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*	World Health Organization	
(B) Type of Organization*	☐ UN Agency ☐ International NGO ☐ Local NGO — UN Agency	
(C) Project Title* For standard allocations, please use the CAP title.	Response to and control of communicable disease outbreaks in informal and temporary settlements in Somalia, and provision of access to essential health services in underserved areas	
(D) CAP Project Code	SOM-12/H/48509	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*	$ 539,480.00	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		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	1174680	1320260	2494940
Total beneficiaries include the following:			
	0	0	0
	0	0	0
	0	0	0
	0	0	0

(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	VHW - Swisso Kalmo	Budget:	$ 45,000
2	VHW - AFREC	Budget:	$ 30,000
3	Wardhigley CTC - Mulrany	Budget:	$ 48,000
4	Hamarjajab CTC - WARDI	Budget:	$ 48,000
5	Hospitals Kismayo, Baidoa, Banadir	Budget:	$ 18,000
6		Budget:	$ -
7		Budget:	$ -
8		Budget:	$ -
9		Budget:	$ -
10		Budget:	$ -
	Total	Budget:	$ 189,000
	Remaining	Budget:	$ 350,480

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 Antony Angalukia	Title	
	Email*	angalukia@nbo.emro.who.int	Phone*	+254736100177
	Address	WHO Somalia		

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) *

On 20 July 2011, famine was declared in parts of south Somalia (Lower Shabelle and Bakool). In Bakool agro-pastoral and Lower Shabelle, 30% of the urban and rural populations (excluding Afgoye town) are in famine, amounting to 270,000 people . On 3 August, FAO's Food Security and Nutrition Analysis Unit (FSNAU) declared that the situation had deteriorated to famine conditions in three new areas including (i) the IDP-crowded Afgooye corridor north-east of Mogadishu, (ii) areas of high IDP concentration inside Mogadishu and (ii) two districts of Middle Shabelle region (Balcad and Cadale). Tens of thousands of deaths have already occurred as a result of the on-going and extending famine and famine is expected to spread across all regions of the south in the coming four to six weeks, and likely to persist until at least December 2011 (Source: FSNAU).

Malaria, pneumonia and diarrhea remain a major public health challenge in Somalia especially among children. The majority of cases of severe disease and death are due to delays in seeking prompt, appropriate and effective treatment. So far, no single intervention has proved effective in reducing the levels and child deaths in Somalia. The under five mortality rate is at 225 per 1,000 live births .

(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) *

Arising informal settlements and expanding IDP camps pose major challenges for disease control programs, targeting populations on the move and improving sanitation remains a major challenge.Women and children bear the greatest burden among the displaced. Prolonged conflict had vastly affected disease prevention activities such as the enlarged immunization program. Poor access to clean and safe drinking water resulted in high endemicity/sporadic outbreaks of waterborne diseases such as acute watery diarrhea/ cholera and other epidemic prone disease outbreaks. Current data collected no routine basis reveals that women and girls account for as many as 47% of all reported outbreaks. Already high case fatality rates due to poor health seeking behavior and access to healthcare are worsening by the underlying malnutrition. Women and girls are the main caretakers of the sick and are more at risk of person to person transmission as has been been observed in the past.Outright withdrawal and suspension of aid programs by some aid agencies aggravated the public health situation and resulted in weakened surveillance networks. The poor distribution of healthcare facilities/ health work force, and the high endemicity of communicable diseases result in a dangerous delay in detection and response to avoidable outbreaks, which in turn contribute to increase morbidity and mortality among vulnerable populations. Health education activities targeting individuals and groups such as women, men and school children had a positive impact on prevention and control of outbreaks.
Cholera remains endemic in Somalia, with already 5 cases confirmed positive for Vibrio cholera of the 21 samples collected in February this year. Population displacement has taken a new dimenbtion with returnees from Afgooye corridor intyo Mogadishu and observer re-dispolacement of last years IDPs from areas in Bay, the Jubbas and parts of the Shabelles. Current data collected from the CSR reveals many cases of suspected measles with some lab confirmed across the whole country. Also seen are increasing number of confirmed malaria cases especially fro lower Jubba, the Shabelles and Banadir region. The delay of the the Gu rains is indicator for possible change in transmission of communicable diseases associated with the rains. Although this provides for better preparedness, challenges due to the ban by Al shabba and diminished access to some areas could neccessitate the change of intervention strategies adopting more emergency interventions which will be very costly. Lack of access means transportation of supplies costs twice and sometimes thrice the past budgets. Also staff trainings can be done freely only in Mogadishu due to restricted gathering in other locations.

From week 1 to 10 over 106,000 consultations have been reported from an average 70 sentinel sites in SCZ. These included 45% children under 5 years. The leading causes of morbidity were confiremd malaria accounting for 6% of all consultations; suspected cholera accounting for 4% cases; and suspected measles for 1.3%. Current mrobidity trends show a steady increase in the three diseases especially in the areas of priority in the Shabelles, the Jubbas and Banadir.

(C) List and describe the activities that your organization is currently implementing to address these needs.(maximum 1500 characters)

The joint program between WHO and UNICEF is working with 7 international NGOs to urgently address the major causes of childhood illnesses in South and central Somalia. This project is being supported by the government of Switzerland and is expected to train 600 village health workers (VHWs) in selected regions to roll out integrated community care (iCCM). This approach sends VHWs out to find, diagnose and treat sick children, in partnership with their families in communities. It includes promoting timely care-seeking, encouraging appropriate home care, as well as referrals to and continuous supervision.

The project involves training of our partners, the training cascade is designed and made up of three levels of training, each level's output is the input for the next level. In the case of iCCM, the national trainers trained the local trainers who will in turn train the VHWs. Under the leadership of WHO, all seven health partners attended the first-level training for national trainers/supervisors that was held from 14 to 17 November 2011 in Nairobi, Kenya. From the seven participating NGOs, a total of 13 national staff was trained. During the training, feedback was provided on the Somali translation.

The first consignment of 300 VHW kits was procured by WHO, the kits have been distributed to the implementing partners for distribution to the VHWs after being trained.

Training of 150 health facility based health workers will be conducted in multiple batches in Mogadishu. Supplies will be distributed to individual target partners while subcontracting of activities will be done under WHO-partner MoUs and payments through the direct financial credits (DFC) protocols. WHO will meet the additional in-country transportation costs through the SAUDI fund while excess of kits required will also be supplied from existing ending CERF and SAUDI funds. 1 DDK is only adequate for 100 severe cases of cholera/AWD and 400 mild cases whilst 1 DDK is only adequate for a population of 10,000 people for 3 months only. Monitoring of activities will be done jointly by WHO staff and slected partnes as agreed at the health cluster level.

4. LOGICAL FRAMEWORK (to be completed by organization)

(A) Objective*	To reduce morbidity and mortality through timely detection and appropriate response to control communicable diseases			
(B) Outcome 1*	Capacity building of health workers done in priority areas.			
(C) Activity 1.1*	Training of 100 village health workers (VHW-iCCM)			
(D) Activity 1.2	Training of 150 health workers from health facilities in 4 districts of Banadir, Middle and Lower Jubba regions and Middle Shabelle			
(E) Activity 1.3	Conduct population health situation monitoring and health activity monitoring in selected areas			
(F) Indicator 1.1*	Health	Number of health workers trained on common illnesses and/or ir	**Target***	100
(G) Indicator 1.2	Health	Number of health facility based health workers trained on standa	**Target**	
(H) Indicator 1.3	Health	Number of population and health activity monitoring visits conduc	**Target**	
(I) Outcome 2	Supplies and support provided for cholera treatment centres and mobile clinics			
(J) Activity 2.1	Implementation of cholera treatment centres and mobile clinics in priority areas			
(K) Activity 2.2	Procurement of inter-agency health kits (IAHK) and diarrheal disease kits (IDDK) and village health workers kits (VHW kits)			
(L) Activity 2.3	Distribute all procured supplies to partners			
(M) Indicator 2.1	Health	Number of health facilities supported	**Target**	7
(N) Indicator 2.2	Health	Number of kits procured and distributed to partners	**Target**	
(O) Indicator 2.3	Health	Number of kits distributed to village health workers and health fa	**Target**	
(P) Outcome 3	Disease surveillance and early detection of outbreaks			
(Q) Activity 3.1	Collect weekly data from sentinel sites and mobile clinics			
(R) Activity 3.2	Conduct outbreak investigation and sample collection for all outbreak rumors			
(S) Activity 3.3	Generate weekly updates by zone and region and highlight districts of concern and Reporting of cholera treatment centre activities a			
(T) Indicator 3.1	Health		**Target**	52
(U) Indicator 3.2	Health	Number of outbreak rumors investigated and responded to withir	**Target**	
(V) Indicator 3.3	Health	Number of weekly updates disseminated and number of field he	**Target**	
(W) Implementation Plan* Describe how you plan to implement these activities (maximum 1500 characters)	The training for village health workers cascade has been designed and is made up of three levels of training, each level's output was the input for the next level. In the case of iCCM, the national trainers will train the local trainers who will in turn train the VHWs. Under the leadership of WHO, the selected partners who will implement will be trained by WHO. Training for health facility based workers is conducted by WHO in collaboration with the Banadir University faculty of medicine teaching team. External facilitators sometimes include medical officers from other organizations in the partnerships. Trainings will be conducted in Somalia, more specifically in Mogadishu with health workers being transported from their locations in middle and lower Jubba, middle and lower Shabelle and the sorounding districts within Mogadishu. Implementation of CTC and support of MCHs will be done through provision of supplies and where elegible sub-contracting of partners in the designated locations such as Kismayo, Dharkinely and Hodan. MCHs in areas difficult to access such as Cadale and Warsheikh will received direct financial or supplies support. Prior negotiations have been done for these activities and some are ongoing partly funded under the expiring CERF and are crucial activities. The expansion of activities neccessitates the increase in availability of supplies as partners will be diverse as a strategy to counter the effect of the current ban. All supplies will be unbranded.			

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) *

Monitoring will be conducted at all the three levels of intervention. The team based in Nairobi (UNICEF, WHO and selected partners will meet quarterly) to share information on progress of the project. Data collected will be reviewed, challenges, constrains and success stories will be shared on an open forum (health cluster meetings). Where security allows the Nairobi team will visit the project sites to monitor and provide the required support.

At the field level the village health workers will be supervised by the trainer supervisor, who will in turn be supervised by central trainers. Feedback will be provided on spot and support provided where needed.

Outbreak investigations and rumor verifications are conducted by field staff and so is the sentinel sites surveillance. Monitoring will be done through scheduled impromptu visits where and when there is access without jeopardizing the programes by our implementing partners.

(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* Training of 100 village he	X		X		X	
1.2 Training of 150 health w	X		X	X	X	
1.3 Conduct population heal	X	X	X	X	X	X
2.1 Implementation of chole	X		X	X		
2.2 Procurement of inter-age	X					
2.3 Distribute all procured su		X	X	X	X	X
3.1 Collect weekly data from	X	X	X	X	X	X
3.2 Conduct outbreak invest	X	X	X	X	X	X
3.3 Generate weekly update	X	X	X	X	X	X

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	UNICEF partners	Nutrition programs for referal of malnourished children
2	CCM	participation in outbreak investigation and rumor verification
3		
4		
5		
6		
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	Ensure equal access for both boys and girls.	
Capacity Building			