For **'new-line' in text fields pres [ALT] and [ENTER] keys on keyboard** (do not insert spaces to create line shift)
Please do not change the format of the form (including name of page) as this may prevent proper registration of project data.
**For new proposals, please complete the tab for 'Project Document', 'Budget' and 'Locations'**
**Mandatory fields are marked with an asterisk***

CHF SOMALIA

# Project Document

## 1. COVER (to be completed by organization submitting the proposal)

| | | |
|---|---|---|
| **(A) Organization*** | Islamic Relief Worldwide | |
| **(B) Type of Organization*** | ☐ UN Agency ☐ International NGO ☐ Local NGO — International NGO | |
| **(C) Project Title*** For standard allocations, please use the CAP title. | To Increase Access to Emergency Obstetric, Neonatal and epidemic controls in Health Care Services and Information to Vulnerable IDPs and hosts communities of South Central Somalia: | |
| **(D) CAP Project Code** | SOM-12/H/48516 | Not required for Emergency Reserve proposals outside of CAP |
| **(E) CAP Project Ranking** | High | Required for proposals during Standard Allocations |
| **(F) CHF Funding Window*** | Standard Allocation 1 (Mar 2012) | |
| **(G) CAP Budget** | | Must be equal to total amount requested in current CAP |
| **(H) Amount Request*** | $ 586,100.00 | Equals total amount in budget, must not exceed CAP Budget |
| **(I) Project Duration*** | 12 months | No longer than 6 months for proposals to the Emergency Reserve |
| **(J) Primary Cluster*** | Health | |
| **(K) Secondary Cluster** | Water, Sanitation and Hygiene | Only indicate a secondary cluster for multi-cluster projects |

**(L) Beneficiaries** Direct project beneficiaries. Specify target population disaggregated by number, and gender. If desired more detailed information can be entered about types of beneficiaries. For information on population in HE and AFLC see FSNAU website (http://www.fsnau.org)

| | Men | Women | Total |
|---|---|---|---|
| **Total beneficiaries** | 4000 | 31000 | 35000 |
| Total beneficiaries include the following: | | | |
| **Children under 5** | 6500 | 8500 | 15000 |
| **Internally Displaced People/Returnees** | 15400 | 36400 | 51800 |
| **Urban Poor** | 3500 | 5600 | 9100 |
| **Pregnant and Lactating Women** | 0 | 3200 | 3200 |

**(M) Location** Precise locations should be listed on separate tab

Regions: ☐ Awdal ☐ Banadir ☐ Bay ☐ Gedo ☐ L Juba ☐ M Juba ☐ Mudug ☐ Sanaag ☐ Togdheer ☐ Bakool ☐ Bari ☐ Galgaduud ☐ Hiraan ☐ L Shabelle ☐ M Shabelle ☐ Nugaal ☐ Sool ☐ W Galbeed

**(N) Implementing Partners** (List name, acronym and budget)

| | | | |
|---|---|---|---|
| 1 | | Budget: | $ - |
| 2 | | Budget: | $ - |
| 3 | | Budget: | $ - |
| 4 | | Budget: | $ - |
| 5 | | Budget: | $ - |
| 6 | | Budget: | $ - |
| 7 | | Budget: | $ - |
| 8 | | Budget: | $ - |
| 9 | | Budget: | $ - |
| 10 | | Budget: | $ - |
| | **Total** | Budget: | $ - |
| | **Remaining** | Budget: | $ 586,100 |

**Focal Point and Details - Provide details on agency and Cluster focal point for the project (name, email, phone).**

| | | | | |
|---|---|---|---|---|
| **(O) Agency focal point for project:** | Name* | Dr.M.A.Iffthikar | Title | Country Director- Islamic Relief Somalia |
| | Email* | cd@islamic-relief.or.ke | Phone* | +254737209779 |
| | Address | Kirichwa road off Ngong Road. | | |

## 3. BACKGROUND AND NEEDS ANALYSIS (please adjust row size as needed)

**(A)** Describe the project rationale based on identified issues, describe the humanitarian situation in the area, and list groups consulted. (maximum 1500 characters) *

South central Somalia is facing a catastrophic humanitarian crisis due to on-going conflict and periodic episodes of droughts which have disrupted trade, caused forced displacement of more than 1.5 million, hyperinflation and significant food aid constraints which in turn has dramatically increased humanitarian needs. The worst affected regions include Banadir, Lower-Shabelle, Bay and Bakool regions. Recurrent communicable diseases incidences such as AWD outbreak has been reported as a result of disruption of WASH facilities for both IDP settlements and host communities accompanied by poor seasonal rains and loss of livelihoods and assets that increased level of malnutrition particularly children below 5 years old. Public health system is still nascent, and community-based health service delivery is inadequate to meet public needs in the areas assessed. Somalia is an incredibly challenging context. New military escalation in Somalia risks harming civilians and undermining efforts to recover from famine. The AU military force (AMISOM) and the Transitional Federal Government (TFG) have launched a major new offensive in an area where 400,000 people are living in densely populated camps. Humanitarian organizations on the ground have reported thousands of civilians have already fled the area, known as the Afgooye Corridor, and reported heavier fighting and displacement throughout Thursday night.

The Afgooye Corridor was among the regions of Somalia affected by famine and has only recently begun to show signs of recovery. People in Afgooye have been among the worst affected by the famine and are still extremely vulnerable. Thousands of people are fleeing the fighting towards Banadir regions of Yaqshid, Karaan and Wardhigley which are also on the northern frontline. There is massive influx of people on the move. People are reporting deaths and damage to property as a result of the clashes and endless shelling. They are heading to safer locations in Mogadishu. There are many of trucks, cars and donkey carts packed with mattresses and other household utensils. Some neighborhoods are completely empty.

Access constraints remained significant. IDP communities that use to enjoy services provided by the withdrawing agencies in the areas controlled by armed organization groups have approached IRS to fill the gap left by aid agencies that withdrew from these areas. The Banadir districts of Hodon, Karan, Howl Wadag, Yaqshid, Heliwaa, Shibis and Wardhigley are on the front lines of the conflict and displacement from here is certain. IDP camps are growing by the day in these areas, often in unplanned way that could pose a risk of getting preventable diseases. The growing number of the IDPs in the camps is placing an additional burden on the existing resources and the basic service delivery mechanism.

Furthermore, a recent rapid assessment conducted between 9th and 17st February 2012 by Islamic Relief teams in the field indicated that although previous programs have tried to address the needs of the IDP populations still there are gaps that need to be responded to. These are people without adequate health, water supply, latrines, livelihoods and food. The survey which concentrated in 20 IDP camps discovered that the level of vulnerability among the IDPs is getting worse each passing day. In Mogadishu alone 90,000 IDPs are in dire need for help. During the recent survey it emerged that 60% of the IDPs cannot access adequate primary health services due to its prohibitive cost and the distance they walk to health institutions. There is also a serious lack of health professional cadres, essential medicines/ disposables and basic equipment in almost all areas assessed. These are the IDPs are in need of urgent primary health interventions. Having lost their entire livelihood support systems, almost 80% of the

**(B)** Describe in detail the capacities and needs in the proposed project locations. List any baseline data. If necessary, attach a table with information for each location. (maximum 1500 characters) *

In the recent assessment undertaken by Islamic Relief Somalia (which can be extrapolated to entire South Central region,) that covered a total of 20 IDP camps,with an approximate population of 48,858 people, majority being women and children (72%), paints a very serious ongoing humanitarian situation in the region. The IDP camps received a total of 291 new immigrants per week during the assessment period- (see annex 2 attached.) The IDP camps were characteristically heavily congested with makeshift shelters that lack almost all of the basic facilities. The mean age of selected IDPs interviewed and assessed in this survey was about 23 years old. Almost all lack formal education. There was a strikingly high level of morbidity and malnutrition, even though the survey was carried out in the "jilaal" dry season. Nearly 68% of children had one of the following illnesses in the two weeks preceding the survey: acute respiratory infection (cough with rapid breathing) and diarrhea or fever. Two week period prevalence for acute respiratory infection (ARI) was 49%, diarrhea 35%, and fever 38%. 28% of mothers recognized fast or rapid breathing as a sign of illness that required treatment. 56.3% recognized diarrhea. High fever (presumptive malaria) was cited by nearly 67.8% of all surveyed mothers as a danger sign that required treatment. 27.4% of surveyed caregivers were not able to identify any danger signs that indicated the need for care and treatment (rapid breathing, diarrhea, high fever and convulsions). Other promotive elements of health like hygiene and sanitation, nutrition, schooling and clean water provisions are absent in these IDPs or operate in much lower scale to meet the standards and the needs of the people.

12% of mothers stated that they exclusively breastfed for at least six months. 17% of children 0-5 months were exclusively breastfed during the last 24 hours. 48% of children age 6-9 months received breast milk and complementary foods during the last 24 hours. When caregivers of children with diarrhea were asked what they used to treat diarrhea less than one-third (32.2%) reported giving packaged Oral Rehydration Salts (ORS). The most common treatment (68.7 %) lemon/syrup.28% of mothers reported that their child received a Vitamin A capsule within the past six months. Tetanus toxoid injection coverage was almost none existent during their last pregnancy. 83.6 % said they gave birth at home; 4% delivered at a public hospital and 8% delivered at a private hospital.48% of respondents were able to show their child's vaccination card.

Reported hand washing before food preparation stood at 52 %. Hand washing before child feeding was only cited by 30% of mothers, after defecation was cited by 30 %. 31% of mothers reported using soap when they wash their hands and had soap in the household at the time of the interview.

The most common source of information is from a village health volunteer/TBA (21 %). Mothers were asked if they received health/hygiene messages from any other sources over the past month. Nearly 38 % noted the radio. Other sources were village health volunteers (21.6 %) and village health committees (9.6 %). Bill boards/IEC was only identified by 18.4 % of mothers.

| | | |
|---|---|---|
| **(C)** List and describe the activities that your organization is currently implementing to address these needs.(maximum 1500 characters) | IRS has undertaken a number of primary health assistance to affected IDPs in the region since its inception and funded by a number of reputable donors both internally and externally with resultant big impacts such as ECHO, CHF, WHO, etc. Currently are anumber of projects undergoing such as the provision of emergency health assistance to IDPs in Afgooye corridor funded by CHF, emergency support of IDPs in Bay and Bakool regions, formation of cholera treatment centres - emergency in Bay and Bakool, provision of emergency health systems to Mudug and Puntland. IRS has also availed a number of funding for projects in the regions, streaming internally from its various affiliates and benefits thousands of IDPs in the region. It has also partnered successfully with other charitable organisation and is undertaking a number of health projects such as construction of an eye hospital in Mogadishu with Bahrein Royal charitable organisation. Frequently IRS has organised a number of cataract surgery operations in collaboration with sister IR family organisations such as IR Austarlia.<br>IRS has constructed and is supporting triage cholera treatment centre based at Banadir hospital of Mogadishu.<br>In cooperation with Bahrein royal charity organisation, IRS is planning to construct a national eye centre in Mogadishu city and hand over to TFG governement but still continue assisting it. | |

## 4. LOGICAL FRAMEWORK (to be completed by organization)

| | | | | |
|---|---|---|---|---|
| **(A) Objective*** | To provide immediate life saving emergency obstetric and neonatal support to vulnerable displaced people in South Central Somali | | | |
| **(B) Outcome 1*** | Improved access to primary health care (PHC) and Basic Emergency Obstetric and neonatal Care (BEmONC) services for a total o | | | |
| (C) Activity 1.1* | Provision of OPD and PHC service including Mother and Child Health, BEmONC services to a total of 60,000 people disaggregated | | | |
| (D) Activity 1.2 | Provision of referral services to 8,000 severely ills such as women with complicated obstetrics cases, severely malnourished individu | | | |
| (E) Activity 1.3 | | | | |
| (F) Indicator 1.1* | Health | Number of consultations per clinician per day by Health facility | **Target*** | 50 |
| (G) Indicator 1.2 | Health | 8,000 | **Target** | |
| (H) Indicator 1.3 | Health | | **Target** | |
| **(I) Outcome 2** | Vulnerable IDPs and poor hosts community, community based primary health care providers living in the targetted project areas hav | | | |
| (J) Activity 2.1 | Training to 80 CHWs and 50 TBAs of which 60% are women. | | | |
| (K) Activity 2.2 | Dissemination of repackaged IEC materials developed by UNICEF that are culturally sensitive to the local Somali people. | | | |
| (L) Activity 2.3 | Training of midwives (15 midwives) on safe delivery, post abortion and emergency obstetric care. | | | |
| (M) Indicator 2.1 | Health | Number of health workers trained on common illnesses and/or ir | **Target** | 130 |
| (N) Indicator 2.2 | Health | 1800 | **Target** | |
| (O) Indicator 2.3 | Health | 15 | **Target** | |
| **(P) Outcome 3** | Prevention and control of outbreaks and early warning systems alerts and response mechanisms in place. | | | |
| (Q) Activity 3.1 | Regular submission of epidemiological information/ data and information through integrated disease and surveillance reports (IDSR | | | |
| (R) Activity 3.2 | AWD/Cholera awreness creation especially during the cholera peak months- March/April and September-October- through hygiene | | | |
| (S) Activity 3.3 | | | | |
| (T) Indicator 3.1 | Health | Number of health facilities supported | **Target** | 4 |
| (U) Indicator 3.2 | Health | reductionin cases of AWD/Cholera incidences/cases in the targe | **Target** | |
| (V) Indicator 3.3 | | | **Target** | |
| **(W) Implementation Plan*** Describe how you plan to implement these activities (maximum 1500 characters) | The pro ject will be managed from Mogadishu with a field office in Baidoa. 5 health facilities with examination facilities will be set up in 5 IDP locations with utmost needs. 5 health teams comprising of 2 clinician2, midwives and a nurses will be engaged on a daily basis to the clinic centres with medicines and conduct clinic sessions and health education sessions. Any seriously ill or any cases that require referral to bigger institutions shall be referred. Every clinic sessions shall start with health education sessions. The selected peers shall be trained and disseminated in to the IDPs and host communities with repackeged IEC materials that depict local context with clear local Somali language. Weekly IDSR forms will be sent to WHO/ health cluster regularly. Bay, Afgooye corridor and banadir regions will be served continuosly through out the project period, provided with -EmONC, Health education, training o f health care staff, treatment o f communicable diseases. 5 health facilities will be used as the focal points for both projects areas argetted ie. Banadir and Bakool regions,<br>All mortality and morbidity data will be collecdted on every day at the clinic, compiled in a summary form into the register and sent to Mogadishu for analysis by health staff based in the office for onward transmission to the health clusters and other relevant stakeholders.<br>During trainings of CHWs and TBAs , IRS will ensure that attendance lists for each day during the training is obtained including telephone contacts and records are kept for future follow up.<br>All monthly and quarterly monitoring reports will be prepared and kept in files. IRS will organise joint monitoring with clusters in the region. Minutes of health care staff meetings will be kept on file and made available upon request as well as follow up during subsequent meetings.<br>The tents procured will be handed over to the health facility and used for outreaches. Each health facility will receive 2 tents.<br>Health facilities construction and rehabilitation will be udertaken by funds fron sister organisation- IR Netherlands.<br>Trainings: Staff trainings will be held in Somalia, Nairobi so as to improve on their health intervention skills. IRS will train 15 mid wives in - Assist midwives during the birthing process, Assess mothers and neonates and complete vital signs on both, Monitor contractions and neonate heart rates.- educate during the post-partum period regarding what to expect with the mother's body and infant care. Educate and help with breastfeeding.Teach mother's how to breastfeed, use of a breast pump, and what is normal in a newborn. Care for mothers who have post-partum haemorrhages. Post-c-section care.The trainings will be held 2 times a month at the health facilities targetted by qualified medical practitioners. Refresher trainings will also be undertaken for both nurses and midwives.<br><br>In terms of project staff, IRS will train a total of 7 project staff in terms of assessment, formulation of health intervention, evaluation of health projects, trainers of trainers of health care staff in the field, medical projects and budgetting , etc. The trainings will be held every fortnightly at IRS offices both in the field, Mogadishu and Nairobi.<br><br>IRS will train a total of 10 health project staff in management of health projects, monitoring and evaluation and health information | | | |

## 5. MONITORING AND EVALUATION (to be completed by organization)

**(A)** Describe how you will monitor, evaluate and report on your project activities and achievements, including the frequency of monitoring, methodology (site visits, observations, remote monitoring, external evaluation, etc.), and monitoring tools (reports, statistics, photographs, etc.). Also describe how findings will be used to adapt the project implementation strategy. (maximum 1500 characters) *

Daily updates, weekly disease surveillance reports and monthly clinic returns shall be submitted from the field to WHO and Nairobi IR Somalia Office. An interim and final repo rts shall be submitted to OCHA. The activities shall be communicated regularly through health cluster and health cluster bulletin. Direct monitoring shall be done by Program managers and emergency program coordinator at the site of implementation.Monitoring will be carried out on regular basis (monthly and quarterly) at different implementation levels that is the reproductive health outreach package at the IDP sites where different reproductive health intervention will be carried, implemented activities will be checked monthly against implementation plan to ensure planned activities are done, regular meetings will also be held with health care staff to discuss project progress and any need for modification of strategies. IRS will also monitor implementation and distribution of emergency RH kits. A senior nurse/midwife will make field visit to monitor trainings and repro ductive health outreach package implementation.
IRS will have all supported patients registers, kept at health facilities during the implementation of the project and analysed on weekly basis by IRS health project coordinator before sharing the report with WHO, UNOCHA, health cluster members and other health project agencies in the region interested on the information.

Monitoring missions in the project areas will be recorded and uploaded onto the CHF database frequently during this project implementation.
Cholera outbreaks are quite common in the project targetted area as data from area shows (Banadir) confirmed cases standing at 3 cases last month of March 2012.

The IDP locations where the project will be held include the following: Daynile district_ Guryasamo, Danwadaag, Arwaax, Sowdo: Wadajir Siliga- Alnasri, Harwanaag, Golol, Cawale: Korsan are: Sabriye, Burdaar, Xareed, Bakool-Wajid- Bakar Weyne IDP camp.

**(B) Work Plan**
Must be in line with the log frame.
**Mark "X"** to indicate the period activity will be carried out

| Activity | Timeframe (Please select 'weeks' for projects up to 6 months, and 'months' for projects up to 12 months) | | | | | |
|---|---|---|---|---|---|---|
| | **Month 1-2** | **Month 3-4** | **Month 5-6** | **Month 7-8** | **Month 9-10** | **Month 11-12** |
| **1.1*** Provision of OPD and PH | X | X | X | X | X | X |
| **1.2** Provision of referral serv | X | X | X | X | X | X |
| **1.3** Training to 80 CHWs an | X | X | X | X | X | X |
| **2.1** Dissemination of repack | | X | X | X | X | X |
| **2.2** Training of midwives (15 | | X | X | X | X | X |
| **2.3** Regular submission of e | X | X | X | X | X | X |
| **3.1** AWD/Cholera awreness | | X | X | | X | X |
| **3.2** AWD/Cholera awreness creation especially during the cholera peak months- March/April and September-October- through hygiene e | | | | | | |
| **3.3** 0 | | | | | | |

## 6. OTHER INFORMATION (to be completed by organization)

**(A) Coordination with other activites in project area**
List any other activities by your or any other organizations, in particular those in the same cluster, and describe how you will coordinate your proposed activities with them

| | Organization | Activity |
|---|---|---|
| **1** | WHO | Trainings, assessments, information sharing, evaluations, rapid assessments, co |
| **2** | UNICEF | Trainings, assessments, information sharing, evaluations, rapid assessments, co |
| **3** | UNOCHA | Trainings, assessments, information sharing, evaluations, rapid assessments, co |
| **4** | health cluster members/partners | Trainings, assessments, information sharing, evaluations, rapid assessments, co |
| **5** | TFG/local authority | coordination, information sharing, beneficiaries selection, permits issues, etc. |
| **6** | Banadir hopistal | strengthen the triage cholera centre already built by IRS before. |
| **7** | | |
| **8** | | |
| **9** | | |
| **10** | | |

**(B) Cross-Cutting Themes**
Please indicate if the project supports a Cross-Cutting theme(s) and briefly describe how. Refer to Cross-Cutting respective guidance note

| **Cross-Cutting Themes** | (Yes/No) | **Outline how the project supports the selected Cross-Cutting Themes.** | **Write activity number(s) from section 4 that supports Cross-Cutting theme.** |
|---|---|---|---|
| **Gender** | Yes | The project has seriously mainstreamed gender from the conception, | |
| **Capacity Building** | | | |