

Health, Nutrition and HIV/AIDS Cluster Contingency Plan

Humanitarian consequence of the scenario (planning assumption for the sector)	Cluster response plan			Preparedness (level of preparedness required vs current deployment capacity)	Operational gaps	Estimated Budget in USD	Operational constrains
	Operational consequences	Operational objective	Activities				
Poor access to farm land leading to increased level of malnutrition	The malnutrition level will increase from 5% to over 10% GAM and 1% to 3% SAM	To treat existing cases of SAM and GAM and to reduce the risk of death due to malnutrition	i. Community based screening and referral of cases; ii. Treatment of identified cases in existing TFC, SFC and CTCs, iii. Open 2 new TFC sites in Karamoja, 4 SFC in Kitgum and Pader and 3 CTC centers per district.	i. Train and equip community based screening team, ii. Train more health workers to manage TFC, SFC, CTCs iii. Order therapeutic and supplementary feeding supplies iv. Community screening and referral of malnourished children v. Community sensitization vi. Rapid nutrition assessments.	i. Lack of nutrition partners in Karamoja ii. Inadequate and under staff health facilities iii. Insecurity iv. Sparsely populated community v. Lack of capacity to implement TFC in a large scale vi. The community structure are not operational at community level	150,000	Security to run CTC's;
Increased insecurity leading to: i. increased incidences of trauma cases; ii. Disruption of health services	Increase incidences of trauma	To effectively manage all trauma cases and reduce the effect of trauma	i. Manage all cases of trauma that presents at the health facility	i. Inventory of surgical supplies and equipments at health facilities ii. Training of health workers in emergency surgical care iii. Preposition of essential surgical supplies and equipments iv. Strategic deployment of staff to IV and hospital in selected districts	20 Surgical supplies (kits), Health staff (general practitioners/surgeons) for HC IV and hospitals with functional theatre	200,000	
(reproductive health, HIV/TB, essential drugs supply) iii. Reduction in # of HRH ii. Lack of infrastructure	Disruption of health services (RH/Child heath)	Provide RH/Child health services to the community	i. Conduct outreach services in selected camps (ANC and immunization) ii. Treatment of presenting cases at community (HBMF) and health facility level iii. Provision of logistic support to mobile clinics (fuel and SDAs) iv. Appropriate referrals of cases	ii. Training of VHTs (community drug distributors) ii. Training of health workers iii. Procurement of drugs for CBDD iv. Procurement of delivery and mama kits and its distribution vi. Monitoring and supervision of CBDD and TBAs	Provision of 219 RH kits (block I), 73 RH kits (block II) and 15 RH kits (Block III);	1,168,243	
	Disruption of HIV/TB services and increased incidences of HIV and TB	To reduce the incidence of HIV and TB	i. Treat existing cases of TB and opportunistic infection in HIV/AIDS ii. Conduct outreach services iii. Support supply of drugs, equipment to HF and community iv. Continue provision of community services (TB-DOTS) v. Continue community sensitization vi. continue saupporting network of people livin with HIV/AIDS to conduct psychosocial support	i. Training of health workers, ii. Establishment of outreach sites, iii. Maintain surveillance iv. Continue with community sensitisation v. continue supporting network of people living with HIV/AIDS to conduct psychosocial support iv. Provide HIV testing kits and laboratory supplies v. Increase HIV/AIDS testing sites to all health centres III and above vi. Increase PMTCT services to all HC III and above. vii. Strengthen existing ART sites	i. Lack of supplies (testing kits etc) ii. Few functional sites iii. Poor community uptake of HIV/AIDS services iv. Inadequate skilled personnel	600,000	

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	Disruption in supplies and equipment chain	To insure availability of supplies, drugs, and equipment to maintain adequate services according to level	i. Identify gap (needs), ii. Order and deliver supplies according to needs	i. Assess drug management capacity, ii. Prepare inventories of drug, supplies and equipment for all health facilities, iii. Assess the cold chain and logistics capacity and plan for mobilization in the event of an emergency	Poor inventory management at all levels	20,000	
	Disruption of malaria control activities and increased incidence of malaria among IDPs	Reduce incidence of malaria among the IDPs	i. Continue distributing ITN in the community ii. Conduct IRS in camps and institution iii. Treat existing cases at health facilities and community level iv. Carry out IPT activities	i. Conduct IRS in camps, community and institutions ii. Train VHTs (CBDD) on HBMF iii. Preposition drugs at the district health office iv. Train HW and VHTs on IPT v. Carry out IPT activities vi. Procure and distribute 219, 000 LLNS	i. 219,000 LLNS ii. Icons iii. ACTs	2,000,000	Local population may resist implementation of IRS
	Lack of infrastructures	To ensure functionality of health facilities	i. setup treatment centers, field hospitals; ii. Conduct minor repairs as needed; iii. Install essential equipment (generators, water tanks etc.)	i. assess immediate infrastructure and repair needs (generator, water supply, storage capacity); ii. Availability of tents that can be used as clinic iii. Conduct minor repairs of health facilities	i. setup treatment centers in very crowded camps; ii. Install essential equipment (generators, water tanks etc.)	600,000	Insecurity may prevent access of contractors to affected camps
	Reduction in HRH from the current 36% to 30%	To reduce avoidable death in IDP camps as a result of lack of health staff.	i. Deploy temporary staff to main health facilities	i. identify the main health centers in the IDP camps likely to serve the surge of IDPS due to insecurity; ii. Mobilize resources for strategic deployment of staff	i. Recruit and assign short-term health staff to HC III & IV	100,000	Insecurity may affect willingness of staff to be deployed
Over crowding in camps leading to disease outbreaks (Meningitis, cholera, Measles and malaria)	Epidemic outbreak of meningitis	Reduce CFR and AR of meningitis to below epidemic level	i. Strengthen IDSR and conduct active case searches ii. Community mobilization and education iii Treatment of cases iv. Conduct mass vaccination campaigns where necessary	i. Training of VHT and establishment of CBDS in IDP camps and community ii. Strengthening HMIS/IDRS at district level iii. Existing EPR committees in place at district level iv. Community sensitization and education	300,000 doses of bivalent meningitis vaccine., 10,000 vials of oily CAF, assorted medical and laboratory supplies	500,000	
	Epidemic outbreak of Cholera	Reduce CFR and AR of cholera to below epidemic level	i. Community based disease surveillance ii. Treatment of cases iii. Follow up of suspected cases iv. Community mobilization and education,	i. Training of VHT and establishment of CBDS in IDP camps and community ii. Strengthening HMIS/IDRS at district level iii. Existing EPR committees in place at district level iv. Community sensitization and education	Provision of 20 cholera kits	200,000	

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	Epidemic outbreak of measles	Reduce CFR and AR of measles to below epidemic level	i. Community based disease surveillance ii. Treatment of cases iii. Follow up of suspected cases iv. Continue with community mobilization and education,	i. Training of VHT and establishment of CBDS in IDP camps and community ii. Strengthening HMS/IDRS at district level iii. Strengthen routine and conduct accelerated immunization services iv. Community sensitization and education v. Assess the cold chain and logistics capacity and plan for mobilization in the event of an emergency	i. Procure 300,000 vials of each vaccines ii. Continue routine vaccination activities iii. Community sensitization for uptake of immunization services	250,000	
Increased incidences of SGBV leading to increased incidences of STI, psychological trauma, disability and undesired pregnancies)	Increase incidences of SGBV related illnesses	To provide timely care and support to 80% of reported SGBV, disability and psychological trauma cases	i. Delivery of PEP kits, STI and ECP drugs; ii. Treatment and counseling of survivors of SGBV	i. stock-pile PEP, ECP; ii. Determine numbers of trained health workers able to deal with survivors; iii. Awareness creation	i. deliver and distribute PEP, ECP and STI kits ii. Awareness creation at community level	300,000	Cultural barriers to SGBV activities
Coordination efforts affected by emergency situation and mobility restrictions	Poor coordination and duplication of efforts	To ensure that proper coordination is in place	i. Frequent coordination meetings ii. Frequent joint planning iii. Frequent joint review meeting and supervision	i. Frequent scheduled coordination meetings ii. Joint planning	Not all organisations attend monthly coordination meetings	150,000	Lack of willingness of some partners to take part in coordination activities
TOTAL COST						6,238,243	