South Sudan Humanitarian Crisis

Health Emergency Response Funding Proposal

Written and submitted by:

WHO South Sudan

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World Health Organization

Project Summary

1.	**Project Title**:	Responding to Health-related Emergencies in Populations of Humanitarian Concern in the Republic of South Sudan		
2.	**Country**:	South Sudan	**Beneficiary Population:**	680.000
3.	**Date Contribution Received (month/year)**:		**Amount (US$)**:	**11,134,000**
4.	**Period of Implementation**:	Six months from 1 Feb 2014	**Extension**:	
5.	**General Project Objective:** To contribute the reduction of excess morbidity and mortality among displaced people and host communities affected by the current crisis, through strengthening health emergency preparedness and response capacity at all levels in South Sudan **Project Purpose:** 1. To ensure access to and delivery of quality primary and secondary health care services through restoration and expansion of life-saving health care services to affected population, with particular focus on the most vulnerable group. 2. To strengthen emergency preparedness and response capacity at all levels, and ensure availability of emergency medical kits and supplies in all high risk areas 3. To strengthen early warning diseases surveillance, information management and epidemic response among displaced people and other vulnerable groups through existing surveillance system 4. To improve and expand the overall health cluster coordination mechanism at central and state levels for better coordination of health emergency response activities in high risk areas and surrounding communities			

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1. Background and Overview

South Sudan is facing its worst humanitarian crisis in many years, which is characterized by open internal conflict between government and opposition groups, major internal displacement and refugees, increasing food insecurity and high malnutrition rates, limited access to basic services and access challenges to crisis affected areas. Humanitarian operations in South Sudan remain precarious, complex and uncertain. The current humanitarian crisis in South Sudan is widespread and severe, with more than 4.8 million people in need of emergency assistance. The epicentre of the humanitarian crisis continues to be in Jonglei, Upper Nile, Unity states, due to the ongoing conflict. The country's very fragile health system (lack of skilled staff, supplies, equipment and leadership at all levels) was negatively impacted by the crisis, and further hampered the humanitarian response.

Heavy fighting broke out in Juba on 15 December, 2013 with heavy gunfire and shelling in several parts of the city, and there after the violence spread to the neighbouring states of Jonglei, Unity, Upper Nile and Lakes. The fighting was orchestrated by the long standing political difference between the president and his former vice president, and later the president accused his former vice president and other opposition politicians of attempting to overthrow the government. South Sudan, which became an independent state on 9 July 2011, remains one of the poorest and least developed countries of the world, with less than 44% of the population have access to basic services[1].

Despite the signing of an agreement for the cessation of hostilities, the security situation across conflict affected areas continues to be tense and volatile. Clashes continue to be reported in the states of Jonglei, Unity, Lakes and Upper Nile, and access and delivery of humanitarian assistance are becoming a major challenge. These clashes have resulted in increased population displacement in major urban and rural areas in the conflict affected states, with the number of IDPs exceeding over 730,000. Of these IDPs, 76,100 are living in the UNMISS compound in Juba, Malakal, Bor and Bentiu, while another 91,700 are living in Awerial county in Lakes State close to Bor[2]. Nonetheless, it is estimated that the actual number of displaced people is far higher than recorded figure as the aid agencies estimating that over 1,900,000 thousand people may have been affected by the ongoing crisis in conflict affected areas[3]. People continue to flee to neighbouring countries of Ugandan Kenya and Sudan, and over 150,000 South Sudanese sought refuge in neighbouring countries. The conflict has taken an ethnic dimension; mainly between the Nuer to which the former Vice President versus the Dinkas; the ethnic group of the President, and there may be a reoccurrence of retaliatory attacks especially in the three affected states.

[1] Health Sector Development Plan 2011-2015
[2] OCHA Humanitarian snapshot and Humanitarian report Feb 6 2014
[3] Health Cluster Response Plan 2014

Table 1: Summary of overall displaced people per state in South Sudan

State	Number displaced
CES	90,100
Upper Nile	100,800
Unity State	118,400
Jonglei	117,300
Lakes State	91,400

The overall humanitarian situation among the displaced people has further deteriorated, and basic services including food, shelter, water and sanitation and health are in great demand. Despite the diligent effort by the humanitarian actors in the country to meet the basic necessities among displaced people, the living conditions inside and outside UN compounds is appalling. The displaced people are sheltering in makeshift and overcrowded camps with limited access to food, water or sanitation, and the risk of disease outbreaks is a serious concern. In the past two weeks, more humanitarian actors have returned into the county and are making efforts to respond to the humanitarian crisis by providing food, water health and other essential services to the displaced people. Nonetheless, access to affected communities or counties is becoming a major challenge due to unpredictable security situation.

2. Health Situation

The health situation across South Sudan remains fragile, and the on-going crisis has seriously impacting the health service delivery. As the result of the on-going fighting and subsequent displacement, the humanitarian need has risen as over 4.8 million people have affected by the on-going humanitarian crisis and requires urgent humanitarian assistance. Humanitarian needs among displaced people and other vulnerable groups continue to growth, and the humanitarian operations in South Sudan remain precarious. Many of the displaced people due to the on-going fighting in greater Upper Nile states do not have access to life-saving primary health care services among other basic services. This is exacerbated by already very fragile health systems (lack of skilled staff, supplies and equipment, leadership, etc. at all levels) that have further affected the humanitarian response. Most of the health facilities in Juba and affected states are almost non-functional as the health personnel fail to report due to insecurity. Bor, Bentiu and Malakal State Hospitals and other primary health care facilities were looted and not operational, while Juba hospital continues to be overwhelmed. The Ministry of Health has limited capacity to manage the current health emergencies response and any public health risks that may be of concern given this current crisis.

As the result of the deteriorating humanitarian situation, there are still large-scale humanitarian needs and the health situation remains fragile with extremely low health care coverage, high infant

and under five mortality and morbidity rates. South Sudan has some of the worst health indicators in the world with a Maternal Mortality Ratio of 2,054/100,000 live births and an Infant Mortality Rate of 102/1000 live births. The national and state-specific immunization coverage surveys were conducted in 2012, and indicate that the age cohort (12-23 months) born in between December 2009 and November 2010 had a crude DTP-3 coverage of 54% (44-64% CI) compared to 63% reported in the same year. The immunization coverage surveys also showed that despite the good and comparable coverage, there remains poor card retention (40%), low card verified DTP-3 coverage (24.7%) and low proportion of fully immunized children by 1 year of age (13%). The measles virus is endemic in South Sudan and over the recent years, numerous measles outbreaks have been documented in many parts of the country. The routine EPI coverage is below 53%, while the measles coverage is less than 50%.

In the last seven weeks, the health situation across the country has further deteriorated, and over 75% of health facilities in the counties of Jonglei, Unity and Upper Nile remain closed or not accessible to the affected population. Preliminary assessments by the health cluster indicates that three state hospitals and 25 health facilities were vandalized during the crisis, while many accessible service delivery points are operating at a minimum capacity. Due to the large number of displaced persons living inside the UN bases, there is limited and inadequate health care services available for these displaced people, despite efforts by UNMISS clinics and health cluster partners to beef up provision of primary health care services. Health cluster partners are also having difficulties accessing existing health facilities in areas affected by the on-going conflict, while severe shortage of life-saving drugs was also reported across the country. The displaced people living inside and outside the camps are at high risk of contracting communicable diseases due to poor sanitation, shortage of water, crowded living conditions, malnutrition, and poor immunity, with young children and pregnant women particularly vulnerable. In the last few weeks, on average the daily OPD consultations across the five states were at 500 patients/day, and over 40,000 patients received treatment through mobile clinics or outreach services in the IDP camps. The most common morbidity reported includes Respiratory Tract Infection (21%), Malaria (16%) and AWD (12%)[4]. The trend of malaria and watery diarrhea has been increasing in the last few weeks in most of the camps, as the sanitation and hygiene condition in the camps are very poor. Currently health partners are responding to measles outbreak confirmed in most of the IDP camps, and over 650 cases and 80 deaths (CFR 12.3%) due to measles were recorded as of week 6. Measles virus is currently spreading to other displaced people outside the camps and host communities in high risk counties. In respond to the measles outbreak, emergency measles vaccination campaigns were conducted in all major camps and over 150,000 children were vaccinated against measles and polio. Malaria is endemic in the country, and most of the displaced populations are at risk of contracting malaria infection as there is no proper shelter, no mosquito nets and access to timely diagnosis and treatment is very limited. There is a significant risk of water borne disease outbreaks

[4] *Disease surveillance Report from IDP camps as of epidemiological week 6*

occurring in the overcrowded IDP camps, cholera in particular as the sanitation and hygiene condition in the camps are very dreadful.

Over 1,200 people living with HIV and a considerable number of patients with non-communicable disease are currently unable to access their treatments in Jonglei, Upper Nile and Unity states. The absence or disruption of treatment for chronic diseases such as HIV, TB, high blood pressure, diabetes and mental illness is not only life threatening for displaced populations, but may also give rise to complications e.g. multidrug-resistant forms of TB and HIV, resurgence of life threatening opportunistic infections, transmission of resistant strains, stroke, diabetic retinopathy resulting in reduction in quality of life and deaths. In the last 7 weeks, over 5,114 people received surgical treatment for gunshot wounds across 21 facilities, and an additional 197 were medivac to Juba for further treatment. Enormous gaps in life-saving surgical intervention remain evident, especially in state and county hospitals that serve the population in the affected areas. Reproductive health services may not available in all camps, and over 250 deliveries were recorded in the camps. Severe malnutrition among children were recorded in all camps, and the latest preliminary nutrition data from nutrition cluster indicates that 1.5% of children with SAM and 4.6% with GAM[5].

The impact of this crisis goes beyond the basic services, and it's expected to negatively impact the overall economy, with inflation, price increases and unavailability of basic commodities likely in 2014. Oil revenue will likely be reduced in the months to come as oil-flow is severely disrupted. A possible failure or delay in delivering support for agricultural activities for affected people in time for planting seasons will increase food insecurity and worsen nutrition among already at-risk communities. There is no law and order in the affected states, and many health workers or health managers have fled for their safety. The supply chain and logistics management of the MOH has been affected and there will be stock out of regular drug supplies to all health facilities across the country in the next few months. The expected stock out and refusal of the government to deliver medical supplies to opposition areas may further strain the health core pipeline that is already inadequate. Therefore, there is an urgent need for health partners to mobilize additional emergency drugs stock and vaccines to fill the expected gap. Gender issues, in particular gender-based violence, are also aggravated by the crisis and survivors require appropriate medical services and referral pathways for support.

3. Current Response to the Humanitarian Crisis

- WHO continues to support the current health emergency response with focus on the delivery of medical and surgical supplies to hospitals, Primary Health Care Units/Centers and mobile clinics through health partners and health authorities.
- Provision of mobile clinics to provide life-saving health care services in the IDP camps

[5] Nutrition Cluster response update 19th Jan 2014

- Supported health coordination mechanisms at central and state levels in the past few weeks, but more needs to be done. Currently, WHO has deployed additional staff to enhance the health cluster coordination at central and sub-national levels.
- Provision of emergency drugs and other medical supplies to 21 health partners operating in five states in which the current crisis affected. With these support, Nongovernmental organizations (NGOs) and UN agencies are providing life-saving emergency health care services to IDPs who have sought refuge in the UN compounds and those living outside the camps.
- Through the health cluster, WHO supported the management and referral of the wounded patients since the beginning of the conflict. In addition, the Health cluster supported the coordination of over 197 medavac of patients to referral facilities with surgical capacity.
- Supported the provision of reproductive health services in the camps through technical support, capacity building and dissemination of RH messages
- Systems for communicable disease surveillance and early warning to detect and respond outbreaks have been established in the camps.
- Supported the gathering, analysis and dissemination of surveillance data so to ensure proper monitoring of trend epidemic prone diseases.
- Supported health promotion campaigns in the camps to promote key health message, importance of hygiene, water sanitation and health environment
- Participated in over 12 initial rapid assessments in conflict affected areas.
- Advocated the involvement of more health cluster partners to the emergency health response in the high risk states
- Promoted mental health and psychological support for displaced people currently living in UN compounds

4. Priority Needs and Response Strategy

Despite tangible progress to implement key emergency response activities, there are still major gaps in health services delivery in Jonglei, Unity and Upper Nile States, which needs to be urgently addressed to ensure that all displaced people and other vulnerable groups are accessing life-saving health care services. WHO will continue to strengthen the emergency preparedness and response capacity at central, 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. Currently, the emergency health response activities are confined more on urban centers, and there is urgent need to expand the health services to counties and communities where most of the displaced people are believed to be residing. WHO will continue to procure and distribute essential emergency medical supplies through health authorities and partners providing life-saving health care services in high risk areas, and priority will be given to those partners re-

establishing primary care services in new counties or community with high number of displaced people or other vulnerable groups.

The Ministry of Health already informed WHO and other cluster partners that there will be unanticipated stock out of routine drugs in the next 3-5 months, and WHO as core pipeline manager was asked to plan additional emergency drugs to fill the expected drug gaps, especially referral facilities. Many referral hospitals in the affected states are not operational, and re-establishment of secondary health care services in the conflict affected states will be given to the highest priority in collaboration with different stakeholders so to improve accessibility and availability of secondary health care services including surgical capacity, reproductive health and mental health services. All essential medical equipment and supplies required by the looted hospitals or other key facilities will be procured and deployed to state/county hospitals for timely operationalization. Logistics, warehouse and transportation of emergency medical supplies to high risk areas will be very challenging due to insecurity, and upcoming rainy season will complicate and delay the operation. Nonetheless, WHO is expected to facilitate the distribution and prepositioning of these supplies in collaboration with logistics cluster. In the previous emergencies, UNHASS and UNMISS planes were facilitating the medevac or referral for war wounded patients to the nearest hospitals, but WHO/health cluster is expected to handle all medevacs through chartered planes as UNHASS management decided to pool out the medevac operation as of the end of January 2014. Although early warning disease surveillance were established in the camps and other areas, the system remains fragile and vulnerable due to availability of resources and capacity to meet the growing needs, and WHO will continue to support the surveillance system across the country.

Given WHO's comparative advantage including its acceptability as the health cluster lead in the county, it's imperative to deploy more technical officers in three states affected by the conflict regardless of which group may be in control so to strengthen the health cluster leadership and coordination mechanism. Even though WHO currently deployed additional surge team to support the health cluster coordination at Juba and states level, it's important to maintain the same level of staffing in the next six months. Epidemiologist and public health officers to support the emergency health response will be deployed in Juba and other conflict affected states as the risk of communicable disease outbreaks is very high considering the poor living condition among displaced people and outbreak seasonality in the country.

The conditions for implementing humanitarian health emergency operations in the affected states are still extremely difficult. In many parts of the country, the safety of the relief workers is not guaranteed, neither is the minimum required- supporting infrastructure available. This poses severe logistical and security problems for the implementation of WHO response, thus making humanitarian operation in South Sudan highly costly and enormously challenging. To address most of the critical gaps identified above, WHO is planning to work with health authorities and cluster partners to

strengthen and expand the emergency health response activities in areas affected by the conflict as well as other areas. Not all health needs can be met by WHO through humanitarian emergency response, and WHO will collaborate with other stakeholders to address other health needs among displaced people, refugee and other vulnerable groups including IOM, UNHCR, ICRC and MSF. The proposed project activities will focus more on providing the health needs among emergency affected population including scaling up access to life-saving health care services; preposition adequate emergency medical supplies; re-establishing secondary health care services; epidemic response through strengthening disease surveillance capacity; and improving the health cluster coordination at central and state level. Procurement of emergency supplies will be done directly through WHO Geneva and warehousing and local transportation arrangements will be negotiated with the logistics cluster and private transporter.

5. The Proposal

5.1 Objectives

5.1.1 General Objective

To contribute the reduction of excess morbidity and mortality among displaced people and host communities affected by the current crisis, through strengthening health emergency preparedness and response capacity at all levels in South Sudan.

5.2 Specific Objectives

The above objective can be achieved through the following strategic objectives:

- To ensure access to and delivery of quality primary and secondary health care services through restoration and expansion of life-saving health care services to affected population, with particular focus on the most vulnerable group.
- To scale up emergency preparedness and response capacity at all levels including surgical interventions (health facilities equipped with skilled personnel, equipment and supplies) and ensure that 60% of the state hospitals are able to offer life-saving surgery by end of June 2014.
- To strengthen early warning diseases surveillance, information management and epidemic response among displaced people and other vulnerable groups through existing surveillance system
- To improve and expand the overall health cluster coordination mechanism at central and state levels for better coordination of health emergency response activities in high risk areas and surrounding communities.

5.2 Project Results

1. **To ensure access to and delivery of quality primary and secondary health care services through restoration and expansion of life-saving health care services to affected population, with particular focus on the most vulnerable group.**

   Activities

   a) Strengthen or re-establish primary health centres in the affected areas including provision of basic equipment and related supplies to deliver essential health services package to displaced people and host communities, including providing reproductive health services with a focus on most vulnerable groups (children, women, persons with disability)
   b) Support and facilitate the medevac of injured patients to the nearest referral facilities
   c) Support the MOH and health cluster partners to conduct real time assessment for health facilities and available services, and document critical needs and design appropriate strategies to ensure health gaps are filled
   d) Advocate greater involvement of health cluster partners to provide life-saving health care services in the affected communities, with emphasis on counties with high concentration of displaced people
   e) Support the restoration of state and county hospitals through provision of essential equipment and personnel
   f) Ensure key cluster partners and health authorities are regularly supplied with essential medicines, and there is no shortage of essential drugs
   g) Provision of health services to the affected people through mobile and fixed health units in areas where health facilities were looted or not functioning.
   h) Support the provision of mental health and other Non Communicable Disease in the affected population
   i) Deploy more health workers in the areas with high concentrations of displaced persons and in areas with more health needs so to improve the access and availability of health services
   j) Organize refresher training among health workers on case management of common illnesses, trauma management and RH services
   k) Support the implementation of emergency measles vaccination campaigns and re-establish the routine EPI activities
   l) Conduct health promotion and community awareness in the camps and surrounding host communities on epidemic prone diseases, RH, HIV, TB and GBV

m) Support monitoring and evaluation of health emergency response activities implemented by health cluster partners in the conflict affected areas

2. **To strengthen emergency preparedness and response capacity at all levels, and ensure availability of emergency medical kits and supplies in all high risk areas**

Activities

a) Procure and preposition emergency medical kits, supplies, logistic and transport equipment in strategic locations in the high risk areas.
b) Coordinate the provision of life saving surgeries to the critically injured and ensure an effective referral mechanism is clearly defined including medical evacuation of critically injured to Juba, Bor, Bentiu and Malakal Hospitals
c) Support the deployment of short-term surgeons and anaesthesiologist in the state hospitals of Bor, Malakal, Kwajok, Rumbek and Bentiu hospitals
d) Consolidate and update the 3Ws and map health resources availability including functionality of health facilities, damage to health facilities, and the available services, including surgical and RH capacities across the states
e) Organize technical meetings with health authorities and cluster partners to review/adapt health emergency response guidelines and protocols

3. **To strengthen early warning diseases surveillance, information management and epidemic response among displaced people and other vulnerable groups through existing surveillance system**

Activities

a) Enhance early warning surveillance activities in all affected areas and host communities
b) Scale up community based surveillance system inside and outside the camps on detecting and reporting cases and deaths occurring in the camps
c) Enhance the capacity of front-line health workers to detect, verify, and respond to public health events through training and mentoring on disease surveillance, laboratory techniques and community surveillance
d) Improve timeliness and completeness of health facilities reporting to counties, states and central levels through regular supervision visits and mentoring
e) Support verification of health events, outbreak response and rapid health assessments and containment of outbreaks
f) Enhance health tracking and communicable disease surveillance in areas of concern by supporting/strengthening the detection of, response to and containment of epidemic-prone diseases.

g) Support documentation (patient monitoring and tracking) for chronic care including HIV, TB and NCD's among IDP camps
h) Conduct a measles vaccination campaign for children from six months to 15 years of age
i) Produce weekly epidemiological and health situation reports and disseminate to all stakeholders including health authorities, donors and health partners
j) Support and provide technical support to measles, meningitis and oral cholera vaccination campaigns as a measure to prevent epidemic prose disease inside and outside the camps
k) Deploy short-term emergency public health officers, epidemiologists, data/information manager and technical officers to MOH facilities in acute emergencies as part of surge capacity
l) Maintain payment of salaries for emergency staff for health coordination, epidemiologists, communication/ information management, logisticians to support emergency coordination and response activities.

4. **To improve and expand the overall health cluster coordination mechanism at central and state levels for better coordination of health emergency response activities in high risk areas and surrounding communities**

Activities

a) Strengthen health cluster coordination capacity at central and state levels by maintaining/deploying surge teams to support cluster activities.
b) Support the national/state emergency task force to better coordinate with cluster partners on health emergency response activities in high risk states
c) Advocate the greater participation of all health partners and key MoH officials to the weekly health cluster and EP&R meetings.
a) Provide regular technical support to finalize the health cluster emergency response strategy and operational plan
d) Support regular monitoring and support supervision of the public health activities in the IDP camps
e) Provision of SOP, technical guidelines and protocols to use in health emergencies

5.3 Expected outcomes

1. All displaced people and other vulnerable groups benefit from life-saving health services inside and outside the camps
2. 95% of children under 15 in camps and counties with high concentration of IDPs are vaccinated against measles

3. 400 health workers trained on case management, trauma management, disease surveillance, MISP, clinical management of sexual violence and RH standards of care and others
4. 90% of outbreak alerts/rumors investigated within 48 hours of notifications
5. Health cluster coordination and emergency preparedness and response strengthened and critical gaps filled promptly and timely with minimal duplication of services being delivered.
6. Emergency supplies (inter-agency emergency health kits, trauma, diarrhoea disease, HIV/TB drugs and PEP kits) strategically pre-positioned and distributed to health care service providers in the ten states including the strengthening of supply chain management and improved warehouse capacity.
7. Emergency preparedness and response capacity strengthen at central and states levels
8. Health Assessments conducted and critical health needs documented and clearly defined to guide focused interventions
9. Information products developed and disseminate to the right audience, key donors and stake holders
10. Timely detection and containment of common communicable disease outbreaks and improved early warning surveillance and response capacity for communicable disease control at state and county level.
11. Emergency preparedness and response capacity strengthen at central and states levels
12. A strong administrative and logistic support to WHO and Health Clusters operation according to WHO Emergency SOPs

6 Monitoring and Evaluation

The successful implementation of the proposed project will depend on availability of required inputs (funds, human resources, supplies etc) which are needed to ensure that the right processes (services, medevacs, procurement, training, technical support, development of EPR and contingency plans etc) take place and result in the right outputs and outcomes. WHO country office with the technical backstopping by the regional and headquarter will monitor project performance and achievements at all levels of project implementation to determine whether the project objectives and expected outcomes have been met (in terms of scope, timeliness, quality, equity, and cost). A number of tools and methods will be used to monitor the delivery of health services, coordination, disease surveillance and other project components. This will be achieved in part through the monitoring of progress against the five key indicators outlined above. Below is a summary of the indicator matrix for measuring the different aspects of the project.

6.1 Indicators of progress

Project Objectives	Indicators of progress	Means of verification
To ensure access to and delivery of quality primary and secondary health care services through restoration and expansion of life-saving health care services to affected population, with particular focus on the most vulnerable group	• Percentage of displaced people and vulnerable accessing health services • Availability of secondary health care services including surgical, RH and mental health in three high risk states • Number of health providers trained • Number of functioning hospitals in the affected states • Number of children vaccinated against measles • Number of facilities providing routine EPI services	• Health facility registers • Assessment reports • Weekly/health bulletin copies • Outbreak investigation reports • Training reports • HR reports, copies of reporting form for epidemiologists • Mass campaign reports and evaluation reports
To strengthen emergency preparedness and response capacity at all levels, and ensure availability of emergency medical kits and supplies in all high risk areas	• Emergency SOP activated and in place • Emergency administrative services in places • WHO hubs in Bor, Unity, Awerial and Malakal restored and operational • Emergency medical kits distributed and strategically prepositioned in high risk areas • Adequate vehicles with MOSS compliant available in field offices • Ware housing space expanded and available for use	• Way bills, logistics ledgers, stock cards in the field • GSM records and requisition registration numbers • Number of functional vehicles that are MOSS complaint • WHO hubs restored and functional and utilised by state teams APW performance contracts
To strengthen early warning diseases surveillance, information management and epidemic response among displaced people and other vulnerable groups through existing surveillance system	• Availability of surveillance tools and EPR disease specific guidelines • 90% of all outbreak alerts investigated with 48 hours • Functioning early warning surveillance sites in all IDP camps • Cases Fatality Rate (CFR) as indicator of effective epidemic management at the facility and camp level • Attack Rate (AR) as an indicator of effective epidemic control • Number of weekly surveillance bulletin's produced and disseminated • Surveillance officers in place in	• IDSR database • Event log • Laboratory database • Outbreak investigation report • Distribution plans for tools and guidelines • Minutes of EP&R meetings

	high risk areas • Reduced turnaround time for specimen analysis	
To improve and expand the overall health cluster coordination mechanism at central and state levels for better coordination of health emergency response activities in high risk areas and surrounding communities	• Weekly health bulletin, HC bulletin and surveillance produced and disseminated • WCO internal sitrep produced on a weekly basis • Data manager in place to support the response • All key states have an epidemiologist deployed to support response • Finding form the regular assessment summarised and shared with RO • 3Ws in place and surgical mapping update on regular basis • All health events and outbreaks verified within 48hours • 400 health workers trained on emergency response procedures across the ten states	• Minutes of coordination meetings • Updated 3W matrix/surgical capacity matrix • Assessments reports • OPD records/data and service delivery updates • HCC focal point stationed at state level • Training reports

7 Budget

Based on the WHO Emergency Response Framework, South Sudan has been graded as Grade 3 emergency. As of the February 20, 2014, WHO's financial requirement towards the emergency response in South Sudan is estimated at US$11,134,000 for the next six months, and so far only 13% was funded. WHO's operations in high risk states have greatly been affected by the current crisis, as two of WHO offices in Bentiu and Bor were looted and destroyed. This has negatively impacted the ability of WHO to support the on-going health emergency in the affected states, and there is urgent need to restore core health services in the high risk states. WHO continues to play a key role in the provision of health care services and health cluster coordination of emergency health services in South Sudan. This funding will be used to support and contribute to WHO's overall emergency health response in the first six months of 2014 with specific emphasis on the four critical areas of WHO work in emergency.

7.1 Financial Implications

Budget Lines	***Cost Breakdown***			
	Unit	**Quantity**	**Unit Cost**	**Total (USD)**
A. Supplies/commodities/equipment/transport ***(please itemize expendable operational inputs (e.g. quantity of food, medical supplies etc and asset purchases)***				
IEHK Complete Kits	Kits	30.00	$ 32,000	$ 960,000
IEHK Supplementary Kits	Kits	150.00	$ 12,000	$ 1,800,000
IDDK Kits	Kits	30.00	$ 6,350	$ 190,500
Italian Trauma Kit A	Kits	20.00	$ 12,500	$ 250,000
Italian Trauma Kit B	Kits	20.00	$ 17,000	$ 340,000

Pneumonia Kit A	Kits	50.00	$	418	$	20,900
Pneumonia Kit B	Kits	50.00	$	136	$	6,800
Personal deployment Kits	Kits	20.00	$	2,860	$	57,200
Assorted drugs (paediatric drugs/antibiotics)	Lumpsum	1.00	$	339,000	$	339,000
Large tents for mobile clinics or storages	Kits	30.00	$	10,000	$	300,000
Surgical Equipment for 4 hospitals	Lumpsum	1.00	$	317,730	$	317,730
Information/Communication Technology Kits	Kits	5.00	$	9,500	$	47,500
VHF Hand Held radios GP360 or GP380	Unit	60	$	800	$	48,000
Thuraya Phones	unit	20	$	900	$	18,000
MOSS Compliant Toyota Land Cruisers	Unit	4	$	66,000	$	264,000
ICT equipment and furniture	Per office	4	$	33,000	$	132,000
Staff Accommodation containers in four locations	Per state	10.00	$	47,000	$	470,000
Sub-Total A:	——	——		——	**$**	**5,561,630**
B. Personnel (staff, consultants, travel) ***(please itemize travel costs, salaries and entitlements of UN staff and consultants)***						
Health cluster State officers	Person per month (3 x 5)	15	$	24,000	$	360,000
Epidemiologist/public health officer	Person per month (3 x 5)	15	$	24,000	$	360,000
Data manager at Juba level	Person per month (1 x 6)	6	$	12,000	$	72,000
Surgeon and Anaesthesiologists	Person per month (3 x 4 month)	12.00	$	15,000	$	180,000
National Public Health Officers	Person per month (5 x 5)	25.00	$	3,000	$	75,000
Logistic Officers (3 states)	Person per month (1 x 6)	6.00	$	18,000	$	108,000
Staff travels (tickets, perdiem etc)	lumpsum	1.00	$	85,000	$	85,000
					$	-
Sub-Total B:	——	——		——	**$**	**1,240,000**
D. Operational Activities						
Refresher training of 500 health workers on trauma management and case management	per session	15.00	$	12,000	$	180,000
Refresher training for 300 health workers and surveillance officers on IDSR and outbreak investigation	Per session	10.00	$	13,000	$	130,000
Refresher training for 200 community health workers on case management and health promotion	per session	5.00	$	7,500	$	37,500
Trainings on HCC and emergency response strategy	per session	2.00	$	25,000	$	50,000
Outbreak investigation and response (measles, meningitis, cholera and others)	lumpsum	1.00	$	650,000	$	650,000
Operation support to state surveillance officers	Lumpsum	1.00	$	150,000	$	150,000
Logistics, warehousing and transport for emergency supplies	Lumpsum	1.00	$	440,000	$	440,000
Sub-Total B:	——	——		——	**$**	**1,637,500**
C. Medevac Operation						

Chartering private planes for medevac (6 months)	Lumpsum	1.00	$	540,000	$	540,000
Medical escort teams (6 months)	Lumpsum	1.00	$	185,000	$	185,000
Ambulances to facilitate referral	per state	3.00	$	65,000	$	195,000
Patient maintenance in the referral hospitals	per state	3.00	$	50,000	$	150,000
Fuel for ambulance and surgical teams	drums	50.00	$	750	$	37,500
Sub-Total C:	——	——		——	**$**	**1,107,500**
D. Other Direct costs						
Fuel for generator and vehicles	Drums	150.00	$	650	$	97,500
Vehicle Maintenance	Vehicles	6.00	$	2,400	$	14,400
Communication	Lumpsum	1.00	$	95,000	$	95,000
Office stationaries/supplies	Lumpsum	1.00	$	3,000	$	3,000
Sub-Total D:	——	——		——	**$**	**209,900**
E. Monitoring and evaluation						
Internal Project Monitoring and Reporting	Lumpsum	1.00	$	450,000	$	230,000
Technical backstopping from RO and HQ	Lumpsum	1.00	$	340,000	$	206,200
Sub-Total E:	——	——		——	**$**	**649,100**
Subtotal project requirements					**$**	**10,405,630**
Indirect program support costs (PSC) ***(not to exceed 7% of subtotal project costs)***						
PSC rate (Insert PSC percentage, max 7.00%)					**$**	**728,394**
Grand total (total of activities + PSC)					**$**	**11,134,024**

8 Annexes

8.1 Annex 1: Implementation timeline

DETAIL IMPLAMENTATION PLAN							
Project Title: *Responding to health-related emergencies in populations of humanitarian concern in the Republic of South Sudan*							
Overall Objective: *To contribute the reduction of excess morbidity and mortality among displaced people and host communities affected by the current crisis, through strengthening health emergency preparedness and response capacity at all levels in South Sudan*							
Duration: *Six Months (January - June 2014)*							
Amount (US$): *11,134,000*							
		Implementation Timeline					
Activities by Result		***Feb***	***March***	***Apr***	***May***	***June***	***July***
To ensure access to and delivery of quality primary and secondary health care services through restoration and expansion of life-saving health care services to affected population, with particular focus on the most vulnerable group.							
	Strengthen or re-establish primary health centres in the affected areas including provision of basic equipment and related supplies to deliver essential health services package to displaced people and host communities	X	X	X	X	X	X
	Support and facilitate the medevac of injured patients to the nearest referral facilities	X	X	X	X	X	X
	Support the MOH and health cluster partners to conduct real time assessment for health facilities and available services, and document critical needs and design appropriate strategies to ensure health gaps are filled	X	X	X	X	X	X
	Advocate greater involvement of health cluster partners to provide life-saving health care services in the affected communities, with emphasis on counties with high concentration of displaced people	X	X	X	X	X	X
	Support the restoration of state and county hospitals through provision of essential equipment and personnel	X	X	X	X	X	X
	Ensure key cluster partners and health authorities are regularly supplied with essential medicines, and there is no shortage of essential drugs	X	X	X	X	X	X
	Provision of health services to the affected people through mobile and fixed health units in areas where health facilities were looted or not functioning	X	X	X	X	X	X
	Support the provision of mental health and other Non Communicable Disease in the affected population	X	X	X	X	X	X
	Deploy more health workers in the areas with high concentrations of displaced persons and in areas with more health needs so to improve the access and availability of health services	X	X	X	X	X	X
	Organize refresher training among health workers on case management of common illnesses, trauma management and RH services	X	X	X	X	X	X

	Support the implementation of emergency measles vaccination campaigns and re-establish the routine EPI activities	X	X	X	X	X	X
	Conduct health promotion and community awareness in the camps and surrounding host communities on epidemic prone diseases, RH, HIV, TB and GBV	X	X	X	X	X	X
	Support monitoring and evaluation of health emergency response activities implemented by health cluster partners in the conflict affected areas	X	X	X	X	X	X
To strengthen emergency preparedness and response capacity at all levels, and ensure availability of emergency medical kits and supplies in all high risk areas							
	Procure and preposition emergency medical kits, supplies, logistic and transport equipment in strategic locations in the high risk areas	X	X	X	X	X	X
	Coordinate the provision of life saving surgeries to the critically injured and ensure an effective referral mechanism is clearly defined including medical evacuation of critically injured to Juba, Bor, Bentiu and Malakal Hospitals	X	X	X	X	X	X
	Support the deployment of short-term surgeons and anaesthesiologist in the state hospitals of Bor, Malakal, Kwajok, Rumbek and Bentiu hospitals	X	X	X	X	X	X
	Consolidate and update the 3Ws and map health resources availability including functionality of health facilities, damage to health facilities, and the available services, including surgical and RH capacities across the states	X	X	X	X	X	X
	Organize technical meetings with health authorities and cluster partners to review/adapt health emergency response guidelines and protocols	X	X	X	X	X	X
	Deploy short-term emergency public health officers, epidemiologists, data/information manager and technical officers to MOH facilities in acute emergencies as part of surge capacity	X	X	X	X	X	X
To strengthen early warning diseases surveillance, information management and epidemic response among displaced people and other vulnerable groups through existing surveillance system							
	Enhance early warning surveillance activities in all affected areas and host communities	X	X	X	X	X	X
	Scale up community based surveillance system inside and outside the camps on detecting and reporting cases and deaths occurring in the camps	X	X	X	X	X	X
	Enhance the capacity of front-line health workers to detect, verify, and respond to public health events through training and mentoring on disease surveillance, laboratory techniques and community surveillance	X	X	X	X	X	X
	Improve timeliness and completeness of health facilities reporting to counties, states and central levels through regular supervision visits and mentoring	X	X	X	X	X	X

	Support verification of health events, outbreak response and rapid health assessments and containment of outbreaks	X	X	X	X	X	X
	Enhance health tracking and communicable disease surveillance in areas of concern by supporting/strengthening the detection of, response to and containment of epidemic-prone diseases.	X	X	X	X	X	X
	Support documentation (patient monitoring and tracking) for chronic care including HIV, TB and NCD's among IDP camps	X	X	X	X	X	X
	Conduct a measles vaccination campaign for children from six months to 15 years of age	X	X	X	X	X	X
	Produce weekly epidemiological and health situation reports and disseminate to all stakeholders including health authorities, donors and health partners	X	X	X	X	X	X
	Support and provide technical support to measles, meningitis and oral cholera vaccination campaigns as a measure to prevent epidemic prose disease inside and outside the camps	X	X	X	X	X	X
	Maintain payment of salaries for emergency staff for health coordination, epidemiologists, communication/ information management, logisticians to support emergency coordination and response activities.	X	X	X	X	X	X
To improve and expand the overall health cluster coordination mechanism at central and state levels for better coordination of health emergency response activities in high risk areas and surrounding communities							
	Strengthen health cluster coordination capacity at central and state levels by maintaining/deploying surge teams to support cluster activities	X	X	X	X	X	X
	Support the national/state emergency task force to better coordinate with cluster partners on health emergency response activities in high risk states	X	X	X	X	X	X
	Advocate the greater participation of all health partners and key MoH officials to the weekly health cluster and EP&R meetings	X	X	X	X	X	X
	Provide regular technical support to finalize the health cluster emergency response strategy and operational plan	X	X	X	X	X	X
	Support regular monitoring and support supervision of the public health activities in the IDP camps	X	X	X	X	X	X
	Provision of SOP, technical guidelines and protocols to use in health emergencies	X	X	X	X	X	X


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