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.	Surveillance, response to and control of communicable disease outbreaks in IDP camps and settlements in Somalia with strengthened coordination.	
(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 2 (Oct 2012)	
(G) CAP Budget		Must be equal to total amount requested in current CAP
(H) Amount Request*	$ 847,842.00	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	99960	104040	204000
Total beneficiaries include the following:			
Children under 5	87000	87000	174000
	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		Budget:	$ -
2		Budget:	$ -
3		Budget:	$ -
4		Budget:	$ -
5		Budget:	$ -
6		Budget:	$ -
7		Budget:	$ -
8		Budget:	$ -
9		Budget:	$ -
10		Budget:	$ -
	Total	Budget:	$ -
	Remaining	Budget:	$ 847,842

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*	Antony Ajanga/ Kamran Mashhadi	Title	Project Officer/ Health Cluster Coordinator
	Email*	ajangaa@nbo.emro.who.int / mashhadik@nbo.emro.who.int	Phone*	+254736100177
	Address	Warwick Centre, UN Avenue , Gigiri, Nairobi		

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) *

Public health surveillance is an integral part of any successful health system. The infrastructure is limited in the most affected zones of South and Central Somalia which have remained dynamic over 2012. The changes in the political context have resulted in the liberation of new areas and the need to encourage partners to initiate activities in those areas is crucial. Due to low vaccination coverage, outbreaks of vaccine preventable diseases have been observed. Cholera which is endemic also posses the greatest risk for high morbidity and mortality across the country with possible accelerated spread due to population displacement and insecurity. Recent surveillance data received from the field reflects specific needs of women, girls, men and boys how vulnerability to outbreaks affects them at the individual level. Lack of sanitation facilities and clean water sources compels them to use public toilets and water collection points. This situation renders them exposed to environmental and microbial hazards which is a big health threat for young and adolescent girls and boys. Specific collection mechanisms for this individual segments of population has provided insight into the gender dimensions and vulnerability of these groups to the epidemic prone diseases.

In the past 12 months, the CSR reports from the 6 priority regions (Lower Jubba, Middle Shabelle, Bay, Gedo, Galgaduud, and W Galbeed) indicated that the major causes of morbidity were Malaria, suspected cholera and suspected measles, with 24000; 17000; and 7000 consultations respectively. Also see attached to this project sheet mapping of trends and risks of AWD/cholera.

In the area of Health Cluster Coordination, there are over 80 health actors operating in Somalia. Effective coordination of health interventions, supported by reliable and timely information management enhanced the effective provision of essential health services. Consolidated planning and preparedness, strategic prioritization of the health interventions along with pre-positioning and needs-based distribution of medical supplies enabled the health cluster partners to maximize on the available resources (financial, Human Resources and access) to fill identified gaps.

(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) *

Currently sentinel surveillance sites for communicable diseases of epidemic importance are poorly distributed due to challenges in access hence the observed missed detection of two outbreaks in Lower Jubba through the surveillance system. These were detected through the rumor reporting and verification network. Three confirmed cholera outbreaks have been detected in Kismayo, villages in Badade and Afmadow districts. A suspected Shigellosis outbreak is currently being investigated. All these outbreaks occurred outside the known seasonal transmission periods and affect areas that are currently experiencing armed conflict, have thousands of IDPs on the move. As women and children account for the majority in the IDP population (e.g. women lead households) and related conditions such as overcrowding and lack of sanitation, they are particularly affected in outbreaks of communicable diseases. The outbreaks may have been accelerated by the movement of troops that suffered two known fatalities as they move up and down the region from Kismayo surroundings and other border towns. Cases that crossed into the Kenyan side were also reported and some tested positive for cholera. The IDP movement could easily spread the outbreak into Mogadishu and the surround hence the need to ensure that credible partners working in those areas will receive the necessary support to sustain activities.

Areas most at risk include Hiraan, Lower Jubba especially Afmadow, Kismayo, Badade; and Middle Shabelle among others. These areas have pockets of geographical areas that are not covered by health partners.

Staff with training in regard to particular womens health issues will be considered in all recruitment.

Recent surveillance data received from the field reflects specific needs of women, girls, men and boys how vulnerability to outbreaks affects them at the individual level. Lack of sanitation facilities and clean water sources compels them to use public toilets and water collection points. This situation renders them exposed to environmental and microbial hazards which is a big health threat for young and adolescent girls and boys. Specific collection mechanisms for this individual segments of population has provided insight into the gender dimensions and vulnerability of these groups to the epidemic prone diseases.

The main tenet of the Health Cluster Coordination and response strategy is to ensure that the response to famine and displacement is addressed at the IDP settlements, host communities and cross border points. The ongoing support to various regions enhanced through area-based interventions and provision of minimum integrated package of health services at community, primary and secondary health care levels. Capacity building of partners in the areas of emergency planning, surge capacity for human resources, and essential medical supplies was provided through proper training, technical and funding support from various channels through the cluster leadership process.

(C) List and describe the activities that your organization is currently implementing to address these needs.(maximum 1500 characters)	This project has been financed so far in 2012 by CHF and USAID. Achievements of this first phase of the project will be outlined in the respective interim report, and include: training, prepositioning of medical supplies, collection of samples, response to outbreak rumors with investigation, verification and case management. Activities will include regular monitoring of sentinel surveillance sites, investigating rumors and suspected outbreaks, training of health workers, including womens health needs. Subcontracting of partners to implement specific activities such as cholera treatment centers (which are subdivided into male and female wards) will be done as well to ensure care is delivered where, when and as needed. Remote and hard-to-reach rural areas have been and will be covered by outreach activities such as mobile clinics. Samples will be collected and referred for confirmatory diagnosis. The laboratory in Somalia is also being supported to provide for the performing of various confirmatory tests within the context. Due to insecurity, the cost of transportation and prepositioning of supplies has increased exponentially and this project will ensure availability of needed supplies (kits). The new surveillance sites proposed in this proposal will have build-in systems to segregate the data based on these individual groups (women, girls, men and boys). The analysis of data with these special dimensions directed towards gender susceptibility (e.g. chores like fetching water for the family, collection of fire wood,...) to these epidemic prone diseases will further help to design activities that will reduce their expose to these hazards. The current Health Cluster Coordination activities include the ongoint cluster and inter-cluster meetings in the field and at nairobi level, the sharing of information through these forums and a network of working groups such as the AWD working group, the communications working group and task forces. Other medium for sharing information include the weekly health update which is generated on weekly basis. In the field meetings take place regularly in Baidoa, Mogadishu, Garowe, Bossaso and Galkacyo. Some of the specific activties include: Coordinate humanitarian health actors at zonal and regional levels through regular meetings of all health partners; weekly health updates and situation reports; provision of a matrix of partners locations and activities (Who does What, Where and When). Conduct baseline assessments and regular updates of health and nutrition needs and availability of services. Identify, analyze and address gaps. Monitor implementation of the humanitarian health response. Coordinate cluster-wide programmatic and financial planning among health partners to enable up-to-date reports of partner activities, available funding and financing gaps.

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*	disease surveillance and early detection of outbreaks and capacity building of health workers done in priority areas			
(C) Activity 1.1*	train health workers, as much as possible in equal numbers male and female, in priority and affected areas on case detection (surve			
(D) Activity 1.2	conduct outbreak investigation and sample collection for all outbreak rumors and conduct population health situation monitoring (su			
(E) Activity 1.3	collect weekly data from sentinel sites and mobile clinics and generate weekly updates by zone and region, and highlight districts of			
(F) Indicator 1.1*	Health	Number of health workers trained on common illnesses and/or ir	**Target***	400
(G) Indicator 1.2	Health	number of health facility monitoring visits conducted and	**Target**	
(H) Indicator 1.3	Health	number of weekly updates disseminated	**Target**	
(I) Outcome 2	supplies and support provided for cholera treatment centers (CTCs) and mobile clinics for communicable diseases (i.e. suspected c			
(J) Activity 2.1	implement CTCs and mobile clinics in priority areas in Lower Jubba, Middle Shabelle, Bay, Gedo, Galgaduud, W Galbeed, and as/w			
(K) Activity 2.2	procure and distribute medical supplies to partners and heatlh facilities in outbreak-prone and - affected areas			
(L) Activity 2.3				
(M) Indicator 2.1	Health	Number of health facilities supported	**Target**	14
(N) Indicator 2.2	Health	number of kits procured and distributed	**Target**	
(O) Indicator 2.3			**Target**	
(P) Outcome 3	Coordination of all health activities through cluster coordination support is strengthened			
(Q) Activity 3.1	Organize zonal health coordination meetings on a regular basis with dissemination of minutes and follow up of action points. Expans			
(R) Activity 3.2	Plan and carry out joint assessments and analyze the collected data, share results for decision making purposes, identify and priorit			
(S) Activity 3.3	Organize a refresher zonal health cluster approach workshop for health partners and health authorities. Train health cluster partner			
(T) Indicator 3.1	Health		**Target**	90
(U) Indicator 3.2	Health	Number of inter cluster joint plans replicated in other zones (Bay	**Target**	
(V) Indicator 3.3	Health	Number of health cluster partners trained on the use of tools	**Target**	

(W) Implementation Plan*
Describe how you plan to implement these activities (maximum 1500 characters)

CTCs and health facilities of partners will be supported in terms of supplies and where eligible sub-contracting of partners in designated locations where WHO or others may not have direct access for implementation.
Surveillance for communicable diseases is not particular to beneficiaries of sentinel sites. Surveillance for outbreaks occurs in areas where there may be no sentinel sites as this covers the whole population in the four zones. Surveillance is also conducted through non sentinel sites, rumors which are reported from affected communities by community elders or even the media. There is a rumor reporting network established in the field at the moment, besides scanning media reports on daily basis for both in border and cross-border health events of public importance.
The selected partners who will implement surveillance and outbreak response activities, both at facility level and through mobile clinics, will be trained by WHO. External facilitators sometimes include medical officers from other organizations in the partnerships. Trainings will be conducted in various locations of South and Central Somalia, as well as Galgaduud and Berbera.
Implementation of CTC and support of MCHs will be done through provision of supplies by WHO and where eligible sub-contracting of partners in the designated locations such as Kismayo. MCHs in areas difficult to access can receive direct financial or supplies support. Prior negotiations have been done for these activities and some are ongoing partly funded under other funds and are crucial activities. The expansion of activities necessitates the increase in availability of supplies as partners will be diverse as a strategy to counter the effect of the current ban in some areas in South and Central Somalia. All supplies will be unbranded.

The Health Cluster has developed a strategic plan for strengthening field coordination, capacity building of partners and monitoring and assessment activities. Based on the guidance received from cluster partners and OCHA colleagues, health cluster will adopt a phased implementation approach in order to maximize emergency response surge capacity and to minimize the disruption of its critical operations in newly accessible areas. Need-based meetings will be scheduled to review and update the contingency plans with all cluster partners and OCHA. Regular monthly coordination meetings and mid-term and end-of-year meetings will be scheduled as per timelines provided by CAP Secretariat. Training on cluster coordination and contingency planning for cluster partners, technical capacity building will be provided on a regular basis. Plans for joint monitoring and evaluation missions will be scheduled and feedback will be shared with partners through regular reporting processes. Terms of reference will be developed for pro-active field participation at all levels and forthcoming Strategic Cluster Planning will be realigned to the agreed goals and outcomes. Health Cluster will update existing coordination tools, processes and guidelines for partners to facilitate the translation of strategic plan at field level. Regional profiles will be updated with field inputs, all of which are aimed at gap analysis and facilitating training and capacity building of cluster focal agencies and partners in various Somali regions. The capacity building programmes will enhance the positioning of health cluster by establishing strong communications, advocacy and knowledge transfer mechanisms. Geographical operational collaboration and inter-cluster coordination (Protection, Health, Nutrition, Shelter & WASH) is envisioned to complement preventive, promotive and curative aspects through complementary approaches.

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 three levels of intervention. The team based in Nairobi (UNICEF, WHO and selected partners) meet quarterly to share information on project progress. Data is being reviewed, challenges, constraints and success stories shared in an open forum such as the heatlh cluster meetings. Where security allows, the Nairobi teams will visit project sites to monitor and provide required technical support. At the field level, community health workers are supervised by regional surveillance focal points. Feedback will be provided on the spot and support provided where neeedd. Outbreak investigations and rumor verifications are conducted by field staff and so is the sentinel surveillance. Monitoring of this information will be done through scheduled and adhoc visits where and when there is access without jeopardizing the programmes by implementing partners. Monthly visits to the health facility are scheduled by designated WHO staff to collect various data including verification of the quality of data received. An external performance evaluation for the surveillance system will be conducted by CDC and WHO teams in order to determine the best way possible for surveillance in Somalia.

Currently the Health Cluster is involved in the process of development of due diligence and risk assessment system in collaboration with OCHA and risk management unit (RMU) based at the RC/HC office. The system will enable to generate a database of all implementing partners with the provision of critical information and documentation of their standard operating procedures and formal mandate for humanitarian operations. This is vital component of the overall M&E system. The M&E Framework of the Health Cluster Strategic Plan defines the respective roles of the Health Cluster Coordination team, Cluster Focal Agencies, and health cluster partners in oversight and reporting. To be accountable, all must be involved in measuring the efficiency, effectiveness and impact of cluster activities, managing risks and producing results. Monthly cluster updates on coordination during outbreak alert and response, as well as Health Cluster Bulletin will highlight the effectiveness or gaps as lessons learned. Start and End-Year-Reports will establish baselines and final results achieved through these interventions. Reports of the Health Cluster meetings will be shared with OCHA and partners. The Nairobi-based Health Cluster Coordinator will play a central role in strengthening regional monitoring systems and to keep track of progress on implementation. Field monitoring visits will be undertaken with focal agencies and mid-term evaluation will be conducted as per established OCHA guidelines. Additionally, OCHA field coordinators and Health Cluster focal points/agencies will be invited to strengthen regular communication loops in order to apprise each other of the current situation and preparation of sitreps. Rapid field assessments tools will be developed encompassing feedback on coordination effectiveness beside the regular emergency response activities. The M&E plan will include quarterly reporting on all coordination activities at all levels to ensure adequate coverage and relevant public health issues, as well as establish task forces and working groups where relevant.

(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* train health workers, as t	X	X	X	X	X	X
1.2 conduct outbreak investi	X	X	X	X	X	X
1.3 collect weekly data from	X	X	X	X	X	X
2.1 implement CTCs and m	X	X	X	X	X	X
2.2 procure and distribute m	X		X		X	
2.3 Organize zonal health c	X	X	X	X	X	X
3.1 Plan and carry out joint a	X		X		X	
3.2 Organize a refresher zo			X		X	
3.3 Organize a refresher zonal health cluster approach workshop for health partners and health authorities. Train health cluster partners						

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 Health and UNICEF WASH	Water and sanitation including chlorination; the routine supply of essential medic
2	Health cluster agencies	Strengthening health cluster coordination
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	Over 50% of beneficiaries are women and girls. They form as much as 60% of	
Capacity Building			