OCHA Coordination Saves Lives

Project Proposal

Requesting Organization :	Universal Intervention and Development Organization
Allocation Type :	1st Round Standard Allocation

Primary Cluster	Sub Cluster	Percentage
HEALTH		100.00
		100

Project Title :	Increasing access to essential life saving emergency clinical health care services packages to vulenerable populations, IDPs, returnees and conflict affected communities in Mayendit, Leer and Panyijiar (Nyal) counties of the former Unity state.
Allocation Type Category :	Frontline services

OPS Details

Project Code :		**Fund Project Code :**	SSD-18/HSS10/SA1/H/NGO/8049
Cluster :		**Project Budget in US$:**	250,000.00
Planned project duration :	6 months	**Priority:**	
Planned Start Date :	20/03/2018	**Planned End Date :**	30/09/2018
Actual Start Date:	20/03/2018	**Actual End Date:**	30/09/2018

Project Summary :

This project is aimed to maintain the delivery of the emergency primary health care services, treatment of SAM with complication and scale up of mobile teams and RRMs responses in Mayendit, Leer and Payinjiar counties in former Unity state and to enhance access to life-saving health services at the IDPs and the host communities. These two counties apart from Payinjar county are much devastated by the conflict and have always remain volatile for the last 4 years in terms of lost to human lives, destruction and looting of the health infrastructures and the livelihood of the inhabitants also severely ruined.
People have continuously been forced out from their homes and hence could not access the health care services at the facilities since huge population resort to living in the islands for their safety and comfort.
The data on the HNO for 2017 released earlier in the year by UNOCHA estimated the number of IDPs in Unity to be at 463,736. Over 5million people in the country need humanitarian assistant in a situation where the proportion of clinicians per patients is estimated at only 1doctor per 65,000 patients. And based on the population projection data released by NBS in the Jan 2017, the population of these 3counties is at 282,124.
IPC in May 2017 reported 6.0million people (50% of the population) in the country are expected to be severely food insecure in June-July 2017 compared to 5.5million (45% of the population) in May 2017. Koch, Mayendit, Leer and Panyijiar are population in crisis although the declared famine has been lifted; the two counties (Leer and Mayendit) are still under emergency humanitarian situation.
A SMART Survey conducted by UNIDO in Nov 2017 reported GAM rate at 17.9% and SAM at 3.5% in Mayendit county, while in a reference made to SCF SMART Survey conduct in April 2017 shows a prevalence of malnutrition rates among children in Leer county is high – estimated GAM prevalence of 20.1% (15.6-25.5 95% C.I.) and SAM of prevalence of 5.0% (3.2- 7.7 95% C.I.) based on weight-for-height/WFH z-score; this is alarming and classified as 'Critical'.
Therefore the plan in the provision of these emergency primary health care services shall include the OPD curative consultation at 6 mobile sites and 6 PHCUs that requires more capacity support (Meer island, Tuochriak island, Tuochnhialchang island, Dongol, Rupnor, Dhorleak mobile sites and Bow, Dindin, Pabuong, Dablual, Duong and Majak PHCs), therefore a 6 mobile teams will be establish for the mobile health care services and response to Acute Watery Diarrheoa/cholera and other diseases outbreaks in the islands and hard to reach areas in Leer and Mayendit Counties. Because it is worth mentioning that measles suspected case was identified by partners in Tuochriak island of Leer county last month. The project will support two stabilization centers i.e. Mayendit PHCC and Rupkuay PHCC to treat SAM cases with medical complications. UNIDO has been and will still be part of RRMs team with its existing teams which were established and participated in last year (2017) RRMs in Leer and Mayendit Counties. We will support the health promotion activities through health education sessions and ensure the availability of the preventive measures specially the routine immunization (EPI) services at the facilities and the outreaches and UNIDO is already at the advance stages in the establishment of cold chain system in Leer TPA in partnership with UNICEF, WHO and MOH. We will also support the psychosocial and basic mental health services through updating/on-job trainings the clinicians on clinical management of sexual violence protocols to deliver the First aids such as protection and care for the survivors. And also with this project UNIDO will support the response to disease Outbreaks such as Cholera and Measles as we did in 2016 in Mayendit county, Leer highlands and Nyal. We will ensure that the hygiene promotion activities are conducted in collaboration with the WASH.

Direct beneficiaries :

Men	Women	Boys	Girls	Total
13,825	14,389	3,675	3,825	35,714

Other Beneficiaries :

Beneficiary name	Men	Women	Boys	Girls	Total
People in Host Communities	11,305	11,766	2,940	3,060	29,071
Internally Displaced People	2,520	2,623	735	765	6,643

Indirect Beneficiaries :

Catchment Population:

Link with allocation strategy :

This allocation will support
1. X PHCU
2. X mobile teams
3. X PHCC covering (SAM with medical Complications and Clinical management of rape (CMR) and will focus on all the activities and indicators aligned to the clinical packages as per the Health Cluster strategy for this allocation
4. X RRM/ICRM
The project aims at ensuring access to essential emergency health care to IDPs and vulnerable community in A, B C counties.
The implementing partner (insert the name of the organization) will strengthen X PHCCs, X PHCUs and X Mobile teams and X RRM/ICRM mission to reach (insert target population) targeting X payams of A B C Counties.
The activities aligned with the Health Cluster clinical packages as identifies will be implemented.
The project will ensure gender sensitivity by stratifying all gender parameters (Men/Women/Boys/girls)

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

Organization focal point :

Name	Title	Email	Phone
James Keah Ninrew	Executive Director	ed@unidosouthsudan.org	+211955008160
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BACKGROUND

1. Humanitarian context analysis

Mayendit, Leer and Panyijiar counties are located in the Southern part of the former Unity state where the conflict inflicted enormous destructions both on the health care delivery system and the general livelihood of the people. Compare to 2016 where security was not allowing humanitarian access to war affected population in southern Unity state, it has been somehow possible in 2017 for humanitarian response after declaration of famine in central unity, however due to sporadic fighting in the areas, there are still a big proportion of IDPs population living in islands of Mayendit and Leer TPA and the people in Leer town is also increasing these days. IPC in May 2017 reported 6.0million people (50% of the population) in the country are expected to be severely food insecure in June-July 2017 compared to 5.5million (45% of the population) in May 2017. A SMART Survey conducted by UNIDO in Nov 2017 reported GAM rate at 17.9% and SAM at 3.5% in Mayendit county, while in a reference made to SCF SMART Survey conduct in April 2017 shows a prevalence of malnutrition rates among children in Leer county is high – estimated GAM prevalence of 20.1% (15.6-25.5 95% C.I.) and SAM of prevalence of 5.0% (3.2- 7.7 95% C.I.) based on weight-for-height/WFH z-score; this is alarming and classified as 'Critical'. A SMART Survey conducted by IMC in March 2017 reported GAM rate at 16.0% and SAM at 3.5% in Panyinjiar county. Although through many RRMs, a good number of children were reached with vaccination campaigns especially in Leer and Mayendit where the routine EPI service has been affected due to destruction of cold chain system in the two counties shortly after the eruption of conflict in Dec 2013. The installation of cold chain system in Leer TPA has been discussed with UNICEF so that by 2018, the routine EPI service should be resumed.
In between famine and Malnutrition is disease: There is a projected 10% Increased number of vulnerable children in need of medical treatment in stabilization centres in IPC4&5 locations. Major investments in health need to continue in select locations to mitigate famine scenario and avert famine related morbidity and Mortality (Southern unity –Leer and Mayendit).
There is also a great need to strengthen and improve the HIV/AIDS & TB services in emergency, psycho-social supports and mental health services at the health facilities and the communities' levels in addition to focus on GBV/CMR since much of the population has been subjected to numerous atrocities which include rape, torture, killings and many other human rights abuses. UNIDO program data and monitoring visit reports submitted to clusters continue to show great needs for comprehensive health intervention in this areas, and if funded we will ensure our mandate to serve the beneficiaries is upheld.
UNIDO`s Strategic Response:
This project will maintain and improve the existing essential emergency PHC services through providing BPHSS and emergency referral services by Mobile Response approaches at the communities levels in the islands and with focus on maternal and child health services (MCH) especially usage of the IMCI and support the routine EPI in the PHCCs & monthly outreaches in the PHCUs. Special focus will be in place to boost the coverage for measles & polio vaccination through enhanced outreaches and regular cyclic Vaccination Campaigns through supporting the NIDs. UNIDO will scale-up the mobile response mechanism in the highlands of Leer, Mayendit and Nyal to take the services to the hard to reach areas and to participate on RRMs. UNIDO will support community participation through VHCs/BHCs and allow them to participate in planning and review of the services delivery. Health workers will be provided with continuous on-job/refresher trainings and support the task-shifting activity to ensure sustainable services delivery. UNIDO will implement ICCM component in 2018 as part of primary health care packages in line with MOH an

2. Needs assessment

Mayendit –The needs assessment was conducted through the SMART survey conducted by UNIDO in Nov 2017 which showed a critical Global Acute Malnutrition (GAM) of 17.7 % , which is classified as CPC 3 as per WHO standards. The prevalence of underweight 3.4 and 4.7%, was also classified as serious. In addition, the crude mortality rates found were classified as an emergency (out of control threshold) at 4.08 (3.12 – 5.33 95% C.I). Programmatic Data continues to show poor health and nutrition situation in Mayendit,Leer and Payinjar which is unavoidable with the interplay of recent insecurity, high prevalence of disease and food insecurity resulting In the morbidity of the children aged 6-59 months reported at 44.3% of the children being sick within the last 2 weeks of the survey .RRM conducted in Rubkuay in February showed Proxy GAM (4.7%) while the Proxy SAM(0.7%) .UNIDO has put a plan in place for speedy scale up of its services in the said location for optimal reach, pending a normalization in the security situation. FSNMS round 19 conducted in November /December 2016 depicts same level of gross need in Mayendit with MUAC Proxy SAM of 2.1 Panyijar ,Nyal – Panyijiar was classified as Emergency (IPC Phase 4) in January 2017, as the only data consistent with Famine was an unprecedented Mass MUAC proxy GAM prevalence of 37.7 percent, including a SAM prevalence of 11.8 percent, more than double the Famine threshold (IPC Phase 5 for Acute Malnutrition – Extremely Critical). High numbers of IDP's have been observed entering Panyijiar from Famine-affected counties to the immediate north, greatly increasing the number of severely vulnerable households in the area and likely contributing to Extremely Critical acute malnutrition levels. A SMART survey conducted by IRC in April 2016 in Panyijar County revealed emergency nutrition concerns, GAM was (93) 16.9% (13.3-21.2 95% CI) and SAM (25) 4.5% (2.5- 8.0 95% CI) . High morbidity for diarrhea and fever, poor health seeking behavior, and food insecurity were cited by the assessment as some of the aggravating factors contributing to high prevalence of malnutrition. It is anticipated that as the hunger gap approaches, food security will worsen towards the beginning of 2017, thereby compounding malnutrition along side the complications which need existing equipped health facilities to respond on the need on time. An RRM conducted in February 20th 2017 , showed Proxy GAM (18.4 %) and Proxy SAM (5.0%) with Proxy MAM (13.4 %) . MUAC <23.0 Pregnant Mothers was at 21.0 % . UNIDO has capable technical staff employed and dedicated to ensure the needs of our target groups are met adequately working in line with the DO NO HARM principle in bridging the gaps.

3. Description Of Beneficiaries

The direct beneficiaries to this project shall include 29,679 men, 24,994 women, 6,383 boys and 6,644 girls in the 3counties combined both host communities and IDPs. This is complimentary to the HPF2 funded activities in Mayendit and Leer for Lot15 and Panyijiar county for Lot17.

4. Grant Request Justification

UNIDO had successfully been implementing the SSHF grants on yearly basis since 2012 and latest ended in August 2017 for Leer, Mayendit and Payinjiar counties. UNIDO also implemented a 6months Rapid Response Projects in Leer islands funded by WHO until November 2017 where the Rapid Response Team was established. We managed to conduct more than 52,000 OPD curative consultations in 2PHCCs (Duong and Mayendit in Nyal & Mayendit respectively plus 11PHCUs in the 3counties combined and a mobile clinic response at Meer Island in Nyal and Leer islands of Kok, Meer and Touchriak in 2017. Up to 107 deliveries out of the 413 deliveries were conducted by SBA and that's around 26%. Up to 1,552 ANC clients were given iron supplementation treatment and about 817 ANC clients were screened for syphilis. These figures were generated from UNIDO`s DHIS reports. Up to 981 under5 children were screen of MUAC less than 115mm & and over 2,000 under5 children were screened of MUAC 125 mm and proper referral were made to our nutrition sector for further management at the same facilities The IPC report of Jan 2017 and the SMART survey result of Feb of this year indicated that in Leer, Mayendit and Payinjar counties of former Unity state the SAM is 11.2, 4.1, 11.8 respectively and the continues insecurity has resulted to famine declaration in the area. With this grant request, UNIDO intends to maintain the provision of the emergency primary health care, treatment of SAM with complication services in the 2PHCCs and 12PHCUs scale up of mobile clinic clinics where there are IDPs in the 3counties. Through a focus on maternal and child health (MCH) especially Basic Emergency Obstetric & Neonatal care (BEmONC), integrated management of childhood& Neonatal illnesses (IMCNI) protocols and routine and outreaches EPI activities (Penta, polio, BCG, Polio & measles vaccination) as well the TT injection for the pregnant women, UNIDO intends to ensure the promotion of mother and child survival in its supported HFs and outreaches in line with the Basic Package of Health & Nutrition Services (BPHNS). UNIDO shall procure and distribute essential medicines, basic medical equipment and laboratory reagents/supplies which are not in the existing CAIPA supply chain and more importantly by using pull system. UNIDO shall maintain the partnerships with UNFPA and UNICEF to ensure the timely procurement and distribution of essential RH kits and reestablishment of the routine EPI services. UNIDO shall continue to improve the diagnostic capacity of laboratory services at the PHCCs to ensure timely and accurate diagnosis treatment of the most common diseases and properly document the data in the existing MOH HMIS reporting tools (registers, IDSR & DHIS) which will be used as means of verification. UNIDO shall conduct an integrated in-services/refresher training with Nutrition, WASH and protection sectors to the facilities` staff/health workers and community-based health workers to update their skills and knowledge.

5. Complementarity

UNIDO will complement previous existing nutrition interventions in Mayendit,Leer and Panyijar,counties implemented by well trained staff and CHWs. This project is a continuation of UNIDOs ongoingHealth program to host community & IDPs in Mayendit,Leer& Panyijar Counties and will help UNIDO continue responding to Health emergency needs throughout the remainder of 2017 . . Given the close link between malnutrition and other illnesses and infections, UNIDO will continue to integrate health programming with nutrition by participating in NIDs, FSL(Through Kitchen gardens formation),Education (Creating awareness in TLS's) and WASH(sanitation awareness sessions) activities to strengthen the response. Access to basic services for women of reproductive age , Men and under 5 children Boys and Girls remain inadequate, therefore UNIDO health department will continue with the close multi sectoral link as mentioned above to address these challenges . In Nyal ,we will continue to work hand in hand with the existing IPs to avoid duplication of activities and adhere to National primary health care/WHO guidelines to achieve maximum outcomes at the end of the project period .UNIDO being HPF 2 partners for lot 15 we will ensure we complement the Objectives set forth by HPF as well. UNIDO shall monitor the project supervised by the clinical officers & Lab tech/ Assistants on ground and theHealth Manager based in Juba. This will be technically supported by the Programme Monitoring & Evaluation Manager who will support field teams to establish a detailed monitoring plan which will be used to guide teams in collecting appropriate and timely data. Monitoring tools (indicator tracking template) will include the Departmental Questionnaires, CHF reporting tool, Health cluster tool, Programme Tally sheets, and Pictorial evidence especially during HF visits, we will also use FGDs with thenutrition Workers and the local Authority to collect views on how the project is impacting on their lives. The above mentioned tools will be used during the implementation cycle which will be part of the monitoring components throughout the life cycle of the program. The tools will allow routine health monitoring data to be collected and analyzed in one place and allow for easy disaggregation across time and geographic location. There will also be monthly joint supervisory visits together with the CHD using the QSC tool in order to see the HFs compliance as per the HSS pillars. The databases and additional monitoring tools such as supervisory checklists, staff appraisals, training reports and post-distribution monitoring reports will feed into an Indicator Performance Tracking Table (IPTT).The IPTT will allow the program to track progress towards results and indicators on a monthly basis throughout the project period. Internal monthly reports will provide information to management on the progress of activities and the impact they are having on the communities. Donor reports will also be submitted as per the time line. Activities will be continuously monitored by the project team and will be formally monitored on a routine basis by the Health and Nutrition Project Manager supported by the Monitoring and Evaluation Officer. UNIDO and its stakeholders and actors will entirely take up the role and responsibilities for collecting, recording, reporting, and using information as M&E is a collective duty. The local authorities in Monitoring and Evaluation is a participatory activity by both UNIDO ,the CHD staff and the SSRA . Security is given by the SSRA especially when doing HH visits .The reports are always shared with the CHD for ownership of the project
Page No :

LOGICAL FRAMEWORK

Overall project objective

To scale up rapid response modalities to provide emergency lifesaving primary health care services focusing on the causes of morbidity and mortality among under 5 children (malaria, diarrhea, pneumonia),treatment of SAM with complication and clinical management and care of sexual and gender based violent (SGVB) survivors.

HEALTH

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Improve access and scale-up responsiveness to essential health-care needs of the vulnerable populations by focusing on the major causes of morbidity and mortality	SO1: Save lives by providing timely and integrated multisector assistance to reduce acute needs	100

Contribution to Cluster/Sector Objectives : The planned emergency response aims at ensuring access to essential life-saving services to targeted IDPs and vulnerable host communities which is in line with the Cluster objectives. This project stems from the needs, justification and findings of assessments and reports that explains the level of conflict and health risk exposure and the needs of vulnerable groups in the area of interest. The project also targets specific protection risk groups (Rape survivors, victims of physical and psychological trauma-women/men/ girls/boys) which contributes to the strategic objective of the cluster.
The target locations are aligned to the Health cluster priority locations for this allocation.
Beneficiaries and activities are derived from the HC clinical packages which efficiently and effectively contributes to the overall strategy of ensuring access to life saving essential health care services including health protection and reduction in morbidity and mortality of vulnerable groups.

Outcome 1

Scale up rapid response modalities to provide emergency lifesaving primary health care and nutrition services to the vulnerable communities both in host and IDPs.

Output 1.1

Description

Strengthen the PHCUs and mobile teams and RRMs responses to ensure equitable and timely access to the emergency healthcare services.

Assumptions & Risks

security stable and timely desbursement of funds.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	HEALTH	(Frontline Services) Number of OPD Consultations					76,670
Means of Verification : DHIS ,facilities registers,and UNIDO reports							
Indicator 1.1.2	HEALTH	(Frontline Services) Number of health Facilities providing SGBV/CMR services					30
Means of Verification : DHIS and health facility registers							
Indicator 1.1.3	HEALTH	(Frontline Services) Number of people reached by health education /promotion	14,070	14,430	3,430	3,570	35,500
Means of Verification :							

Activities

Activity 1.1.1

Provide OPD curative consultations for common diseases

Activity 1.1.2

Uncomplicated cases of malaria: RDT, ACT, Rectal Artesunate, Paracetamol

Activity 1.1.3

Uncomplicated cases of respiratory infection (Pneumonia): Amoxicillin

Activity 1.1.4

Uncomplicated cases of diarhoea: ORS, Zinc,

Activity 1.1.5

Uncomplicated cases of diarhoea: ORS, Zinc,

Activity 1.1.6

Provision of MHPSS for people in need

Activity 1.1.7

Psychological First Aid (PFA) and Psychological First Aid for Children (PFA-C), mhGAP-HIG

Activity 1.1.8

Provision of MHPSS for people in need

Activity 1.1.9

Conduct health education sessions on health and hygiene messages

Outcome 2

Strengthen routine and outreaches EPI services and NIDS compaign for polio.

Output 2.1

Description

Ensure child health through application of preventive measures

Assumptions & Risks

security stable and timely disbursement of funds

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 2.1.1	HEALTH	(Frontline Services) Number of children 6 months to 15 years receiving measles vaccination in emergency, outbreak or returnee situation.			5,000	6,500	11,500

Means of Verification : Health facility records, child health card and UNIDO report

Activities

Activity 2.1.1

Conduct routine and outreaches EPI services for the common preventable childhood illnesses and also provide TT injection to ANC clients.

Outcome 3

Strengthen emergency preparedness and response to health related emergencies including the control of prone epidemic disease outbreak at the supported health facilities and the community level.

Output 3.1

Description

Increase capacity of health facilities and community levels in communicable disease control , prevention and emergency response and equal utilization of the available health services.

Assumptions & Risks

Community leaders and other stakeholders corporate.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 3.1.1	HEALTH	(Frontline Services) Number of staff trained on disease surveillance and outbreak response	10	23			33

Means of Verification : DHIS and UNIDO report

Indicator 3.1.2	HEALTH	(Frontline Services) Number of health workers trained on infection prevention and control (Wash in health facilities)	25	8			33

Means of Verification : Training report

Activities

Activity 3.1.1

Conduct community awareness on prevention and control of disease outbreaks

Activity 3.1.2

Conduct staff training on disease outbreak surveillance and response.

Activity 3.1.3

Conduct staff training on infection prevention and control in health facilities

Additional Targets :

M & R

Monitoring & Reporting plan

The Project Log- frame and Work plan will be used to plan and measure implementation of activities.
1. Cluster M&E tools (FGD, support supervision assessments, accountability to affected population modalities) will be used to evaluate project response and performance.
2. The implementing partner will be contributing to the health cluster clinical package performance tracking on a monthly basis.
3. Guidelines on SSHF reporting will be adhered to as per mid-term and End of project submission.
4. Joint evaluation exercises will be conducted by partner, health cluster team and the CHD
5. Project reporting will use graphs and charts to represent project progress at all times.
6. Financial reporting will be analysed on a monthly basis and shared with SSHF at the end of the project

Workplan

Activitydescription	Year	1	2	3	4	5	6	7	8	9	10	11	12
Activity 1.1.1: Provide OPD curative consultations for common diseases	2018			X	X	X	X	X	X	X			
Activity 1.1.2: Uncomplicated cases of malaria: RDT, ACT, Rectal Artesunate, Paracetamol	2018			X	X	X	X	X	X	X			
Activity 1.1.3: Uncomplicated cases of respiratory infection (Pneumonia): Amoxicillin	2018			X	X	X	X	X	X	X			
Activity 1.1.4: Uncomplicated cases of diarhoea: ORS, Zinc,	2018			X	X	X	X	X	X	X			
Activity 1.1.5: Uncomplicated cases of diarhoea: ORS, Zinc,	2018			X	X	X	X	X	X	X			
Activity 1.1.6: Provision of MHPSS for people in need	2018			X	X	X	X	X	X	X			
Activity 1.1.7: Psychological First Aid (PFA) and Psychological First Aid for Children (PFA-C), mhGAP-HIG	2018			X	X	X	X	X	X	X			
Activity 1.1.8: Provision of MHPSS for people in need	2018			X	X	X	X	X	X	X			
Activity 1.1.9: Conduct health education sessions on health and hygiene messages	2018			X	X	X	X	X	X	X			
Activity 2.1.1: Conduct routine and outreaches EPI services for the common preventable childhood illnesses and also provide TT injection to ANC clients.	2018			X	X	X	X	X	X	X			
Activity 3.1.1: Conduct community awareness on prevention and control of disease outbreaks	2018			X	X	X	X	X	X	X			
Activity 3.1.2: Conduct staff training on disease outbreak surveillance and response.	2018				X			X					
Activity 3.1.3: Conduct staff training on infection prevention and control in health facilities	2018			X			X						

OTHER INFO

Accountability to Affected Populations

UNIDO will develop a culture of engaging the community from the initiation of the project in order for the community to own it
Stakeholder workshops will be organized in the location identified for implementation of the response. The community will be consulted and provided with information regarding the project implementation. This will include engaging existing CHD, Community elders, Women, Youth groups, religious leaders and representatives of beneficiaries.
This will be the medium through which communities will be encouraged to express their concerns, views and provide regular feedback to the implementing partner in a regular structured modality. Other reasonable modalities for feedback that is useful to the communities/beneficiaries will also be considered. These feedbacks will form part of the project performance reporting to the health cluster and will help guide the fine tuning of the project to enhance positive beneficiary experience.

Implementation Plan

Implementation plan
1. Capacity building of the clinical and community staffs: All clinical and community teams involved in the implementation of the response will be provided initial orientation on their deliverables (Health, WASH, Nutrition and Protection as it pertains to the essential lifesaving packages
2. Technical guidelines, standard reporting formats (data collections tools) and protocols will be availed to ensure efficiency of the deliverables
3. Plan will be in place to mitigate stock outs
4. Implementing partner will closely coordinate with the health cluster at National and subnational levels to ensure the response is in-line at all time with the health cluster strategy
5. The cluster will be informed regularly on the status of the implementation of the repose in-order to mitigate issues that will affect the response

Coordination with other Organizations in project area

Name of the organization	Areas/activities of collaboration and rationale

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

The project will focus on gender disparity and sensitivity to ensure that all the vulnerable populations enjoy the same positive essential life-saving health services. Women bear the economic responsibilities of their families, are not in a position to make family and personal choices including reproductive issues.
The project will ensure that women and girls are empowered proportionally to be given equal opportunity to be employed and serve their community. Women and girls must receive equal treatment in accessing essential lifesaving clinical health and protection services.
Special effort will be made to ensure that the needs of adolescent youth (Boys/Girls) will be provided equal opportunities.

Protection Mainstreaming

1. Standardized psychosocial support will be provided ensuring confidentiality and privacy of individual who seek such services.
2. Capacity building for staff in the health facility will be conducted.
3. The implementing partner will conduct robust awareness and sensitization campaigns to raise awareness about their protection concerns and human rights.
4. The project will make use of community-based local protection mechanisms such as Community Complaints and Management Structures,
5. Persons with specific needs like the unaccompanied boys and girls; older people (Men and women) and disable women and men in our project implementation area will be given priority in emergency health services.
6. Gender parity in this project will be reflected in staffing and during treatment of patient in the health facilities.

Country Specific Information

Safety and Security

Throughout the conflict period, humanitarian actors have been targeted actions from the armed militants in the country. It has therefore not been easy to guarantee the safety of both the beneficiaries and the services providers alike. Many lives were lost, properties looted and many humanitarian actors were sexually and physically assault. The situation relatively returned to normalcy since the formation of Transitional Government of National Unity (TGoNU) in April 2016 especially in Southern Unity although some interruptions in services delivery was encountered after the eruption of July 2016 conflict, the humanitarian actors including UNIDO gained comfortable access to the populated areas in and around the Southern Unity counties. And UNIDO having been a long time humanitarian actor in Mayendit and Leer counties usually has an added advantage because of the cemented partnership relation with the community and local authorities and is well conversant with the communities` needs and in the other hand the mitigation measures to ensure the safety of the host community and UNIDO staff (both relocatable and non-relocatable) as well. But with the starting of the conflict again in Juba in July 2016, the security situation began to deteriorate in North Mayendit, Koch and Leer. People displaced, humanitarian actors evacuated their staffs and properties again looted. However, with all the unpredictable risks therein, UNIDO staffs are dedicated to serve the community as usual. We also have an advantage of being National NGO and have good number of non-relocatable staffs (CHD staffs) on ground in the three counties who usually move with the communities even to the hidings. Prioritization of the staffs` safety is enshrined in the entire UNIDO`s policy. Our field operation areas are equipped with satellite phones (Thuraya) for daily contact with the head office in Juba. Evacuations are planned on need basis especially for the relocatable staffs/expertise/international through our logistics department in coordination with other partners in the area including UN bodies. This same procedure will continue to be put in place throughout the implementation period of this project to ensure the provision of basic essential emergency primary health care services to the Vulnerable IDPs and host communities across our areas of operation.

Access

There has been some challenges for the community/beneficiaries in accessing health care services due to insecurity in most parts of Southern Unity, fortunately UNIDO has adapted a mobile teams response to reach the displaced population (IDPs) with health care services in the islands and hard to reach areas. Ferrying staffs and supplies to the islands and hard to reach areas has been through the use of canoes or by using human transporters, for there has not been any vehicle on the ground since UNIDO vehicles were looted in 2013. The plan is to move in an ambulance and one additional vehicle to facility staffs movements, preposition supplies and facilitate the referral of severely sick patients from the community or PHCUs to Primary Health Care Centers (PHCCs), especially in Leer and Mayendit Counties.

BUDGET

Code	Budget Line Description	D / S	Quantity	Unit cost	Duration Recurrance	% charged to CHF	Total Cost
1. Staff and Other Personnel Costs							
1.1	Health Manager	D	1	4,000.00	6	50.00	12,000.00
	Health Manager in charge of project delivering outputs spending 50% LOE						
1.2	Clinical Officer	D	1	2,135.00	6	100.00	12,810.00
	Mobile Clinic Staff working @ 100% LOE in 6 Mobile stations						
1.3	Drug Dispensers	D	6	200.00	6	100.00	7,200.00
	Mobile Clinic Staff working @ 100% LOE in 6 Mobile stations						
1.4	GBV Project Officer	S	1	1,500.00	6	20.00	1,800.00

	GBV Project Officer working 20% LOE to build Health Staff capacity in GBV issues and monitor GBV related activities in the project						
1.5	Driver	S	3	700.00	6	50.00	6,300.00
	Mobile Clinic Staff working @ 50% LOE in 6 Mobile stations spread in the counties utilizing Ambulance and referal Vehicles						
1.6	Community Health Workers	D	6	300.00	6	100.00	10,800.00
	SC Staff working @ 100 % LOE at the two SC in Mayendit County						
1.7	Cold Chain Technician	D	1	200.00	6	100.00	1,200.00
	PHCU Staff working @ 100 % LOE at the Cold Chain Facility in Leer County						
1.8	Assistant Cold Chain Technician	D	1	160.00	6	100.00	960.00
	PHCU Staff working @ 100 % LOE at the Cold Chain Facility in Leer County						
1.9	Executive Director	S	1	8,900.00	6	15.00	8,010.00
	Staff in charge of overal project accountability working 10% LOE						
1.10	Programs Coordinator	S	1	7,500.00	6	15.00	6,750.00
	Staff in Charge of project staff supervision working 10 % LOE						
1.11	Finance Director	S	1	7,400.00	6	15.00	6,660.00
	Staff in Charge of project Financial reporting and Budgetary monitoring working 10 % LOE						
1.12	State Coordinator	S	1	4,500.00	6	15.00	4,050.00
	Staff in charge of State Level and County coordination with partners and Cluster working 10 % LOE						
1.13	Finance Officer	S	1	2,000.00	6	15.00	1,800.00
	Staff in Charge of Field Finance reports working 20 % LOE						
1.14	Logistics & Procurement Manager	S	1	4,000.00	6	10.00	2,400.00
	Staff in Charge of project Procurement and staff and materials logistics @ 10 % LOE						
1.15	Logistics & Procurement Officer	S	1	2,000.00	6	10.00	1,200.00
	Staff in charge of field procurements and logistics working @ 20 % LOE						
1.16	M & E Manager	S	1	3,500.00	6	10.00	2,100.00
	Staff in charge of project activity monitoring and reporting, mid term & end of project evaluation working @ 10 % LOE						
1.17	Employer NSI contribution	D	1	7,436.00	6	10.00	4,461.60
	Employer NSI contribution @ 17 % of Gross Pay						
1.18	Staff Medical Insurance	D	1	4,374.00	6	10.00	2,624.40
	Employer Medical contribution @ 10 % of Gross Pay						
	Section Total						**93,126.00**
2. Supplies, Commodities, Materials							
2.1	Procurement of Essential Drugs	D	1	30,000.00	1	100.00	30,000.00
	Purchase of Drugs not supplied in the pipeline- assorted essential drugs						
2.2	Procurement of medical Equipment	D	6	425.00	1	100.00	2,550.00
	Purchase of Stethoscopes @ 15 usd each, Thermometers @ 10 usd each for the Mobile Units						
2.3	Printing of OPD cards	D	9000	1.00	1	100.00	9,000.00
	Procurement of 1500 cards per Mobile unit @ 1 usd each						

2.4	Procurement of metallic Drug storage boxes for Mobile Units	D	6	50.00	1	100.00	300.00
	Procurement of Metallic boxes for carrying Drugs in the Mobile sites @ 50usd each						
2.5	Procurement of Hand washing facilities	D	9	200.00	1	100.00	1,800.00
	Nine units to be procured @ 200 usd each						
2.6	Procurement of IEC Materials	D	1	2,200.00	1	100.00	2,200.00
	T - shirts 100 pcs @ 10usd each , Laminated cards with Health messages for Health education 12 sets @ 100each						
2.7	Procurement of furniture for Mobile Units	D	1	2,040.00	1	100.00	2,040.00
	Folder able 4 metallic chairs costing 60 usd each and 1 table costing 100usd for each of the mobile sites						
2.8	Procurement of fuel and Oils for Mobile Unit Vehicles	D	1800	1.50	8	100.00	21,600.00
	Fuel for three vehicles for Mobile Health Activities 600 liters each oer month costing 1.5usd per liter						
2.9	Procurement of casual services for EPI vaccinators during the campaigns	D	24	150.00	2	100.00	7,200.00
	Incentives for 24 vaccinators each @ 150 usd						
2.10	Training on Disease Surveilance and Outbreak response	D	1	4,800.00	1	100.00	4,800.00
	Training of 30 pax for three days each using 50Usd per day for food and drinks, and Workshop materials (Stationery) @ 300 usd						
2.11	Training on Clinical Managenment od Raped cases (CMR)	D	1	1,800.00	1	100.00	1,800.00
	10 pax trained for 3 days each participant using 50 usd for food and drinks per day and Workshop materials (stationery) @ 300 usd						
2.12	M & E Field Visits	D	1	3,000.00	3	100.00	9,000.00
	6 pax each daily per diem of 100usd for 5 days (3x 100 x 5) = 3000 to cover for the M & E manager, Project Manager, Programs Coordinator, CHD, County M & E and Surveillance Officer at the county						
	Section Total						**92,290.00**
3. Equipment							
NA	NA	NA	0	0.00	0	0	0.00
	NA						
	Section Total						**0.00**
4. Contractual Services							
NA	NA	NA	0	0.00	0	0	0.00
	NA						
	Section Total						**0.00**
5. Travel							
5.1	Flights Costs - Juba to Field Locations	D	24	275.00	2	100.00	13,200.00
	Flight on UNHAS for the project manager, Project coordinator, M & E finance Officer (8 rotations)and 8 field staff coming to Juba for R & R (16 rotations)						
5.2	Staff Visas and Work Permits	S	2	2,450.00	1	100.00	4,900.00
	Visas for Field staff working on the project and Work permits (2000 x 2) for Clinical officers and visas (450x2)						
	Section Total						**18,100.00**
6. Transfers and Grants to Counterparts							
NA	NA	NA	0	0.00	0	0	0.00
	NA						
	Section Total						**0.00**

7. General Operating and Other Direct Costs							
7.1	Stationeries & Printing	S	1	867.38	6	20.00	1,040.86
	Assorted stationeries and printing for both Juba and field location @ 938 usd per month						
7.2	Thuraya Airtime	D	6	100.00	6	20.00	720.00
	5 thuraya phones in the field location and one in Juba each 100 usd worth airtime per month						
7.3	Office Internet subscription	S	2	1,100.00	6	15.00	1,980.00
	Office Internet subscription for two sites each @ 1100 usd per month						
7.4	Mobile Airtime	S	6	20.00	6	25.00	180.00
	Airtime for Juba program staff @ 20 usd per staff per month for 6 staff working on the project						
7.5	Motor vehicle repair and Maintenance	S	1	18,000.00	6	15.00	16,200.00
	Repair costs for 4 vehicles 3 in the field used for mobile activity one in Bentiu for coordination and 1 in Juba						
7.6	Office Rent	S	1	7,000.00	6	15.00	6,300.00
	Office Rent for Juba Office						
7.7	Generator Fuel & Oils	S	2	500.00	6	20.00	1,200.00
	Fuel Cost for Electricity in Both Field and Juba offices shared cost						
7.8	Office Supplies	S	4	400.00	6	23.00	2,208.00
	Assorted office supplies items shared costs						
7.9	Bank Charges	S	1	200.00	6	25.00	300.00
	Bank Charges incurred on project funds on withdrawals						
	Section Total						**30,128.86**
SubTotal			10,931.00				**233,644.86**
Direct							158,266.00
Support							75,378.86
PSC Cost							
PSC Cost Percent							7.00
PSC Amount							16,355.14
Total Cost							**250,000.00**

Project Locations

Location	Estimated percentage of budget for each location	Estimated number of beneficiaries for each location					Activity Name
		Men	Women	Boys	Girls	Total	
Unity							
Unity -> Leer	40	5,545	5,756	1,470	1,530	14,301	
Unity -> Mayendit	40	5,545	5,756	1,470	1,530	14,301	
Unity -> Panyijiar	20	2,735	2,877	735	765	7,112	

Documents

Category Name	Document Description
Project Supporting Documents	UNIDO 2018 HRP concept note.doc
Project Supporting Documents	UNIDO 2018 HRP concept note.doc
Project Supporting Documents	Essential drugs.docx