OCHA Coordination Saves Lives

Project Proposal

Requesting Organization :	Cooperazione E Sviluppo - CESVI
Allocation Type :	Reserve 2016

Primary Cluster	Sub Cluster	Percentage
Health	Maternal, Neonatal and Child Health	100.00
		100

Project Title :	Providing Lifesaving Essential Primary Health Care Services to Vulnerable Populations living in the IDP camps of Daynile in Mogadishu.
Allocation Type Category :	

OPS Details

Project Code :		**Fund Project Code :**	SOM-16/3485/R/H/INGO/3911
Cluster :		**Project Budget in US$:**	190,000.00
Planned project duration :	12 months	**Priority:**	
Planned Start Date :	01/12/2016	**Planned End Date :**	30/11/2017
Actual Start Date:	01/12/2016	**Actual End Date:**	30/11/2017

Project Summary :

CESVI responded to the AWD outbreak in early Jan 2016 in Kaxda and Deynille IDPs camps by providing essential life saving primary health care services and by distributing HKs (with support from Health/WASH Clusters and UNICEF) through 2 static health facilities (MCH) and outreach services (mobile teams). Cesvi is present in the area since 2014 with 2 MCHs located in Tabelaha and Elasha (K7 and K13) along the Afgoye corridor. Cesvi is currently referring malnourished cases to ACF and CWW. In addition, Cesvi is implementing livelihood activities in the area under the framework of the Agency's resilience Programme. The proposed project will continue to support one of CESVI most successful programs: the provision of essential life saving primary health care services targeting IDPs and vulnerable host communities. It will also continue CESVI's current efforts to improve healthcare and livelihood conditions, further feeding into the Humanitarian response plan for Somalia 2016. In fact, the intervention will contribute to strategic objective 1, namely to address humanitarian needs by improving access to essential lifesaving health services for crisis-affected populations aimed at reducing avoidable morbidity and mortality. The intervention will target the IDP population, children under the age of 5, pregnant and lactating women. IDPs present the poorest health situation among the target groups, including deliveries at homes, increased cases of diarrhoea, with data from Banadir hospital indicating 40% of the diarrhoea cases from the IDP camps. Moreover poor health seeking behaviour, especially for major childhood illness, is worrisome with slightly less than 50 % of children reporting acute respiratory infections (ARIs) taken to a health professional. A number of gaps identified in the targeted IDP camps influencing the health and nutrition situation include but are not limited to: low access to quality health services, especially in actors providing essential primary healthcare services, coupled with recurrent epidemic disease outbreak that have significantly affected the displaced populations, low health worker knowledge and skills on maternal, new-born and child health, limited awareness and socio-cultural factors around maternal, new-born and child health and low immunization coverage. Poor living conditions and overcrowding increases vulnerability and risk of epidemic disease outbreaks, The project activities prioritize the most vulnerable IDP population in this area and are integrated in nature offering lifesaving assistance to the 41525 target beneficiaries in "emergency" and "crisis", including 8,305 (4028 boys, 4277 girls) under age of 5 who are more vulnerable to frequent shocks such as food insecurity and epidemic disease outbreaks. The lives, dignity and welfare of women/girls will be fully respected and protected in every phase of the project. The project will respond to the gender needs of the IDPs by addressing special needs of women and girls and sensitivities. In particular, Cesvi will provide reproductive health services to women/girls of reproductive age, PLW by-providing antenatal care to pregnant mothers, 24 Hours of maternity service; deliveries by skilled birth attendants, postnatal services to mothers seeking postnatal care, GBV care- treat, counsel, referral and start mothers on modern methods of family planning service. The essential life saving primary health care will focus on the health of the most vulnerable women, boys, girls and men including the elderly and the disabled as well as the minority who may be discriminated in the IDP camps. The health education messages will be carrying negative effect of FGM and underage pregnancies among others.

Direct beneficiaries :

Men	Women	Boys	Girls	Total
12,084	21,136	4,028	4,277	41,525

Other Beneficiaries :

Beneficiary name	Men	Women	Boys	Girls	Total
Internally Displaced People	12,084	21,136	4,028	4,277	41,525
People in Host Communities	0	0	0	0	0

Indirect Beneficiaries :

215,151 individuals

Catchment Population:

The catchment is 37,650 HH which correspond to 215,151 individuals (indirect) beneficiaries.

Link with allocation strategy :

The proposed project is intended to feed into the Humanitarian response plan for Somalia 2016 by contributing to strategic objective 1 which is to address humanitarian needs by providing life-saving and life-sustaining assistance to people in need, prioritizing the most vulnerable internally displaced persons/households in Deynille settlements. The project activities prioritize the most vulnerable IDP population in this area and they are integrated in nature offering lifesaving assistance to the 41525 beneficiaries in “emergency” and “crisis”, including 8,305 children under age of 5 years who are more vulnerable to frequent shocks such as food insecurity and epidemic disease outbreak. This will be done by improving access to quality essential health and WASH services to reduce morbidity and mortality among vulnerable girls, pregnant and lactating women, boys and men. The proposed intervention will feed into area 1 result of the strategic objective 1 (HRP), which is reducing national malnutrition prevalence rates from the average 13.6 per cent to below 11 per cent. Cesvi will do active case finding and screening for malnutrition at both the health facilities and the community and referring cases for treatment and reducing incidence and case fatality rate of AWD/cholera, measles and other diseases by offering lifesaving primary healthcare intervention.
The proposed set of interventions are defined and informed by the needs assessment run by CESVI (the only healthcare service provider since 2014 in this area) and it also takes into consideration the internally displaced persons profiling report done by UNOCHA in 2016 with inputs from Health and Nutrition clusters. The project will provide reproductive health services to women and girls of reproductive ages, PLW by-providing antenatal care to 1453 pregnant mothers, 24 Hours of maternity service; 536 deliveries by Skilled birth attendants, 1163 postnatal services to mothers seeking post natal care, GBV care- treat, counsel and referral and start 415 mothers on modern methods of family planning service. The essential life saving primary health care will focus on the health of the most vulnerable women, boys, girls and men including the elderly and the disabled as well as the minority who may be discriminated in the IDP camps. The health education messages will be carrying the negative effect of FGM, underage pregnancies and basic information about GBV among others.

Sub-Grants to Implementing Partners :

Partner Name	Partner Type	Budget in US$

Other funding secured for the same project (to date) :

Other Funding Source	Other Funding Amount

Organization focal point :

Name	Title	Email	Phone
Isabella Garino	Head Of Mission	isabellagarino@cesvioverseas.org	0714517381

BACKGROUND

1. Humanitarian context analysis

According to the latest report on Internal Displacement Profiling in Mogadishu dated April 2016, There are 1.1 million internally displaced people in Somalia who continue to live in crowded settlements, exposed to protection risks and with limited access to basic services including health, sanitation and hygiene facilities. They make up 68 per cent (648,040), of the people who are in crisis and emergency and are therefore in need of immediate life-saving assistance. The most vulnerable of the IDPs reside in Mogadishu, an area that hosts the largest estimated protracted IDP population in Somalia with more than half residing in the outskirts, along the Afgooye corridor . Events such as clan conflicts, military operations in southern and central Somalia, natural disasters and forced evictions have continued to create new displacements along the Afgooye corridor.
The majority of the over 120,000 IDPs forcibly evicted from Mogadishu city in 2015 joined settlements in Deynille and Kaxda periphery districts where living conditions are deplorable, services are limited or not existing and where human rights violations are commonly reported. Daynille and Kaxda administrative Locations/Districts have the highest number of settlements, however the majority are also being evicted further towards Elesha by owners of the lands they settled in. These ongoing evictions, continued military offensive and increased food insecurity in pockets of southern Somalia is likely to increase the number of displacements and further aggravate the humanitarian crisis in Mogadishu where worrying humanitarian indicators continue to be reported.
Findings from the 2015/16 post Deyr food security analysis by FSNAU and partners issued in early February 2016, based on Integrated Phase Classification (IPC), an estimated 953 000 people are in Crisis and emergency (IPC Phase 3 and 4) across Somalia between February and June 2016. Additionally, about 3.7 million people across the country are classified as Stressed (IPC Phase 2) through June 2016. The total number of acutely malnourished children under-five (based on October-December 2015 survey results) is estimated at 304 700. The food security projections were based on a number of assumptions, including a forecast of near average 2016 Gu (April to June) rainfall.
Slightly more than a third of the population in emergency and crisis are found in Banadir where the current malnutrition rates indicate a sustained serious level of acute malnutrition since Deyr 2014/15 with Global Acute Malnutrition (GAM) and Severe Acute Malnutrition (SAM) prevalence of 14.7 percent and 3.5 percent respectively. Results of Gu 2016 assessment of IDP’s in Mogadishu registered Crude and under five death rates of 0.33 /10 000/day and 0.99 /10 000/day respectively in the Mogadishu IDPs, an improvement from the reported serious level of under- five death rates (1.50/10 000/day) in Deyr 2015 and (1.36) in Gu 2015 assessments with the main causes of under-five deaths being fever, diarrhea and acute respiratory infection. The main drivers of food insecurity and malnutrition, significantly affecting the most vulnerable households in the along the corridor remains to be conflict and insecurity

2. Needs assessment

CESVI conducted quick rapid needs assessment in 5 randomly selected IDP Camps along Kaxda and Deynille locations within Banadir region (August 2016).Though the IDP Camps were not entirely representative of all the settlements along the area, they were selected based on Health and WASH needs of the population attached to 2 health centres operated by CESVI and after extensive consultation with IDP representatives, elders and local administration. The information is complimented by data from FSNAU, WASH cluster & SWALIM. The quick rapid assessment findings show that Kaxda and Deynille host's protracted IDP Population households(68,795HH) with frequent displacement by both owners of land and government entities, there are also reports of newly arrived IDP households (last 6 months), majorly due to clan conflicts, military operations in southern and central Somalia, natural disasters and forced evictions. Acute watery diarrhea outbreak , early January the stretch experienced emergency epidemic outbreak of acute watery diarrhea. Through funding from UNICEF, CESVI responded to the emergency through provision of life saving emergency intervention, hygiene and health promotion. Through this response CESVI Managed to provide this essential life saving intervention to a total of 40133 direct beneficiaries, 32% of them being boys and girls under the age of 5 years, CESVI managed to contain the acute watery diarrhea outbreak, treating in total 700 children under age of 5 years, 80% of the targeted number.
IDP eviction and further displacement: The ongoing evictions continued military offensive and increased food insecurity in pockets of southern Somalia will increase the number of displacements and further aggravate the humanitarian crisis in Mogadishu where worrying humanitarian indicators continue to be reported. According to UNOCHA report 2015, majority of the over 120,000 IDPs forcibly evicted from Mogadishu city joined settlements in Deynille and Kaxda periphery districts where living conditions are deplorable, services are limited or not existing and where human rights violations are commonly reported. Nutrition Situation: Slightly more than a third of the population in emergency and crisis are found in Banadir where the current malnutrition rates indicate a sustained serious level of acute malnutrition since Deyr 2014/15 with Global Acute Malnutrition (GAM) and Severe Acute Malnutrition (SAM) prevalence of 14.7 percent and 3.5 percent respectively. Results of Gu 2016 assessment of IDP's in Mogadishu registered Crude and under five death rates of 0.33 /10 000/day and 0.99 /10 000/day respectively in the Mogadishu IDPs, an improvement from the reported serious level of under- five death rates (1.50/10 000/day) in Deyr 2015 and (1.36) in Gu 2015 assessments with the main causes of under-five deaths being fever, diarrhea and acute respiratory infection. (FSNAU Nutrition update-Preliminary findings from 2016 Gu season). Maternal, newborn and Child health care: According to UNOCHA needs assessment report, the IDP population in Mogadishu presents the poorest health situation among the target groups (HC input). About 80 per cent of deliveries are attended at home. Diarrhea cases are on the increase. Records from Banadir hospital show that 40 per cent of the diarrhoea cases are from IDPs in the outskirts of Mogadishu (Health cluster input). Care-seeking and treatment for major childhood illness remain poor with only less than 50 percent of children with reported acute respiratory infections (ARIs) having been taken to a health professional. Water and Sanitation: While the distance to water points in Mogadishu settlements are about 400 to 500 meters (four to seven minutes) away which meets the SPHERE standards for distance from any household to the nearest water point in emergencies, more than half of the IDPs do not treat drinking water. Majority use communal latrines that are not segregated by sex and are not lockable.

3. Description Of Beneficiaries

The direct beneficiaries for this intervention are the 41525 vulnerable displaced communities/settlements along Deynille, Kaxda in Afgooye corridor. The identification of direct beneficiaries of the project will be 8,305 boys and girls under the age of 5 years in need of primary healthcare services, 2,219 pregnant and lactating women, 2,219 women of reproductive age and 12,084 men in need of outpatient services. CESVI adopts both static facilities and outreach service model of service deliveries to target all the direct beneficiaries described children who are sick and malnourished, mothers in need of reproductive health services, will be identified through active case finding by the network of community health workers and referred to both mobile clinics and 1 MCH, malnourished children aged 6-59 months together with Pregnant and lactating mothers will also be screened using MUAC and referred to actors offering this services, boys and girls under the age of 5 years in need of immunization will also be referred for services using the 2 models of service delivery. CESVI plans to engage the 69,206 vulnerable IDP population through nutrition, hygiene and health promotion awareness messaging, this will be through trained community health workers doing individual counseling sessions, group sessions and through community dialogue sessions, where women through mother to mother support groups (Peer-peer education), group of men, youths, boys and girls, and community leaders are sensitized on maternal, newborn and child healthcare services available.

4. Grant Request Justification

In Mogadishu, CESVI has been working with the MoH since 2014 to respond to extreme gaps in healthcare provision. Through this partnership, CESVI is supporting two primary healthcare facilities in Wardigleey (Barwaaqo and Umbulotorio HC) and Wadajir (Wadajir and Halane HC) districts. CESVI also responded to AWD Outbreak in Afgooye corridor early this year and is currently offering essential emergency life saving intervention along the corridor In Mogadishu, CESVI has been working with the MoH since 2014 to respond to extreme gaps in healthcare provision. Through this partnership, CESVI is supporting two primary healthcare facilities in Wardigleey (Barwaaqo and Umbulotorio HC) and Wadajir (Wadajir and Halane HC) districts. CESVI also responded to AWD Outbreak in Afgooye corridor early this year and is currently offering essential emergency life saving intervention along the corridor through the operation of 2 static health facilities and mobile teams(Outreach services), CESVI is also implementing a DEVCO Project through a consortium with other INGO to support resilience in IDP Camps in Mogadishu and Hiran region.
A number of gaps influencing the health and nutrition situation in Deynille and Kaxda periphery districts where living conditions are deplorable include:
 Low access to quality health services, especially in actors providing essential primary healthcare services, coupled with recurrent epidemic disease outbreak that have significantly affected the displaced populations.
 Low health worker knowledge and skills on maternal, new-born and child health.
 Limited awareness and socio-cultural factors around maternal, new-born and child health.
 Poor physical access to properly equipped primary care services further complicated by culturally- and economically-driven poor demandfor skilled healthcare.
 Poor access to sanitation facilities and safe water sources, under-education of women and food insecurity. All these factors contribute to the top killers of children under five (neonatal causes, malaria, pneumonia and diarrhea) with under-nutrition being a contributing factor in one third of these deaths.
 Poor hygiene, water and sanitation conditions within the IDP Camps and resident populations.
 Inadequate basic services and livelihood opportunities.
 Ongoing armed conflict, further displacement and population movements.
 Low immunization coverage, poor living conditions and overcrowding increase vulnerability and risk of epidemic disease outbreaks.
 The lack of an effective disaster preparedness plan and capacity, management of emergencies.
Through the proposed intervention, CESVI will scale up the provision of essential lifesaving primary healthcare services to 41525 IDP and host community populations in Deynille. CESVI has been providing primary healthcare services in the area t since 2011. No other organization is currently providing healthcare services in these areas. The proposed interventions will feed into area 1 result of the strategic objective 1 (HRP) that is reducing national malnutrition prevalence rates from the average 13.6 per cent to below 11 per cent by doing active case finding and screening for malnutrition at both the facility and community, and referring cases for treatment and reducing incidence and case fatality rate of AWD/cholera, measles and other diseases by offering lifesaving primary healthcare intervention.
Through its extensive community network and community acceptance strategy, CESVI enjoys the support of the communities in Tabelaha. Our recent assessment identifies priority areas, key strategies and proposed primary healthcare services for scale up. These priority areas and activities are scaling up of basic essential primary healthcare service delivery, advocacy and enhancing sectoral through health and nutrition clusters.

5. Complementarity

CESVI is the only healthcare service provider offering emergency lifesaving primary healthcare along the afgoye corridor including Elesha, The current project with UNICEF concluded on 20th of august 2016, however CESVI managed to secure additional resources to sustain the project for another 3 months with support of UNICEF in provision of supplies. With current acute humanitarian needs, it's vital to build on the gains made so far and prevent further deterioration.
CESVI runs several other projects in Banadir region, the essential package of healthcare services in two districts in Banadir region (Wardigleey and Wadajir), DEVCO project run through a consortium of INGO and UNHABITAT livelihood intervention project. In addition to this, CESVI also submitted proposals for WASH and Food security under SHF 2016 Strategy allocation, the plan is therefore to adopt an integrated approach to address the emerging needs in food security, WASH causes of malnutrition and epidemic disease and provision of lifesaving primary healthcare interventions targeting vulnerable boys and girls, Men and Women within Kaxda and Deynille settlements. The convergence will be in leveraging on key resources, to include, logistical, human resource and technical expertise to better maximum the output and impact of the project. The link with DEVCO Project which plans to build resilience aspect of internally displaced persons will mainly be on disaster risk reduction and preparedness plans where disaster committees and IDP populations capacity to respond to shocks is strengthened. CESVI also anticipates funding for Gender Based Violence through UN Women funding and as such plans also to link facilities to offer vital GBV prevention and response services. Its CESVIs belief that synergies that will be created between all projects will further benefit immensely the targeted beneficiaries in need.

LOGICAL FRAMEWORK

Overall project objective

Reduced morbidity and mortality of vulnerable internally displaced population through improved access to emergency primary health care including child health and immunization, maternal and reproductive health, communicable disease surveillance and health and hygiene promotion trough Social Behavior Change Communication (SBCC)

Health		
Cluster objectives	**Strategic Response Plan (SRP) objectives**	**Percentage of activities**
Improved access to essential life-saving health services (quality primary and secondary health care) for crisis-affected populations aimed at reducing avoidable morbidity and mortality	Somalia HRP 2016	50
To contribute to the reduction of maternal and child morbidity and mortality	Somalia HRP 2016	50

Contribution to Cluster/Sector Objectives : The project activities are intended to feed into the Humanitarian response plan for Somalia 2016 by contributing to strategic objective one which is to address humanitarian needs by improving access to essential lifesaving health services (quality primary and secondary health care) for crisis-affected populations aimed at reducing avoidable morbidity and mortality. The project intervention activities prioritize the most vulnerable IDP population in this area and are integrated in nature offering lifesaving assistance to the 41525 beneficiaries in “emergency” and “crisis”, including 8305 under age of 5 years (4028 boys, 4277 girls) who are more vulnerable to frequent shocks such food insecurity and epidemic disease outbreak. The proposed interventions will feed into 2 health cluster objectives related to strategic objective 1 of HSP
- Improved access to essential lifesaving health services (quality primary and secondary health care) for crisis-affected populations aimed at reducing avoidable morbidity and mortality(50%)
- To contribute to the reduction of maternal and child morbidity and mortality(50%)

Outcome 1

Provision of integrated facility and community based essential life saving primary healthcare services for protracted IDPs in Daynile

Output 1.1

Description

People in need access to quality treatment in the static health center and trough the two mobile clinics

Assumptions & Risks

Assumption/Risk 1: the security context improves and Cesvi maintain independence in terms of security related decision, information sharing and coordination with other actors. We assume there will be not dirict risk from armed groups and intrclan clashesthat will affect Cesvi's services delivery
Assumption/Risk 2: Cesvi continues to maintain good community acceptance along the project life
Assumption/Risk 3: Cesvi assumes that there will be not natural disasters such as flooding or any epidemic disease outbreak
Assumption/Risk 4: there will be not population displacement movements and eviction of IDPs;
Assumption/Risk 5: there will be not cultural and religious resistance to prevent the activities from being carried out

Activities

Activity 1.1.1

Standard Activity : Primary health care services, consultations

Support provision of Curative OPD services for common childhood illness, routine expanded program on immunization services and screening and referral of children under five for acute malnutrition.

Activity 1.1.2

Standard Activity : Primary health care services, consultations

Provision of antenatal and postanatal care services through 1static facilities and 2 mobile outreach teams

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 1.1.1	Health	Number of Children < 1 year that received all antigens					1,163
Means of Verification : Project Reports and HMIS data							
Indicator 1.1.2	Health	Number of U5 children suspected with pneumonia treated with antibiotics					1,305
Means of Verification : Project Report and HMIS data							
Indicator 1.1.3	Health	Number of U5 children with diarrhoea received ORS and zinc					2,008
Means of Verification : Project Reports and HMIS data							
Indicator 1.1.4	Health	Number of U5 children treated for malaria					17
Means of Verification : Project Reports and HMIS data							
Indicator 1.1.5	Health	Number of health facilities supported					1
Means of Verification : HMIS report							
Indicator 1.1.6	Health	Number of children 0 to 59 months receiving Vitamin A					3,542
Means of Verification : HIMS report							
Indicator 1.1.7	Health	Number of women accessing pre-natal and postnatal care (ANC 1, 2, 3, 4 and PNC)					4,069
Means of Verification : HMIS data, project reports							

Indicator 1.1.8	Health	Number of deliveries attended by skilled staff					536

Means of Verification : HIMS data

Outcome 2

Increasing capacity and skills of the health staff and raising the awareness of community towards life saving interventions including innovative approaches to integrated primary healthcare services (Demand Generation).

Output 2.1

Description

Health staff trough is trained and gained the capacity to deliver quality services.

Assumptions & Risks

Assumption/Risk 1: the security context improves and Cesvi maintain independence in terms of security related decision, information sharing and coordination with other actors. We assume there will be not dirict risk from armed groups and intrclan clashesthat will affect Cesvi's services delivery
Assumption/Risk 2: Cesvi continues to maintain good community acceptance along the project life
Assumption/Risk 3: Cesvi assumes that there will be not natural disasters such as flooding or any epidemic disease outbreak
Assumption/Risk 4: there will be not population displacement movements and eviction of IDPs;
Assumption/Risk 5: there will be not cultural and religious resistance to prevent the activities from being carried out

Activities

Activity 2.1.1

Standard Activity : Not Selected

Training on Emergency Triage Assessment and Treatment (ETAT)

Activity 2.1.2

Standard Activity : Capacity building

Training on IMCI (Integrated Management of Childhood Ilness)

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 2.1.1	Health	Number of health workers trained on common illnesses and/or integrated management of childhood illnesses, surveillance and emergency preparedness for communicable disease outbreaks.					23

Means of Verification : Project reports, attendance sheets

Output 2.2

Description

Targeted community is aware of the services and well equipped with knowledge about basic hygiene and nutrition practices.

Assumptions & Risks

Assumption/Risk 1: the security context improves and Cesvi maintain independence in terms of security related decision, information sharing and coordination with other actors. We assume there will be not dirict risk from armed groups and intrclan clashesthat will affect Cesvi's services delivery
Assumption/Risk 2: Cesvi continues to maintain good community acceptance along the project life
Assumption/Risk 3: Cesvi assumes that there will be not natural disasters such as flooding or any epidemic disease outbreak
Assumption/Risk 4: there will be not population displacement movements and eviction of IDPs;
Assumption/Risk 5: there will be not cultural and religious resistance to prevent the activities from being carried out

Activities

Activity 2.2.1

Standard Activity : Awareness campaign

Recruitment of a network of community health workers to provide active case finding (screening for malnutrition, sick children, identification of ANC, PNC Mothers), home visit, defaulter tracing and referral for .

Activity 2.2.2

Standard Activity : Hygiene promotion

Conduct Nutrition Hygiene and Health promotion both at Facility and community level.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 2.2.1	Health	Number of community health workers recruited					10

Means of Verification : Project reports

Indicator 2.2.2	Health	Number of mothers having knowledge of at least five danger signs during and after pregnancy and of the 5 signs of childhood illness including malnutrition					2,616
Means of Verification : Project reports							
Indicator 2.2.3	Health	Number of health facilities supported					1
Means of Verification : Project report							
Additional Targets :							

M & R

Monitoring & Reporting plan

Cesvi has 2 levels to monitor activities: First: Filed monitoring conducted by the M&E based on: M&E monthly plan (which set goals/objectives of the monitoring), weekly reports, and checklists. The weekly reports are sent to M&E Unit at coordination level by Field M&E and have details in methodology used during visits and data collection (FGDs, HHs interviews, conversation with Cesvi staff and beneficiaries, checklist, general observation).The findings have clear achievable recommendations/follow up action. There are also standard checklists developed to monitor specific activity where specific evaluation procedures such as post distribution assessments are conducted to measure impact and outcomes, offer lessons learnt and guidance in future programming.

Secondly quality evaluation is done by the M&E Unit at coordination that supervises the quality and performance of indicators. Activities are monitored with a focus on risks, achievements visa-vi to the objectives, selection of beneficiaries, quality of implementation and impact. The M&E Coordinator reviews the reports, gives feedback, seeks clarification from the Field M&E and PM. There is indicator tracking tool developed to assist in tracking the status of implementation on monthly basis. This is sent from field on monthly basis and is composed of a narrative section on activities, achievements; database with disaggregated data for each indicator and activity undertaken; table on progress of indicators.

Workplan

Activitydescription	Year	1	2	3	4	5	6	7	8	9	10	11	12
Activity 1.1.1: Support provision of Curative OPD services for common childhood illness, routine expanded program on immunization services and screening and referral of children under five for acute malnutrition.	2016												X
	2017	X	X	X	X	X	X	X	X	X	X	X	
Activity 1.1.2: Provision of antenatal and postanatal care services through 1static facilities and 2 mobile outreach teams	2016												X
	2017	X	X	X	X	X	X	X	X	X	X	X	
Activity 2.1.1: Training on Emergency Triage Assessment and Treatment (ETAT)	2016												X
	2017	X											
Activity 2.1.2: Training on IMCI (Integrated Management of Childhood Ilness)	2016												
	2017	X	X										
Activity 2.2.1: Recruitment of a network of community health workers to provide active case finding (screening for malnutrition, sick children, identification of ANC, PNC Mothers), home visit, defaulter tracing and referral for .	2016												X
	2017												
Activity 2.2.2: Conduct Nutrition Hygiene and Health promotion both at Facility and community level.	2016												
	2017	X		X		X		X		X		X	

OTHER INFO

Accountability to Affected Populations

Cesvi is accountable to affected populations by ensuring their participation and feedback in the programme identification, design, delivery and lesson learning. This will ensure a programme of higher quality, with greater and more sustainable impact, while enhancing the space for communities to shape their own recovery. Effective information sharing and communication channels will be promoted. Sharing information about Cesvi programmes with Local Authorities, community leaders/representatives, the beneficiaries and other relevant stakeholders in a timely, accessible and inclusive way will allow communities to be in a position to understand and shape decisions that impact their lives. Moreover, Cesvi is committed to ensure that people receiving support participate in and influence all steps of the programme cycle, including initial assessment, project design, beneficiary selection, implementation, monitoring and evaluations. Effective feedback channels as well as complaints and response mechanisms will be put in place, so that Cesvi know what impact programmes are having on participants and can incorporate feedback or address problems rapidly, including prevention of sexual abuse and exploitation.

Implementation Plan

CESVI is currently implementing life saving primary healthcare interventions in Deynille districts through 1 static health facilities and 2 outreach teams and therefore the approach is continuing providing those vital services. The medical staff in charge of the services are experienced personnel that have been continuously working with Cesvi since 2011. the activities will be implemented as follows:
MCH (static) : the team will be composed by 2 midwives, 3 nurse, 1 pharmacist, 2 vaccinator. ! cleaner and 2 security guards
outreach clinics (2): every mobile clinic will be composed by 1 nurse, 2 auxiliary nurses, 1 vaccinator.
The Medical coordinator and the Project Coordinator will providing guidance and technical inputs to the teams both in the static MCH and outreach clinics. 10 CHWs will be responsible for active case finding for malnutrition, defaulter tracing for all services, they assist in Linking the facilities with the IDP Camps and conduct Nutrition Hygiene and Health Promotion services at community level, they do home visits and identify pregnant women, sick children, children in need of immunization and link them with the facility for service delivery .CESVI is currently implementing life saving primary healthcare interventions in Kaxda and Deynille districts through 1 static health facilities and 2 outreach teams and therefore the approach is a scale up of services to a scope that increases more access to life saving activities. The medical staff in charge of the services is experienced personnel that have been continuously working with Cesvi since 2011. The activities will be implemented as follows:
MCH (static) : the team will be composed by 1 midwives, 3 nurse, 2 auxiliaries 1 cleaner and 2 security guards
outreach clinics (2): every mobile clinic will be composed by 1 midwife, 1 nurse, 1 auxiliary nurses.
The Medical coordinator and the Project Coordinator will providing guidance and technical inputs to the teams both in the static MCH and outreach clinics. 10 CHWs will be responsible for active case finding for malnutrition and defaulter tracing for all services. They assist in linking the facilities with the IDP Camps and conduct Nutrition Hygiene and Health Promotion services at community level, they do home visits and identify pregnant women, sick children, children in need of immunization in order to link them with the facility for service delivery.

Coordination with other Organizations in project area

Name of the organization	Areas/activities of collaboration and rationale
CONCERN	referral of malnutrition cases
ACF	referral of malnutrition cases
SAVE THE CHILDREN	referral of malnutrition cases
WARDI	coordination to avoid duplication

Environment Marker Of The Project

A+: Neutral Impact on environment with mitigation or enhancement

Gender Marker Of The Project

2a- The project is designed to contribute significantly to gender equality

Justify Chosen Gender Marker Code

The project has integrated gender in the activities. This project will aim at achieving optimal health service provision for caregivers of both boys and girls between the ages of 0-59 months, while advocating for social behavior changes for all and contributing to increasing the influence of women on decision making in maternal, newborn and child health. The project considers vulnerability of both boys and girls to disease outbreak, malnutrition and seeks to address this and ensure equality among the boys and girls with regards to service provision in gender sets. The project also ensures equal selection of participants for planned capacity building activities. The project considers the socially construed roles for each gender ensuring that women do not spend so much time in the program at the expense of their other children who are not sick and malnourished. As already mentioned, the project is designed to respond to the gender needs of the IDPs by addressing special needs of women and girls and sensitivities. In particular, Cesvi will provide reproductive health services to women/girls of reproductive age, PLW by-providing antenatal care to pregnant mothers deliveries by skilled birth attendants, postnatal services to mothers seeking post natal care, counselling on modern methods of family planning. A special focus will be given to the health of the most vulnerable women, girls, boys, and men including the elderly and the disabled as well as the minority. Data are provided disaggregated by sex and age at all stages.

Protection Mainstreaming

CESVI will endeavor to ensure protection and gender is mainstreamed within all stages of the programme. For instance, it will engage equal number of men and women in personnel and in communities to act as change agents in communities. All beneficiaries (boys and girls, men and Women) will have an equal opportunity to engage and participate in all Programme activities without discrimination. The project will address and resolve gender inequalities by focusing on children under the age of five years and pregnant and lactating mothers given their vulnerabilities to environmental shocks like drought, floods and displacements. This is through Linkages with other actors and different primary clusters in advocating for women participation in decision making processes and empowering them to demand for better services, increasing their access to resources through linkages to safety nets/livelihood projects. The project also plans to address and reach the very the most vulnerable IDPs in Deynille Districts. Females and males, pregnant/breast feeding mothers, boys and girls under 5 will be given preference in service delivery. Men and women will be equally targeted with Nutrition, hygiene and health promotion sessions, community dialogue sessions and community action days. CESVI has a child safeguarding/protection policy and code of conduct which all our staff abide by.
In addition, the Do Not Harm principle will be incorporated in the project in order to avoid exposing people to further harm as a result of your actions, and ensure that:
-the environment and way in which assistance is provided do not expose people to further hazards, violence or human rights abuses or violations;
-Information will be managed in a sensitive manner.
-the proposed activities do not undermine local capacities for self protection.
Moreover, the Non discrimination principle will be adopted in order to ensure equitable and impartial access to assistance, without discrimination on any grounds:
-Ensure all parts of the affected population have access to humanitarian assistance;
-Challenge any deliberate attempts to exclude parts of the affected population;
-Provide support and assistance on the basis of need and guard against any form of direct or indirect discrimination.
Finally, a Human rights based approach will be ensured to:
-Promote respect for human rights, and assist and support affected people to claim their rights and access remedies from relevant authorities;
-Ensure consultation with the target population at all stages, and the participation of all in the design and targeting of interventions, in particular vulnerable and marginalized groups.

Country Specific Information

Safety and Security

Mogadishu faces 2 major security risks:
-The risk from Armed groups and Inter clan or tribal clashes.Incursions of Al Shabaab or other armed opposition groups common.
- Deynille is classified by UNDSS as security level 4 (substantial).
Probability: High
Impact: Population displacement, Access, Protection centers /Health facility closure disrupting the continuum of care.
Mitigation: CESVI have context specific safety and security plan and measures are in place to mitigate the risks, which include banditry, inter-tribal clashes and risks from armed groups.
While CESVI maintains independence in terms of security related decisions, information sharing and coordination with local partners, other NGOs and UN agencies, as well as contacts with embassies and donors, are a crucial part of its approach to security. Community participation and acceptance are at the core of this intervention. Both CESVI also has extensive experience working in volatile and potentially dangerous contexts in which community acceptance represents an absolutely necessary requisite not only for the achievement of the expected results, but for the security of the mission itself.
Specific tools that favor community acceptance and participation are integrated in all different aspects of the intervention, from logistics to human resources management and outreach in the community.

Access

CESVI has been working in the area since 2011 and is currently operating in the area delivering life saving primary healthcare services. Cesvi long engagement with the community ensures that the selected area of operation are accessible to both national and international staff.

BUDGET

Code	Budget Line Description	D / S	Quantity	Unit cost	Duration Recurrance	% charged to CHF	Total Cost
Staff and Other Personnel Costs							
1.1	Project Coordinator National	D	1	2,500.00	12	80.00	24,000.00
	Medium national position based in Mogadishu, will be in charge of the implementation of the project. the Project Coordinator has supervisory responsibility for all activities, coordinates the project in the area with the MoH, UNICEF and other partners in Mogadishu, and provides technical support to the project-Facility staff. Charged 80% on the budget. Remaining % : Cesvi contribution.						
1.2	Medical Coordinator	D	1	3,500.00	12	68.00	28,560.00
	Based in Mogadishu, the medical Coordinator is a SENIOR POSITION. He spends 68% of his time on this project and has direct implementation responsibility for all activities,follows up day to day activities of the project, closely monitors supplies,epidemic outbreaks and quality of the medical services offered at the facility and provides direct technical support to the project-facility staff.						
1.3	Maternal & Child Health Center Supervisor	D	1	500.00	12	100.00	6,000.00
	Based in Mogadishu, the MEDICAL Staff will be the overall responsible person for day to day implementation oversight for the MCH, He/She has supervisory roles in allocation of duties, ordering of supplies, consumption, staff motivation making sure that she/he fosters in quality in service delivery by mentoring staff. 12 Months equivalent salary charged on SHF .						
1.4	Health Management Information System Officer	D	1	420.00	12	68.00	3,427.20

	Based in Mogadishu, the MEDICAL Staff will be the overall responsible person for health information management system for the facility and outreach teams , He/She is responsible for data collection, entry, follow-up and feedback to health facility staff regarding all aspects of information management, including documentation, reporting, quality checks, audits and arching of data. Charged 68% on SHF. Cesvi will cover the remaining % with internal funds. PLEASE BE AWARE THAT THIS POSITION IS CRUCIAL TO ENSURE THE SENDING OF RELIABLE DATA TO MOH AND TO THE HEALTH CLUSTER. THE ORGANIZATION CANNOT CONTRIBUTE MORE THAN THE 20 %.						
1.5	Qualified Nurses	D	5	410.00	12	100.00	24,600.00
	MEDICAL STAFF. Qualified nurse is responsible the follow up of the patient's treatment revolution. The nurse under the guidance of medical coordinator provides treatment to the patients(Adults, Under fives, immunizations services, Follow up. This staff is charged 100%(12m) on SHF.						
1.6	Qualified Midwifes	D	2	410.00	12	100.00	9,840.00
	MEDICAL STAFF. Qualified Midwife is responsible the follow up of all mothers in need of reproductive health services. The Midwife under the guidance of medical coordinator provides treatment to the pregnant women patients in need of ANC Services, Skilled Deliveries, refferral of obstetric emergencies and Follow up. This staff is charged 100%(12m) on SHF.						
1.7	Auxillary Nurses	D	5	220.00	12	100.00	13,200.00
	MEDICAL STAFF. The Axuillary nurse is responsible for screening children for Malnutrition, assists the nurses and midwifes in patient follow up and management, drug dispensation, laboratory testing using RDT kis, patients education and sensitization, follow up including linkages with community healthcare workers at different IDP Camps. This staff is charged 100%(12m) on SHF.						
1.8	Community Health Workers	D	10	100.00	12	100.00	12,000.00
	Community Health STAFF. The community health workers are responsible for active case finding for malnutrition, defaulter tracing for all services, they assist in Linking the facilities with the IDP Camps and conduct Nutrition Hygiene and Health Promotion services at community level, they do home visits and identify pregnant women, sick children, children in need of immunization and link them with the facility for service delivery.This staff is charged 100%(12m) on SHF.						
1.9	Cleaner- Maternal & Child Health Center	S	1	150.00	12	100.00	1,800.00
	Support staff to be based at the health facility responsible for maintaining cleanliness.						
1.10	Guards- Maternal & Child Health Center	S	2	230.00	12	100.00	5,520.00
	The security guards provide security to the MCHS .They ensure Cesvi resources and personnel are protected. The 2 security guards are charged 100% in this action. *.*						
1.11	Field Monitoring & Evaluation Officer	D	1	1,100.00	12	10.00	1,320.00
	Monitoring of activities. Remaining months: Cesvi contribution						
1.12	Banadir Area Coordinator	S	1	3,100.00	12	9.01	3,351.72
	Supervisory responsibility for all activities. Grantees the respect of donor and Cesvi'rules and the coherence with the agency and cluster's strategy Remaining months: Cesvi contribution.						
1.13	Outreach Supervisor	D	1	500.00	12	66.00	3,960.00
	Based in Mogadishu, the MEDICAL Staff will be the overall responsible person for day to day implementation oversight of the 2 outreach teams , He/She has supervisory roles in allocation of duties, ordering of supplies, consumption, staff motivation making sure that she/he fosters in quality in service delivery by mentoring staff. Charged on 66 % on SHF						
	Section Total						**137,578.92**
Supplies, Commodities, Materials							
2.1	Emergency Triage Assessment and Treatment (ETAT) Training	D	1	2,000.00	1	100.00	2,000.00
	Cost of training 23 medical staff for a total of 5 days, on WHO Course on Emergency Triage Assessment and Treatment, the training will build the capacity of the HCW to contribute towards ealry identification and treatment of childhood illnesses. See Boq						
2.2	IMCI (Integrated Management of Childhood Illness) Training	D	1	2,000.00	1	100.00	2,000.00
	Cost of training 23 medical staff , for a total of 5 days, on WHO Course on Integrated Management of Childhood Illnesses, the training will build the capacity of the staff to contribute towards early identification and treatment of childhood illnesses. See Boq						
2.3	Facility Running Cost & maintainance HC	S	1	300.00	12	100.00	3,600.00

	Cost of electricity and water for the 1 HF- Tabelaha MCH. See BoQ attached						
2.4	Hire Vehicle - Outreach	D	2	1,900.00	12	67.00	30,552.00
	Cost of Hiring 2 Outreach vehicles @ 1900 USD/Vehicle/Month for 67% of the action. the 2 vehicles(Minibuses) will be used by the 2 outreach teams to further reach the vulnerable internally displaced persons who are geographically not able to acess the MCH,This activity helps increase lifesaving interventions . see BoQ attached						
	Section Total						**38,152.00**
General Operating and Other Direct Costs							
7.1	Communication & Internet	S	1	400.00	12	18.00	864.00
	Cost of communication for staff and internet use. Remaining months: Cesvi contribution						
7.2	Financial costs (bank transfer fees)	S	1	2,650.36	1	100.00	2,650.36
	cost for money transfer from kenya to somalia. Equal to approximately 1.6% of the total budget						
	Section Total						**3,514.36**
SubTotal			39.00				**179,245.28**
Direct							161,459.20
Support							17,786.08
PSC Cost							
PSC Cost Percent							6.00
PSC Amount							10,754.72
Total Cost							**190,000.00**

Project Locations

Location	Estimated percentage of budget for each location	Estimated number of beneficiaries for each location					Activity Name
		Men	Women	Boys	Girls	Total	
Banadir -> Mogadishu-Daynile	100	12,084	21,136	4,028	4,277	41,525	

Documents

Category Name	Document Description
Project Supporting Documents	160920_SHF_ Drug_List.pdf
Project Supporting Documents	PLEASE DO NOT CONSIDER THIS FILE
Project Supporting Documents	Comments_SHF CESVI.docx
Project Supporting Documents	Revised Budget & BoQs_SHF CESVI.xlsx
Project Supporting Documents	Revised Budget BoQs_SHF CESVI rev 03 11 2016.xlsx
Project Supporting Documents	Signed allocation letter 3929 3911 3826 3789 4155.pdf
Budget Documents	160920_SHF_ Drug_List_final.pdf