SECRETARY-GENERAL'S PEACEBUILDING FUND
PROJECT DOCUMENT TEMPLATE

PBF PROJECT DOCUMENT

(Length: Max. 12 pages plus cover page and annexes)

Country: Somalia	
Project Title: Improving psychosocial support and mental health care for conflict affected youth in Somalia: a socially-inclusive integrated approach for peace building **Project Number from MPTF-O Gateway (if existing project):**	
PBF project modality: ☒ IRF ☐ PRF	**If funding is disbursed into a national or regional trust fund (instead of into individual recipient agency accounts):** ☐ Country Trust Fund ☐ Regional Trust Fund **Name of Recipient Fund:**
List all direct project recipient organizations (starting with Convening Agency), followed type of organization (UN, CSO etc): World Health Organization (WHO), UNICEF, IOM **List additional implementing partners, Governmental and non-Governmental:** Somalia National University (SNU)	
Expected project commencement date[1]: **Project duration in months:[2]** 15 months **Geographic zones (within the country) for project implementation:** Kismayo (Jubbaland), Baidoa (South West State), Dollow (Jubaland), Galkaayo, and Mogadishu	
Does the project fall under one of the specific PBF priority windows below: ☐ Gender promotion initiative ☒ Youth promotion initiative ☐ Transition from UN or regional peacekeeping or special political missions ☐ Cross-border or regional project	
Total PBF approved project budget* (by recipient organization): 1,500,000 USD **WHO:** 770,400 USD **UNICEF**: 254,948 USD **IOM**: 474,652 USD Total: $ 1,500,000 **The overall approved budget and the release of the second and any subsequent tranche are conditional and subject to PBSO's approval and subject to availability of funds in the PBF account. For payment of second and subsequent tranches the Coordinating agency needs to demonstrate expenditure/commitment of at least 75% of the previous tranche and provision of any PBF reports due in the period elapsed.* Any other existing funding for the project (amount and source): None	

PBF 1st tranche (60%):	**PBF 2nd tranche (40%):**	**PBF 3rd tranche* (0%):**
WHO: $462,240	WHO: $308,160	WHO: 0
UNICEF: $152,968.8	UNICEF: $101,979.2	UNICEF: 0
IOM: $284,791.2	IOM: $189,860.8	IOM: 0
Total: $900,000	Total: $600,000	Total: 0

Two-three sentences with a brief project description and succinct explanation of how the project is time sensitive, catalytic and risk-tolerant/ innovative:

[1] Note: actual commencement date will be the date of first funds transfer.
[2] Maximum project duration for IRF projects is 18 months, for PRF projects – 36 months.

This project is aimed at improving Mental Health and Psychosocial Support Services (MHPSS) for conflict affected youth in Somalia, through a socially inclusive integrated approach for peacebuilding. This pilot project is a first of its kind in Somalia, where an estimated third or more of the population suffers from mental illness, and where much of the population faces psychosocial problems stemming from the effects of acute and protracted conflict, further exacerbated by climatic and other shocks. It will break new ground in improving understanding of the links between mental health and conflict in Somalia. Through partnership between UN agencies, Somali authorities, and a prominent national academic institution, the project will not only establish the first institutional response to mental health and psychosocial issues affecting young Somali men and women, but it will also be a catalytic intervention aimed at systematically addressing one of the most critical, yet never previously addressed, barriers to lasting peace and reconciliation in the country. The project will also aim to reduce stigma and promote community-based approaches to reach vulnerable youth. Furthermore, the project will be the first of its kind to collect and analyze primary data on inter-linkages between mental health and peacebuilding in Somalia and, as a result, has the potential to catalyze significant support from other donors towards addressing MHPSS as one measure to help achieve and sustain peace in Somalia.

Summarize the in-country project consultation and endorsement process prior to submission to PBSO, including through any PBF Steering Committee where it exists, including whether civil society and target communities were consulted and how:

Two rounds of consultation meetings were conducted with project stakeholders in the UN, government and academia. The first round was for the initial submission of the summary proposal and the second round was after its initial approval. A project development team comprising of technical officers from the three agencies was formed. This team met several times, consulted with local PBF coordination team, the Ministry of Health, local stakeholders, and youth leaders from two of the target IDP settlements. The project team has incorporated the feedback they received from the different stakeholders into the proposal.

Project Gender Marker score: _2__[3]
Specify % and $ of total project budget allocated to activities in direct pursuit of gender equality and women's empowerment: A total of USD 800,518 (53%) is allocated towards Gender Equality and Women Empowerment.

Project Risk Marker score: ___1__[4]

Select PBF Focus Areas which best summarizes the focus of the project *(select ONLY one)*: Increasing equitable access to social services (3.2). [5]
If applicable, **UNDAF outcome(s)** to which the project contributes: Outcome 5.1 of the United Nations Strategic Framework (UNSF 2017-2020): The Somali population has improved access to and

[3] **Score 3** for projects that have gender equality as a principal objective and allocate at least 80% of the total project budget to Gender Equality and Women's Empowerment (GEWE)
Score 2 for projects that have gender equality as a significant objective and allocate at least 30% of the total project budget to GEWE
Score 1 for projects that contribute in some way to gender equality, but not significantly (less than 30% of the total budget for GEWE)

[4] **Risk marker 0** = low risk to achieving outcomes
Risk marker 1 = medium risk to achieving outcomes
Risk marker 2 = high risk to achieving outcomes

[5] **PBF Focus Areas** are:
(1.1) SSR, (1.2) Rule of Law; (1.3) DDR; (1.4) Political Dialogue;
(2.1) National reconciliation; (2.2) Democratic Governance; (2.3) Conflict prevention/management;
(3.1) Employment; (3.2) Equitable access to social services
(4.1) Strengthening of essential national state capacity; (4.2) extension of state authority/local administration; (4.3) Governance of peacebuilding resources (including PBF Secretariats)

benefits from equitable and quality essential social services. If applicable, **Sustainable Development Goal** to which the project contributes: Achievement of goal number 3 – Good Health and Well-Being, as well as goal number 17— Partnerships for the Goals. If applicable, **National Strategic Goal** to which the project contributes: *National Strategy and Action Plan for Preventing and Countering Violent Extremism* through addressing barriers of youth to participate peace building and conflict resolution initiatives, and the *National Health Sector Strategic Plan* which identifies mental health's critical gap and proposes mental health as part of its key priorities.	
Type of submission: ☒ **New project** ☐ **Project amendment**	**If it is a project amendment, select all changes that apply and provide a brief justification:** **Extension of duration:** ☐ Additional duration in months (number of months and new end date): **Change of project outcome/ scope:** ☐ **Change of budget allocation between outcomes or budget categories of more than 15%:** ☐ **Additional PBF budget:** ☐ Additional amount by recipient organization: USD XXXXX **Brief justification for amendment:** *Note: If this is an amendment, show any changes to the project document in RED colour or in TRACKED CHANGES, ensuring a new result framework and budget tables are included with clearly visible changes. Any parts of the document which are not affected, should remain the same. New project signatures are required.*

PROJECT SIGNATURES:

Recipient Organization(s)	Representative of National Authorities
Dr Sk Md Mamunur Rahman Mallick Representative WHO Somalia *Date & Seal* 20/09/2019	Dr Fawziya Abikar Nor Minister of Health Federal Republic of Somalia *Date & Seal* 20/09/2019
Head of UN Country Team	**Peace building Support Office (PBSO)**
Adam Abdelmoula Deputy Special Representative of the Secretary-General, Resident and Humanitarian Coordinator for Somalia *Date & Seal* 22/09/2019	Oscar Fernandez-Taranco Assistant Secretary-General, Peace building Support Office *Date& Seal* 19 November 2019
Ms. Dyane Epstein Chief of Mission IOM Somalia *Date and Seal* 20/9	Mr. Werner Schultink Representative UNICEF Somalia *Date and Seal* 19/9/2019

I. Peacebuilding Context and Rationale for PBF support (4 pages max)

a) *A brief summary of **conflict analysis findings** as they relate to this project, focusing on the driving factors of tensions/conflict that the project aims to address and an analysis of the main actors/ stakeholders that have an impact on or are impacted by the driving factors, which the project will aim to engage. This analysis must be gender- and age-sensitive.*

Somalia has suffered from protracted conflict and social unrest since the collapse of the central government in 1991. The conflict, exacerbated by recurrent climactic shocks and mass displacement, has fragmented society, eroded resilience and coping mechanisms, and amplified underlying problems of economic inequality and social injustice. Following an in-depth context analysis, Kismayo (Jubaland), Dollow (Jubaland), Baidoa (South West State), Mogadishu, and Galkaayo have been identified as priority areas. In the recent years, the main drivers of displacement are connected to both natural and man-made factors, including drought and climatic variability (eg. varying rainfall and temperature) and conflict, particularly related to Al-Shabaab (AS) activities in the rural areas. As a result, Baidoa is currently hosting over 300,000 IDPs, with expanding number of IDP camps that rose from 2016 to 2018 by 72 new sites. In Kismayo city, IDP arrivals tend to originate mainly from Lower Juba region, of which Kismayo city is the capital. Kismayo also receives many returnees from the Dabaab refugee camp in Kenya, and these returnees coupled with the ongoing drought have led Kismayo's IDP population to swell. Similar to Kismayo, the urban centre of Dollow hosts a large number of IDPs affected by prolonged drought, as well as road restrictions by AS around Garbaharey and Bardhere districts, which are key areas for pastoral communities which have since migrated to more urban locations in search of food, water and other necessities for livelihoods. Finally, Banadir Regional Administration (BRA) covers the area of the city of Mogadishu, making it the smallest region with the highest population, and simultaneously, a host of the largest IDP population in the country (estimated at over 700,000 persons). Mogadishu has also experienced the greatest frequency and concentration of armed attacks in Somalia since 2012.

As a result of the mass disruptions experienced in Somalia over the past 25 years, much of the population especially youth are dealing with multi-layered psychosocial problems and challenges that have never been addressed. Further, according to the most recent data from WHO (2010) on mental health in Somalia, one in three Somalis are affected by mental illness. In addition to these complexities, more than two thirds of the country's population (15.4 million) is made up of young men and women, of which 73 percent are below the age of 30, the majority of whom have only known conflict for much of their lives. Most have directly experienced, witnessed, or been exposed to extreme violence, destruction, displacement, and personal loss, or had their lives uprooted and aspirations denied.

The psychosocial vulnerability and mental health context for young men and women is more complex due to traditional gender and societal norms and practices, where stigma associated with mental illness and psychosocial problems often inhibits all avenues and opportunities for recovery. Population sub-groups that are particularly at increased risk and more vulnerable include displaced individuals, young women with high likelihood of experiencing gender-based violence (GBV), and certain groups of young men (i.e. ex-combatants, idle young men who have lost the means to take care of their families, young men at risk of detention or who are targets of violence). Moreover, conflict and insecurity affect men and women differently. Women and children are often the most vulnerable and thus prone to being hit the hardest. Security needs, perceptions, roles and participation in

decision-making differ according to socio-cultural gender roles; and, as a result, women, men, girls and boys face different threats to their security and distinct obstacles to accessing services where available. Women are more vulnerable to abuses and different forms of GBV including rape, sexual assault, forced prostitution, and domestic violence. In 2018, more than 76 percent of recorded GBV survivors were reported to be from IDP communities[6]. Widespread Female Genital Mutilation (FGM) and forced marriage at a very early age may also prove as potent risk factors for mental illness and psychosocial disruption in women. Women and young girls are thus exposed to a higher risk of experiencing harmful ordeals leading to psychological problems and increased psychosocial vulnerability, which if not addressed through community support structures and/or focused services, can become chronic and long-lasting. As an additional barrier, women are less likely than men to utilize MHPSS services when available, according to available data.

Overall, MHPSS services are largely non-existent in Somalia. Services are neither available in the public sector, nor supported by humanitarian or development actors. In a system where traditional and formal institutions are ill-equipped to deal with mental illness and psychosocial problems, youth often resort to harmful coping strategies, (e.g. self-medication, substance abuse), which worsen mental health and the psychosocial effects of mass disruption while increasing sense of disenfranchisement and reinforcing the existing stigma around psychosocial problems and mental illness.

Most mental illnesses begin during adolescence and continues into adulthood, with major depression occurring approximately twice as often in women than men. The effects of psychosocial problems originating during the formative period of youth are likely to carry over into adulthood. Youth, particularly males, tend to have higher rates of substance abuse, which in Somalia consists predominantly of the use of *khat*. A recent youth and peace building study in Somalia, conducted by the UN and World Bank, found that youth want to actively participate in Somalia's peace building efforts, expressing a deep responsibility to help bring about sustainable peace in their country.[7] However, mass disruption (trauma), and recurrent conflict and displacement is damaging the social capital of young Somali men and women and further contributes to their disenfranchisement and vulnerability. The large number of disenfranchised youth feeds into an already serious problem of marginalization, which is an established conflict driver. As a consequence of all of the above, the natural ties, rules and bonds between people and within communities that strengthen coping and resilience, are damaged – a contributing factor to ongoing and prolonged conflict in Somalia, and part of a vicious cycle that prevents lasting peace from taking hold.

Youth in Somalia constitute the majority of the population and they have the potential to play a crucial role in the recovery of the country. At the same time, when deprived of education and economic opportunities and whilst being exposed to continuous violence, young people can hardly contribute to improving the stability of their communities. In addition, they are at risk of being exploited in partisan dynamics in the community that fuel tensions and lead to conflict. Youth and adolescents who experience early aggression and a violent childhood are at the highest risk of perpetrating violence[8]. In this context, support for youth becomes a pressing issue for the effective recovery and stabilization of at-risk

[6] Somalia Protection Cluster – Midyear review 2018
[7] Youth as Agents of Peace (World Bank, UN Somalia, UN Habitat), Final Report, 2018
[8] World Youth Report – Youth and Conflict – Accessible at:
http://www.un.org/esa/socdev/unyin/documents/ch14.pdf

communities. It is critical to empower youth to be positive change agents for reducing conflict and increasing peace building.

b) *A brief description of how the project aligns with/ supports **existing** Governmental and UN **strategic frameworks,** how it ensures **national ownership** and how the project builds on any previous phase of PBF support and/or any **concrete lessons learned**.*

The proposed project will complement existing primary health care services and peacebuilding initiatives implemented by the UN, by addressing a critical service delivery gap – MHPSS – which is currently not provided by any humanitarian or developmental programmes in Somalia. The project will also address stigma and isolation of young men and women; promote their participation and contribution to conflict resolution and peacebuilding; and proposes a sustainable solution for mental health, psychosocial service and substance abuse prevention in Somalia.

Increasingly recognized amongst MHPSS and peacebuilding practitioners is that interventions aiming to achieve peace building would benefit from closer inter-linkages with mental health interventions, as both disciplines add vital elements to countries rebuilding their social, economic and political structures after violent conflict. Therefore, post-conflict rebuilding must take place in an interdisciplinary and inter-sectoral way, incorporating the psychological, social, political, historical, cultural and economic nuances that define each society. This project therefore recognizes that for peace building efforts in a protracted conflict context like Somalia to be successful, MHPSS services must be integrated to enable youth to be positive change agents in the peace building process, rather than further exacerbating and driving conflict cycles. It is important to note that mental illnesses, if not supported and treated, may contribute to disability with its rights-related challenges, and since the rights of persons with disabilities are now part of the priorities of the Federal Government, as per the Universal Periodic Review commitments and the signing of the Convention on the Rights of Persons with Disabilities, this proposal is very timely.

Furthermore, this project was also developed in close consultation and alignment with the Somali Mental Health Strategy the UN Strategic Framework, and the Somalia National Development Plan by contributing to the social and human development chapter which prioritizes MHPSS.

Additionally, the project aligns with and contributes to a number of other Government youth polices, strategies and plans, including: the Federal Government of Somali's (FGS) *Social Development Roadmap Goal 4*, which prioritizes provision of affordable and accessible basic social services, such as health, education, clean water and electricity; the *National Reconciliation Framework*, which identifies trauma healing as an important piece of reconciliation; the FGS's *National Youth Policy* and *National Mental Health Strategy*, which supports the provision of mental health in conflict settings; the *National Health Sector Strategic Plan*, which identifies MHPSS as a critical gap and proposes that it be part of key priorities; the *National Strategy and Action Plan for Preventing and Countering Violent Extremism*, by addressing barriers of youth to participate in peace building and conflict resolution initiatives; and finally the *Somali Youth 4 Peace Pact* and *Convention on the Rights of Persons with Disabilities*, which the Government signed in October 2018.

c) *A **summary of existing interventions** in the proposal's sector by filling out the table below.*

Project name (duration)	Donor and budget	Project focus	Difference from/ complementarity to current proposal
There are currently no dedicated MHPSS projects being implemented in Somalia.			

II. Project content, strategic justification and implementation strategy (4 pages max Plus Results Framework Annex)

a) *A brief **description of the project content** – in a nutshell, what are the main results the project is trying to achieve, the implementation strategy, and how it addresses the conflict causes or factors outlined in Section I (must be gender- and age- sensitive).*

The project aims to address a critical gap contributing to persistent conflict in Somalia—lack of psychosocial support and mental health services for conflict affected youth—through a socially-inclusive integrated approach for peace building. The activities in this project will directly empower conflict-vulnerable youth to be agents of peace and positive change in their communities, re-directing youth away from harmful or self-damaging practices that fuel tension and contribute to conflict. This will lead to improved individual and collective youth well-being and resilience, reduced vulnerability of youth to conflict drivers, and stronger community social cohesion.

The project will avail focused and community-based mental MHPSS services to youth suffering from mental illness, context-driven psychological problems, and psychosocial vulnerability in conflict-affected IDP settlements.

Care and treatment of mental illness will be integrated into the primary healthcare services delivery at health facilities including the development of a youth-centered and gender-aware MHPSS services training module for health workers, as well as a professional training of clinical staff at health facilities in targeted IDP settlements. The training will also include Clinical Management of Rape (CMR) and care for Victims of Trafficking (VoT), which are especially pertinent to Somalia's context.

Community-based psychosocial support (PSS) structures and services will be established utilizing the local health facilities as an entry point. These include formation of support groups, provision of counseling (youth peer-to-peer counseling, and problem management [PM+] counseling), training of community leaders and health workers in psychological first aid, activation and facilitation of gender-based violence (GBV) referral pathways, mobilization of communities by their own youth for social/traditional/recreational activities to strengthen social cohesion and enhance community bonds, and establishment of MHPSS youth resource centers connected to the health facility (where many of the psychosocial support services (PSS) and positive empowerment activities will be conducted). Community dialogues between youth, community leaders, and local authorities on conflict and peacebuilding will be organized and facilitated at the resource center. Through this combination of community PSS structures and activities, the youth themselves will be mobilized, trained and empowered to engage in delivery of PSS to their peers and communities, fostering and promoting youth to embrace and lead peacebuilding and conflict reduction efforts.

Further, youth will be empowered and supported to raise awareness in their communities and with their fellow youth about substance abuse, negative coping mechanisms and

harmful behaviors that contribute to conflict, and stigmatization of mental illness. This will be achieved using locally contextualized approaches and communication mediums, to help effect change from harmful practices to participation in positive and productive activities, and to encourage and provide avenues for youth to become 'agents of peace'.

Finally, a study will be conducted on the linkages between mental health, conflict and peace building, with a particular focus on youth and gender dynamics. This study complements the other project activities, as it will create a knowledge base about the interplay between MHPSS and conflict drivers in Somalia, helping inform new evidence-based approaches and interventions which can be implemented as a follow-on to the project. The study findings will help contextualize the results and analysis from the other components of this project.

Gender-sensitive approaches will also be incorporated throughout the project life-cycle, including through identification of gender-specific barriers to access MHPSS (which will take place during the initial assessment of each IDP site prior to project implementation); gender-balance among health facility staff trained and deployed in project activities; the collection and analysis of all project data with gender disaggregation, ensuring community health committees (CHCs) have at least 50 percent female representation; capacity building of institutions on mental health and peacebuilding including with emphasis on women and youth-led organizations; and income-generating activities targeting young women. Through improved psychosocial support and the provision of mental health care for conflict affected youth in Somalia, this project addresses a critical social service delivery gap; will help reduce stigma and the isolation of young men and women; promotes youth participation and contribution to conflict resolution and peace building; and proposes a sustainable solution for MHPSS and substance abuse prevention in Somalia through a collaborative and partnership approach between WHO, UNICEF, IOM, the Ministry of Health (MoH), and Somalia National University (SNU).

b) *Provide a **project-level 'theory of change'** – i.e. explain the type of change envisaged by the project and how do you expect the project interventions to lead to results and why have these interventions been selected. What are the assumptions that the theory is based on? (Note: Change may happen through various and diverse approaches, i.e. social cohesion may be fostered through dialogue or employment opportunities or joint management of infrastructure. The selection of which approach should depend on context-specific factors. What basic assumptions about how change will occur have driven your choice of programming approach?)*

If social isolation and harmful behavior associated with mental illness and psychosocial problems can be mitigated through provision of mental health and psychosocial support activities, including awareness raising to youth in IDP sites and marginalized communities in conflict-affected areas,

Then the youth will contribute to breaking the negative cycle of exclusion and reducing marginalization and drivers of conflict,

Because youth affected by mental health illnesses and psychosocial problems will be empowered to positively contribute to social cohesion and stability of their communities.

The project assumes provision of mental health and psychosocial services to young men and women, reduction of stigma associated with mental and psychosocial disorders, and improved social cohesion will reduce youth disenfranchisement and marginalization,

which is an established conflict driver, and thereby enabling them to become positive change agents who are contributing to peace building opportunities.

c) ***Project result framework****, outlining all project outcomes, outputs, activities with indicators of progress, baselines and targets (must be gender- and age- sensitive). Use* ***Annex B****; no need to provide additional narrative here.*

d) ***Project targeting and sequencing strategy*** *– provide justification for geographic zones, criteria for beneficiary selection, expected number and type of beneficiaries and justification, timing among various activities, any measures to ensure coherence and connection between outcomes, and any other information on implementation approach (must be gender- and age-sensitive). No need to repeat all outputs and activities from the Result Framework.*

This project will target urban centres of Kismayo (Jubaland state), Baidoa (in South West state), Dollow (in Jubaland state), Mogadishu, and Galkaayo. These target locations were selected based on a combination of factors including the IDP population, number and density of IDP settlements and communities, the accessibility and relative security of the towns, political context, conflict dynamics and severity (e.g. history of recurrent inter-clan conflicts, and active conflict between the government and Al Shabaab in the region). Indeed, these regions have also been severely affected by the ongoing drought and pre-famine situation in Somalia, triggering large influxes of IDPs into the urban centres, which in turn have only exacerbated the challenging conflict-related dynamics.

The project's direct beneficiaries are estimated at 26,500 individuals across the 4 project implementation sites located in conflict-prone regions/towns. Most direct beneficiaries will be IDP youth and their families, and emphasis will be placed on reaching young women who are otherwise marginalized or fall through the cracks. The direct beneficiaries include 1] IDP youth and their families who will be reached through community-based PSS services and activities (especially youth with PSS needs stemming from years of mass disruptions), 2] IDP youth and family members who will receive care and treatment for mental illnesses at primary healthcare facilities (where mental healthcare has been integrated and mainstreamed), 3] GBV survivors— female and male— who receive care, support, and appropriate referral linkages to needed services (medical/ legal/ protection/ shelter/ security), 4] youth directly addressed and reached in awareness raising activities about substance abuse, harmful practices and opportunities for positive empowerment (as well as the youth leading those activities), 5] health workers trained in provision of MHPSS services within primary healthcare through the new MHPSS curriculum, and 6] community members trained in PFA and GBV response. The IDP youth reached through the project activities will benefit from increased individual well-being, increased emotional resilience, reduced vulnerability to conflict drivers, and empowerment to contribute to community stability and cohesion through active participation in activities that foster reduced conflict and increased community well-being ('agents of peace').

The estimated number of indirect beneficiaries are 288,520, which include the entire communities in the IDP settlements where the interventions are being implemented— the target communities in their entirety will benefit from improved social cohesion and collective well-being, as well as mitigation of potential conflict drivers among youth leading to reduced violence and likelihood of more enduring peace and stability. The communities will benefit from de-stigmatization of trauma, mental illness, psychosocial problems, and benefit from access to PSS and mental health services.

The whole country will benefit from creation of embedded institutional capacity for training of health workers in youth-friendly and gender sensitive MHPSS service provision (including GBV case management and CMR), which will sustain itself beyond the project.

III. Project management and coordination (4 pages max)

a) ***Recipient organizations and implementing partners*** *– list direct recipient organizations and their implementing partners (international and local), specifying the Convening Organization, which will coordinate the project, and providing a brief justification for the choices, based on mandate, experience, local know-how and existing capacity. Also fill out the table below for each recipient organization:*

Agency	Key sources of budget (which donors etc)	Location of in-country offices	Highlight any existing expert staff of relevance to project
WHO Somalia (Convening Organization)	CERF / DFID / Japan / Germany / GAVI / WHO funds from its Regional Office and HQ	Mogadishu, Baidoa, Kismayo, Garowe, Hargeisa	Dr Rizwan Humayun - Medical Officer/Primary Health Care Dr Abdihamid Ibrahim Planning Officer
IOM Somalia	CERF / Japan/ Germany / USG	Mogadishu Baidoa Kismayo, Dollow, Garowe, Bossaso Hargeisa	Fathi Gelle, MHPSS Technical Expert Dr Abdi Hassan, Senior Medical Officer Vijay Narayan, Health Coordinator
UNICEF Somalia	CERF/DFID/OFDA/SIDA/Japan/Denmark/Canada/Holland/ Belgium	Mogadishu, Garowe, Hargeisa, Baidoa	Samuel Sesay CP Specialist (CPIE) Maher Farea CP Specialist (MRM)

WHO Country Office Somalia (WCO), will be the lead and convening organization for this project because of its mandate; technical expertise at country, regional and global level, with respect to the development and implementation of mental health and psychosocial programming activities, particularly in emergency and conflict settings; and its position as co-chair of the Inter-Agency Standing Committee's Task Force on Mental Health.

The main WCO office is located in Mogadishu, with three other sub-offices across Somalia. In addition, WHO's main counterpart is the Ministry of Health (MOH) at Federal and State level, and it possesses a strong physical presence in all regions and States in the country, including through a vast network of international and national staff on the ground.

As part of this project, WHO will sub-contract SNU (a public, but semi-autonomous academic institution) as a civil society organization (CSO). WHO will provide intensive technical guidance and support to SNU in the development and roll-out of the training module on mental health and substance abuse, including with regard to integrating this

training into relevant education curricula. WHO will also lead the implementation of operational research on the linkages between mental health, substance abuse, conflict and peace building. SNU will further implement the training module so as to create a cadre of local expert 'trainers', who through a cascade training, will subsequently train health workers in selected IDP settlements in conflict-affected areas. Additionally, to ensure sustainability of the project, SNU will act as a referral and repository center where data and information from health facilities that are providing mental health and psychological services can be collated and analyzed to better understand the mental and psychosocial disabilities faced by affected communities in Somalia. In addition, WHO in collaboration with SNU and the Federal MOH will conduct a research study on inter-linkages between youth, MHPSS and peace building in Somalia to inform evidence-based strategies/approaches for the Government and international community alike, as well for future advocacy and resource mobilization efforts.

IOM is another UN recipient organization and will lead the implementation of facility and community-based MHPSS delivery, targeting youth in conflict-affected areas and IDP settlements through primary healthcare facilities. IOM is active throughout Somalia, with strong presence and technical staff across all major cities and strategic migration routes. IOM currently supports health-care services at 25 static health facilities and via 10 mobile medical teams, providing frontline medical care to vulnerable populations affected by recurrent climatic shocks and protracted conflict. The agency already operates within the targeted IDP settlements, and has therefore teams in place, community acceptance and a good understanding of local dynamics.

UNICEF is the third recipient UN organization and, considering its mandate and expertise on behavior change and social communication, will support the development and roll-out of an awareness program on MHPSS and substance abuse with the objective of reducing stigma associated with mental and psychosocial disorders and raising awareness on these issues amongst Somali youth.

b) ***Project management and coordination*** *– present the project implementation team, including positions and roles and explanation of which positions are to be funded by the project (to which percentage). Explain project coordination and oversight arrangements and ensure link with PBF Secretariat if it exists. Fill out project implementation readiness checklist in* ***Annex C*** *and attach key staff TORs.*

A joint implementation team consisting of the RUNO (WHO), UNICEF, MOH, IOM and SNU will oversee project implementation. Each team consists of:

- WHO
  - Medical Officer (existing) will be the primary focal and contact person. He will be responsible for overall management of the project including coordination with PBF secretariat.
  - National project Officer (new staff with 100% funding) will be recruited under the Medical Officer. This person will be responsible for day-to-day project operations, including organizing regular coordination and review meetings amongst project stakeholders, and drafting project reports.
  - Monitoring and Evaluation (M&E) Expert (new national with 100% funding) will be recruited to support implementation of monitoring and evaluation framework
- IOM
  - The Health Programme Coordinator and Senior Health Programme Officer will oversee and manage the project.

    - An MHPSS Technical Expert (International staff) will support the project implementation, and the position is co-funded between this project and other funds.
    - Project support and supervision: will ensure adequate staff support to execute the planned activities (a projectized contribution for supporting roles including Head of Sub Offices, programme support, finance, human resources, IT, security, and procurement).
- UNICEF
    - Existing communications for development officer with 50% support from the project will be part of project management team and will support its implementation.
- SNU
    - Mental health and psychosocial services expert will be recruited to support training module development and its roll out. The position will be 100% supported by the project.

Quarterly coordination and review meetings will be held to: assess project implementation and progress; project status against set targets and goals; and review risks and challenges. Timely progress reports, both financial and technical, will also be shared with PBF secretariat.

c) ***Risk management*** *– assess the level of risk for project success (low, medium and high) and provide a list of major project specific risks and how they will be managed, including the approach to updating risks and making project adjustments. Include any Do No Harm issues and project mitigation.*

Risk	Likelihood	Impact	Overall Risk	Mitigation Measures
Movement restrictions due to security related incidents (international staff)	Possible	Significant	Medium	Somali national staff will be implementing the project at field level, and unlike international staff, they are able to move freely in the target project sites.
High turnover rate of trained health facilities staff.	Likely	Significant	Low	Collaboration with MOH to ensure retention of trained staff and conduct on the job training to other staff within target sites
Project sustainability	Possible	Significant	Medium	The project, framed around training and community engagement, has inbuilt sustainability. The structures in place to facilitate community engagement and foster youth leadership/participation will endure, not requiring inputs. The training modules will be incorporated into pre-service and in-service training curricula of the Ministry of Health.

d) ***Monitoring and evaluation*** *– What will be the M&E approach for the project, including M&E expertise in the project team and main means and timing of collecting data? Include a break-down of M&E budget that the project is putting aside, including for collection of baseline and end line data for indicators and for an independent evaluation, and an approximate M&E timeline. Ensure at least 5-7% of the project budget is set aside for M&E activities, including sufficient funds for a quality independent evaluation.*

As this project aims to target an unchartered programmatic area of MHPSS and peace building, it includes a robust monitoring and evaluation plan. A dedicated M&E technical expert will manage the M&E implementation for this project, creating a granular joint M&E micro-plan encompassing all three outputs at the inception of the project (based on the logical framework for the proposal, see Annex B), and then ensuring throughout project period that the M&E plan is implemented and coordinated across agencies. The individual agencies also have strong M&E capacity which will be utilized and feed into the overall M&E system.

The logframe in Annex B details the project outcome and output indicators, the tools that will be developed and utilized at project locations to capture the data, and the frequency of data collection. For recurrent activities, data will be collected monthly from the field, sent to the project administration team in Mogadishu, and relevant data extracted and inputted into databases. For one-off or infrequent activities, data will be collected when those time-phased activities take place. All data will be disaggregated by age and gender except where not applicable. Individual beneficiary data, especially health facility patient data, will be protected for confidentiality in accordance with international and national guidelines. The project will include mechanisms for Accountability to Affected Populations (AAP), such as phone hotline and written complaints boxes, to ensure that community feedback is captured and incorporated into program implementation throughout the project cycle.

The target outcome of the project is for Somali youth in conflict-prone displacement settings to have a reduced likelihood of resorting to negative practices that contribute to conflict, and instead greater likelihood to actively engage in activities that promote peacebuilding and social cohesion— achieved through increased access to youth-friendly mental health care, community-based psychosocial support activities and services, and tailored information dissemination. The outcome will be measured through Knowledge, Attitudes, and Practices (KAP) surveys and Focus Group Discussions with health workers and community stakeholders. The M&E expert will take the lead in developing the baseline and endline KAP surveys which will be conducted at the major IDP settlements in the project. The KAP survey will assess youth awareness and practice of negative coping mechanisms that contribute to conflict (e.g. substance abuse and GBV), and youth participation in positive activities that may contribute to peacebuilding and social cohesion in their communities. Focus-group discussions (FGDs) will be conducted at beginning and end of the project (baseline and endline) to assess perceptions and views of IDP community leaders and health workers about the extent to which they are empowered with avenues to support their local youth who have mental illness or face context-driven psychological problems and psychosocial vulnerabilities.

In addition to the planned M&E activities described above, additional assessments and evaluations may be carried out as the project occurs and needs are identified, such as cross-sectional surveys, interviews, and FGDs.

Joint supervision and monitoring visits will be conducted by the project management team, including the international programme managers from each agency, to all project sites to

ensure smooth and high-quality implementation of the different project components, as well as identify barriers and develop solutions. An independent/third party monitoring company will be deployed in the final month of the project to conduct a holistic evaluation of the project, which will include review of data records at project sites, interviews with beneficiaries and health facility staff, etc.

The research study is a vital component of the project, as it will provide an opportunity to better understand the linkages between MHPSS and peace building in Somalia, and it will complement the other M&E components.

The lessons learned from this project and best practices will also be documented and shared with all relevant stakeholders in Somalia to inform improvements to the implementation model and inform discussions about future directions after project completion.

A total of 95,000 USD (6% of project budget) is allocated to project monitoring and evaluation.	
Monitoring and evaluation activities	Allocated budget
Recruitment of M & E Expert	40,000 USD
Joint monitoring visits	15,000 USD
Data collection and reporting	10,000 USD
Independent evaluation at the end of the project	30,000 USD

e) ***Project exit strategy/ sustainability*** *– Briefly explain the project's exit strategy to ensure that the project can be wrapped up at the end of the project duration, either through sustainability measures, agreements with other donors for follow-up funding or end of activities which do not need further support. If support from other donors is expected, explain what the project will do concretely and pro-actively to try to ensure this support from the start. If relevant, what are project links to any existing platforms or partnerships?*

All current developmental and humanitarian projects in Somalia do not support MHPSS. This pilot project therefore proposes a sustainable mechanism to cover a critical basic services delivery gap in some selected locations and health facilities through integrating MHPSS into existing primary health care services. No additional health facilities staff will be recruited as existing staff and community caregivers in selected conflict-affected IDP settlements within target locations will be trained.

A multidisciplinary training module on MHPSS for youth will be developed and integrated into relevant curricula at SNU to ensure sustainability of the program. In addition, the project will be the first of its kind to undertake a study that will generate evidence-based information on the inter-linkages between mental health and peace building in Somalia, which has the potential to catalyze significant funding from other donors and continuation of this innovative project.

IV. Project budget

If helpful, provide any additional information on projects costs, highlighting any specific choices that have underpinned the budget preparation, especially for personnel, travel or other indirect project support, to demonstrate value for money for the project. Proposed budget for all projects must include funds for independent evaluation. Proposed budget for projects involving non-UN direct recipients must include funds for independent audit. State clearly in how many tranches the budget

will be provided and what conditions will underpin the release of a second or any subsequent tranche. Standard approach is two tranches for UN recipients and three tranches for non-UN recipients with the second tranche being released upon demonstration by the project (by the Coordinating Agency on behalf of the project and through the Resident Coordinator's Office or PBF Secretariat) that the first tranche has been expensed or committed to at least 75% between the recipients and upon completion of any regular PBF reports due in the period elapsed. Additional tranches or conditions may be added depending on the project context, implementation capacity, and level of risk. Fill out two tables in the Excel budget ***Annex D***.

No additional comments.

Annex A.1: Project Administrative arrangements for UN Recipient Organizations

(This section uses standard wording – please do not remove)

The UNDP MPTF Office serves as the Administrative Agent (AA) of the PBF and is responsible for the receipt of donor contributions, the transfer of funds to Recipient UN Organizations, the consolidation of narrative and financial reports and the submission of these to the PBSO and the PBF donors. As the Administrative Agent of the PBF, MPTF Office transfers funds to RUNOS on the basis of the signed Memorandum of Understanding between each RUNO and the MPTF Office.

AA Functions

On behalf of the Recipient Organizations, and in accordance with the UNDG-approved "Protocol on the Administrative Agent for Multi Donor Trust Funds and Joint Programmes, and One UN funds" (2008), the MPTF Office as the AA of the PBF will:

- Disburse funds to each of the RUNO in accordance with instructions from the PBSO. The AA will normally make each disbursement within three (3) to five (5) business days after having received instructions from the PBSO along with the relevant Submission form and Project document signed by all participants concerned;
- Consolidate the financial statements (Annual and Final), based on submissions provided to the AA by RUNOS and provide the PBF annual consolidated progress reports to the donors and the PBSO;
- Proceed with the operational and financial closure of the project in the MPTF Office system once the completion is completed by the RUNO. A project will be considered as operationally closed upon submission of a joint final narrative report. In order for the MPTF Office to financially closed a project, each RUNO must refund unspent balance of over 250 USD, indirect cost (GMS) should not exceed 7% and submission of a certified final financial statement by the recipient organizations' headquarters);
- Disburse funds to any RUNO for any costs extension that the PBSO may decide in accordance with the PBF rules & regulations.

Accountability, transparency and reporting of the Recipient United Nations Organizations

Recipient United Nations Organizations will assume full programmatic and financial accountability for the funds disbursed to them by the Administrative Agent. Such funds will be administered by each RUNO in accordance with its own regulations, rules, directives and procedures.

Each RUNO shall establish a separate ledger account for the receipt and administration of the funds disbursed to it by the Administrative Agent from the PBF account. This separate ledger account shall be administered by each RUNO in accordance with its own regulations, rules, directives and procedures, including those relating to interest. The separate ledger account shall be subject exclusively to the internal and external auditing procedures laid down in the financial regulations, rules, directives and procedures applicable to the RUNO.

Each RUNO will provide the Administrative Agent and the PBSO (for narrative reports only) with:

Type of report	Due when	Submitted by
Semi-annual project progress report	15 June	Convening Agency on behalf of all implementing organizations and in consultation with/ quality assurance by PBF Secretariats, where they exist
Annual project progress report	15 November	Convening Agency on behalf of all implementing organizations and in

		consultation with/ quality assurance by PBF Secretariats, where they exist
End of project report covering entire project duration	Within three months from the operational project closure (it can be submitted instead of an annual report if timing coincides)	Convening Agency on behalf of all implementing organizations and in consultation with/ quality assurance by PBF Secretariats, where they exist
Annual strategic peacebuilding and PBF progress report (for PRF allocations only), which may contain a request for additional PBF allocation if the context requires it	1 December	PBF Secretariat on behalf of the PBF Steering Committee, where it exists or Head of UN Country Team where it does not.

Financial reporting and timeline

Timeline	**Event**
30 April	Annual reporting – Report **Q4 expenses** (Jan. to Dec. of previous year)
Certified final financial report to be provided by 30 June of the calendar year after project closure	

UNEX also opens for voluntary financial reporting for UN recipient organizations the following dates

31 July	Voluntary Q2 expenses (January to June)
31 October	Voluntary Q3 expenses (January to September)

Unspent Balance exceeding USD 250, at the closure of the project would have to been refunded and a notification sent to the MPTF Office, no later than six months (30 June) of the year following the completion of the activities.

Ownership of Equipment, Supplies and Other Property

Ownership of equipment, supplies and other property financed from the PBF shall vest in the RUNO undertaking the activities. Matters relating to the transfer of ownership by the RUNO shall be determined in accordance with its own applicable policies and procedures.

Public Disclosure

The PBSO and Administrative Agent will ensure that operations of the PBF are publicly disclosed on the PBF website (http://unpbf.org) and the Administrative Agent's website (http://mptf.undp.org)

Annex A.2: Project Administrative arrangements for Non-UN Recipient Organizations

(This section uses standard wording – please do not remove)

Accountability, transparency and reporting of the Recipient Non-United Nations Organization:

The Recipient Non-United Nations Organization will assume full programmatic and financial accountability for the funds disbursed to them by the Administrative Agent. Such funds will be administered by each recipient in accordance with its own regulations, rules, directives and procedures.

The Recipient Non-United Nations Organization will have full responsibility for ensuring that the Activity is implemented in accordance with the signed Project Document;

In the event of a financial review, audit or evaluation recommended by PBSO, the cost of such activity should be included in the project budget;

Ensure professional management of the Activity, including performance monitoring and reporting activities in accordance with PBSO guidelines.

Ensure compliance with the Financing Agreement and relevant applicable clauses in the Fund MOU.

Reporting:

Each Receipt will provide the Administrative Agent and the PBSO (for narrative reports only) with:

Type of report	Due when	Submitted by
Bi-annual project progress report	15 June	Convening Agency on behalf of all implementing organizations and in consultation with/ quality assurance by PBF Secretariats, where they exist
Annual project progress report	15 November	Convening Agency on behalf of all implementing organizations and in consultation with/ quality assurance by PBF Secretariats, where they exist
End of project report covering entire project duration	Within three months from the operational project closure (it can be submitted instead of an annual report if timing coincides)	Convening Agency on behalf of all implementing organizations and in consultation with/ quality assurance by PBF Secretariats, where they exist
Annual strategic peacebuilding and PBF progress report (for PRF allocations only), which may contain a request for additional PBF allocation if the context requires it	1 December	PBF Secretariat on behalf of the PBF Steering Committee, where it exists or Head of UN Country Team where it does not.

Financial reports and timeline

Timeline	Event
28 February	Annual reporting – Report **Q4 expenses** (Jan. to Dec. of previous year)
30 April	Report **Q1 expenses** (January to March)
31 July	Report **Q2 expenses** (January to June)
31 October	Report **Q3 expenses** (January to September)
Certified final financial report to be provided at the quarter following the project financial closure	

Unspent Balance exceeding USD 250 at the closure of the project would have to been refunded and a notification sent to the Administrative Agent, no later than three months (31 March) of the year following the completion of the activities.

Ownership of Equipment, Supplies and Other Property

Matters relating to the transfer of ownership by the Recipient Non-UN Recipient Organization will be determined in accordance with applicable policies and procedures defined by the PBSO.

Public Disclosure

The PBSO and Administrative Agent will ensure that operations of the PBF are publicly disclosed on the PBF website (http://unpbf.org) and the Administrative Agent website (http:www.mptf.undp.org)

Final Project Audit for non-UN recipient organization projects

An independent project audit will be requested by the end of the project. The audit report needs to be attached to the final narrative project report. The cost of such activity must be included in the project budget.

Special Provisions regarding Financing of Terrorism

Consistent with UN Security Council Resolutions relating to terrorism, including UN Security Council Resolution 1373 (2001) and 1267 (1999) and related resolutions, the Participants are firmly committed to the international fight against terrorism, and in particular, against the financing of terrorism. Similarly, all Recipient Organizations recognize their obligation to comply with any applicable sanctions imposed by the UN Security Council. Each of the Recipient Organizations will use all reasonable efforts to ensure that the funds transferred to it in accordance with this agreement are not used to provide support or assistance to individuals or entities associated with terrorism as designated by any UN Security Council sanctions regime. If, during the term of this agreement, a Recipient Organization determines that there are credible allegations that funds transferred to it in accordance with this agreement have been used to provide support or assistance to individuals or entities associated with terrorism as designated by any UN Security Council sanctions regime it will as soon as it becomes aware of it inform the head of PBSO, the Administrative Agent and the donor(s) and, in consultation with the donors as appropriate, determine an appropriate response.

Non-UN recipient organization (NUNO) eligibility:

In order to be declared eligible to receive PBF funds directly, NUNOs must be assessed as technically, financially and legally sound by the PBF and its agent, the Multi Partner Trust Fund Office (MPTFO). Prior to submitting a finalized project document, it is the responsibility of each NUNO to liaise with PBSO and MPTFO and provide all the necessary documents (see below) to demonstrate that all the criteria have been fulfilled and to be declared as eligible for direct PBF funds.

The NUNO must provide (in a timely fashion, ensuring PBSO and MPTFO have sufficient time to review the package) the documentation demonstrating that the NUNO:

- Has previously received funding from the UN, the PBF, or any of the contributors to the PBF, in the country of project implementation
- Has a current valid registration as a non-profit, tax exempt organization with a social based mission in both the country where headquarter is located and in country of project implementation for the duration of the proposed grant. (NOTE: If registration is done on an annual basis in the country, the organization must have the current registration and obtain renewals for the duration of the project, in order to receive subsequent funding tranches)
- Produces an annual report that includes the proposed country for the grant
- Commissions audited financial statements, available for the last two years, including the auditor opinion letter. The financial statements should include the legal organization that will sign the agreement (and oversee the country of implementation, if applicable) as well as the activities of the country of implementation. (NOTE: If these are not available for the country of proposed project implementation, the CSO will also need to provide the latest two audit reports for a program or project based audit in country.) The letter from the auditor should also state whether the auditor firm is part of the nationally qualified audit firms.
- Demonstrates an annual budget in the country of proposed project implementation for the previous two calendar years, which is at least twice the annualized budget sought from PBF for the project9
- Demonstrates at least 3 years of experience in the country where grant is sought
- Provides a clear explanation of the CSO's legal structure, including the specific entity which will enter into the legal agreement with the MPTF-O for the PBF grant.

[9] Annualized PBF project budget is obtained by dividing the PBF project budget by the number of project duration months and multiplying by 12.

Annex B: Project Results Framework (MUST include sex- and age disaggregated data)

Outcomes	Outputs	Indicators	Means of Verification/ frequency of collection	indicator milestones
Outcome 1: Somali youth in conflict-prone displacement settings are less likely to resort to negative practices that contribute to conflict, and instead are more likely to actively engage in activities that promote peacebuilding and social cohesion— achieved through increased access to youth-friendly mental health care, community-based psychosocial support activities and services, and tailored information dissemination..	Output 1.1 – Health professionals and community health workers in select conflict-affected IDP communities gain professional-level capacity to deliver youth-centered and gender-sensitive MHPSS services, towards reducing stigma, and alleviating gender-driven psychosocial barriers faced by Somali youth, while building Somalia's long-term institutional capacity to systematically address a key enabler of youth-driven conflict.	**Outcome Indicator 1a:** Youth awareness and practice of negative coping mechanisms contributing to conflict (e.g. substance abuse, GBV), and participation in positive activities contributing to peacebuilding and social cohesion in their communities. • *Baseline/Target: Significant improvement between baseline and endline KAP surveys* **Outcome Indicator 1b:** Perceptions and views of IDP community leaders and health workers about whether they feel empowered with avenues to support their local youth who have mental illness or face context-driven psychosocial problems. • *Baseline/target: Significant change in perception between baseline and endline*	Knowledge, Attitudes and Practices (KAP) survey among target youth *--Disaggregation:* Gender, Age *--Frequency:* Baseline and Endline Focus-group discussions among community leaders and health workers (minimum 60% female representation) *--Frequency:* Baseline and Endline (potentially midline can be added)	
	Overarching activity to achieve this output; Develop multidisciplinary training module on MHPSS for youth developed and integrated into curricula at Somalia National University (SNU) and delivered to health facility nurses and community caregivers in selected conflict-affected IDP settlements. *List of specific activities under this Output:* 1.1.1 Recruit MHPSS Consultant for development of training module 1.1.2 Organize and conduct 4 MHPSS consultative workshops among relevant technical stakeholders for development of the MHPSS training module. 1.1.3 Review MHPSS training module to ensure it is gender sensitive and youth-friendly and features behaviour change communication; translate to Somali; obtain	Output Indicator 1.1.1: Consultant has supported SNU to develop specialize youth MHPSS training *Baseline: 0* *Target: 1*	Training module developed Consultant contract and report	n/a
		Output Indicator 1.1.2: # consultation workshops among key stakeholders conducted for development of MHPSS training module Baseline: 0 Target: 4	Reports of the consultative workshops	n/a
		Output Indicator 1.1.3: Gender-sensitive and youth-oriented MHPSS training module developed, endorsed and published in Somali and English. Baseline: 0 Target: 1	Training module endorsed and translated	n/a
		Output Indicator 1.1.4: # nurses trained in the MHPSS Training of Trainers to enable decentralization of MHPSS in the health system	Training reports	n/a

	endorsement; and publish and launch the training 1.1.4. Support SNU to train 20 health workers from health facilities to create capacity for rapid decentralization of MHPSS services (training of trainers), and conduct follow-up mentorship 1.1.5. Conduct cascade trainings to health facilities staff and community health workers from 15 target health facilities and their catchment communities, and conduct post-training follow-up mentorship visits 1.1.6. Conduct a research study on inter-linkages between youth, MHPSS and peace building in Somalia to inform evidence-based strategies/approaches that the government (Ministry of Heath) and international aid community can implement as follow-on interventions, building upon this project's results **<u>Locations for Output 1.1:</u>** **Mogadishu** (training development and roll out, ToT) **Dollow, Kismayo, Baidoa** – cascade to health facilities in Output 1.2	(sex and age disaggregated) Baseline: 0 Target: 20		
		Output Indicator 1.1.5: % of nurse trainers providing MHPSS services in target health facilities (after the cascade trainings), which may contribute to positive peacebuilding outcomes. (sex and age disaggregated) Baseline: 0 Target: 90%	Facility mentorship reports Health Management Information System (HMIS) data	n/a
		Output Indicator 1.1.6: Study findings on inter-linkages between youth, MHPSS and peace building in Somalia published and disseminated in in a forum with key policymakers, relevant donor and government representatives, and influencers within the MHPSS sectors. Baseline: N/A Target: Yes	Completed and published study report Reports of study dissemination meetings	n/a
	Output 1.2 – Youth with mental illness and psychosocial issues in conflict-vulnerable IDP communities are provided with socially inclusive MHPSS services through community-based PSS approaches and health service delivery, consequently improving individual well-being, building emotional resilience, raising aspiration, and strengthening community social cohesion towards mitigation of conflict drivers and empowerment of youth as peace builders (change agents).			

	Overarching activity to achieve this output: Provide psychosocial support services to young women and men in conflict-prone IDP settlements at the individual, group, family, and community level— taking into considerations and addressing gender dynamics, stereotypes and gender norms— using existing primary health facility as the entry point. *List of specific activities under this Output:* <u>A. Focused Services Activities</u> 1.2.1 Train 60 health workers and community leaders in gender-sensitive Psychological First Aid (PFA), GBV management, CMR, stigma reduction 1.2.2. Support activation of referral pathways for GBV survivors for medical, psychosocial support, and protection services *(through mapping, set up of referrals, and transport and follow-up)* 1.2.3 Train 45 youth and non-youth IDPs to provide individual and peer counseling to address PSS needs *At least 30 counselors will be youth; Individual counseling will utilize Problem Management (PM+) approach* 1.2.4 Facilitate establishment or reactivation of support groups among youth and vulnerable IDPs *("Interest-based", 'activity-based', and "problem-based" support groups)* <u>B. Community and Family Support Activities</u> 1.2.5 Establish and operate MHPSS Resource Center at health facilities, which encompasses youth support groups, counselling, information provision, livelihood/recreational activities.	Output Indicator 1.2.1: # of health workers and community stakeholders trained in PFA, CMR, GBV management, stigma reduction (disaggregated by age, gender, type/cadre of participant) Baseline: 0 Target: 60	Training reports	n/a
		Output Indicator 1.2.2: # of GBV survivors from 3 IDP settlements/facilities identified and referred for PSS and/or medical and/or protection services disaggregated by youth versus non-youth; gender; types of services referred for; point of identification Baseline: 0 Target: 288	GBV referral logbooks (Frequency: monthly)	n/a
		Output Indicator 1.2.3: # of counselors trained, and # of counseling sessions conducted— disaggregated by PM+ versus Peer-to-Peer; Youth versus Non-Youth; Age; Gender; and Resource center versus community based *# counselors trained* Baseline: 0 Target: 30 *# Counseling sessions* Baseline: 0 Target: 3,600 (10 per month per counselor)	Counseling registers and database (Frequency: monthly)	n/a
		Output indicator 1.2.4: # of youth support groups newly formed or re-activated, # of support group distinct participants— disaggregated by type and focus of support group, age, gender, duration of group, *# support groups* Baseline: 0 Target: 20	Support group registers and database (Frequency: monthly)	n/a

	1.2.6 Mobilize, train, and utilize youth mobilizers to gather families and young people for social, cultural & recreational activities **<u>Locations for Output 1.2:</u>** IDP settlements in **Kismayo, Dollow,** and **Baidoa**	*# support group participants* Baseline: 0 Target: 100		
		Output Indicator 1.2.5: Number of MHPSS Resource Centers established within target health facilities and offering youth-focused activities toward strengthening social cohesion and PSS services. Baseline: 0 Target: 3	Activity Reports (Frequency: monthly)	n/a
		Output Indicator 1.2.7: # of youth mobilizers trained and actively mobilizing community activities towards improved social cohesion and peacebuilding Baseline: 0 Target: 30	Training reports Activity Reports (Frequency: monthly)	n/a
	Output 1.3 – Awareness among youth of mental health/substance abuse, stigmatization, harmful behaviors and negative coping mechanisms that drive conflict is increased, with youth empowered to effect positive change through peer sensitization/education.			
	Overarching activity for this output: Develop a youth-led, peer-to-peer mental health/substance abuse awareness program with marginalized communities, and support youth to implement it and empower their peers to become change agents in the communities. *List of specific activities under this Output:*	Output Indicator 1.3.1: Package of locally contextualized and validated messages are developed on substance abuse, stigma, conflict-associated negative coping mechanisms, and the power of youth to be positive change agents for their communities. Baseline: 0 Target: 1	Package of conflict-mitigation messages Report on development and validation process	n/a
		Output Indicator 1.3.2: Radio programme developed, together with youth, to create awareness of substance abuse and negative	Recorded radio clip	n/a

	1.3.1 Develop and validate locally-contextualized messages to address stigma, youth substance abuse (especially Khat), GBV, and negative coping mechanisms— working together with youth in the target areas. 1.3.2. Develop a radio program together with youth to raise awareness of substance abuse and social-related stigma, and negative coping mechanisms that may lead to reduction in unhealthy practices 1.3.3 Disseminate messages through peer education mediums and media (e.g. youth community mobilizers), which may lead to behavior change in empowering fellow youth to become change agents 1.3.4 Orientation of students in schools, and IDP camps to strengthen peer to peer behavior change communication. 1.3.5 Orientation of religious leaders and community leaders on MHPSS, GBV and available services. 1.3.6 Development of messages extracting quotes from religious texts to better sensitize parents, religious and community leaders. **<u>Locations:</u>** **Dollow, Galkio, Kismayo, Baidoa** (link with settlements in Output 1.2) :	coping behaviours that contribute to sustaining conflict. Baseline: 0 Target: 1	Report on development and validation process	
		Output Indicator 1.3.3: Number of community mobilization sessions organized by trained youth for their peers on substance abuse, stigma, and negative coping mechanisms Baseline: 0 Target: 50	Activity reports	n/a

Annex C: Checklist of project implementation readiness

Question	Yes	No	Comment
1. Have all implementing partners been identified? If not, what steps remain and proposed timeline	X		
2. Have TORs for key project staff been finalized and ready to advertise? Plz attach to the submission		X	The ToRs are in the process of being finalized.
3. Have project sites been identified? If not, what will be the process and timeline	X		
4. Have local communities and government offices been consulted/ sensitized on the existence of the project? Please state when this was done or when it will be done.	X		Several rounds of consultations were conducted with the Federal MOH, SNU and the UN Somalia Peace Building Reference Group. Their respective inputs were incorporated into the proposal. The first round of consultations was conducted in May 2019, before the project summary was developed;the second round was done during development of the full proposal in the first two weeks of August 2019.
5. Has any preliminary analysis/ identification of lessons learned/ existing activities been done? If not, what analysis remains to be done to enable implementation and proposed timeline?		X	A pre-implementation assessment and analysis will be conducted in each target IDP settlement in advance of project implementation. The success of many key project activities will depend on an understanding of the current profile of the IDP youth and communities (e.g. identification of cultural/traditional/religious activities, existing youth groups and interests). Therefore, the analysis needs to take place relatively near to the time of project inception.
6. Have beneficiary criteria been identified? If not, what will be the process and timeline?	X		Yes, beneficiary criteria for all activities have been clearly established.
7. Have any agreements been made with the relevant Government counterparts relating to project implementation sites, approaches, Government contribution?	X		WHO, IOM and UNICEF work very closely with the MOH and have engaged respective national counterparts from the very beginning of the process.
8. Have clear arrangements been made on project implementing approach between project recipie organizations?	X		Based on agreed activities, the three UN agencies and SNU have discussed and agreed on roles and responsibilities, as well as set up a joint project implementation team which will support and oversee project implementation.
9. What other preparatory activities need to be undertaken before actual project implementation can begin and how long will this take?	N/A		State level officials, including State MOH in project target locations will need to be engaged in advance. The necessary consultations can be completed within three weeks.

Annex D: Detailed and UNDG budgets (attached Excel sheet)