel for emergency technical officers to enable rapid deployement to sout sudan form the regionla office and HQ in addition to support deployement of consultants to support L3 emergency,two air tickets every two months for for three rotations @1800usd x 6 tickets(50%)									
5.2	Local Travel	D	12	400	1	40.00%	1,920.00	0.00	0.00	
	Local travel cost by TAF account,two officers per month to the field for assesments and outbreak investigation for five days,@400 per UNHAS flight for six months=400x2x6=4800usd									
5.3	DSA for techincal officers	D	4	560	6	40.00%	5,376.00	0.00	0.00	
	Deployement of technical officers for outbreak investicagtion,four officers per month for seven days@80usd per day for six months ie 7x80x4x6=6720									
	Section Total						12,696.00	0.00	0.00	0.00

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		Quarterly Total
								Q1	Q2	
	Section Total						0.00	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		Quarterly Total
								Q1	Q2	
7.1	Operationla support to outbreak response	D	6	35500	1	15.00%	31,950.00	0.00	0.00	
	Support to mass measles campaing in at least two counties as a response to confirmed outbreaks,estimates of a quality campaing cost of each county is at 35,500$ Estimated six counties.outbreaks									
7.2	Fuelt support to WHO humantiation Hubs	D	36	2400	6	8.00%	41,472.00	0.00	0.00	
	Fuel for assesment and outbreak missions in 6 states(6 drums in each emergency state) per month for six months@drum at 400USD,15% of the costs									
7.3	Hub running costs	D	6	3000	6	20.00%	21,600.00	0.00	0.00	
	Office and Hub running costs(Generator-500$,stationary-600$,maintainance-1000$,welfare-400$,casuals-500$)									
7.4	Emergency Communication costs in the field	D	6	2000	6	20.00%	14,400.00	0.00	0.00	
	Airtime(1000$) and,IT support Vsat(1000$), Connection in field offices									
	Section Total						109,422.00	0.00	0.00	0.00

Sub Total Direct Cost	280,406.80
Indirect Programme Support Cost *PSC rate (insert percentage, not to exceed 7 per cent)*	6.99%
Audit Cost *(For NGO, in percent)*	
PSC Amount	19,600.44

Quarterly Budget Details for PSC Amount

2015		Total
Q1	Q2	
0.00	0.00	0.00

Total Fund Project Cost	300,007.24

Project Locations

Location	Estimated percentage of budget for each location	Beneficiary Men	Women	Boy	Girl	Total	Activity
Jonglei	20					0	
Lakes	10					0	
Northern Bahr el Ghazal	10					0	
Unity	20					0	
Upper Nile	20					0	
Warrap	10					0	
Western Bahr el Ghazal	10					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)

Admin Location1	Percentage
Jonglei	20
Lakes	10
Northern Bahr el Ghazal	10

Unity	20
Upper Nile	20
Warrap	10
Western Bahr el Ghazal	10

DOCUMENTS