OCHA Coordination Saves Lives

Project Proposal

Requesting Organization :	Afghan Health and Development Services
Allocation Type :	2017 2nd Standard Allocation

Primary Cluster	Sub Cluster	Percentage
HEALTH		60.00
NUTRITION		20.00
PROTECTION	Gender Based Violence	20.00
		100

Project Title :	Health, Nutrition and Protection for Vulnerable in Kandahar
Allocation Type Category :	

OPS Details

Project Code :		**Fund Project Code :**	AFG-17/3481/SA2/H-N-APC/NGO/6817
Cluster :		**Project Budget in US$:**	564,813.47
Planned project duration :	12 months	**Priority:**	
Planned Start Date :	23/10/2017	**Planned End Date :**	22/10/2018
Actual Start Date:	23/10/2017	**Actual End Date:**	22/10/2018

Project Summary :	The “Health, Nutrition and Protection for Vulnerable” project is aimed to improve the wellbeing of 37,927 populations affected by conflict through improved access to basic health, nutrition and protection services targeting IDPs, returnees, and vulnerable host communities in 4 districts of Kandahar Province during coming 12 months. The project will contribute to the SO-1 and SO-4 that include health cluster objectives 1 and 2, nutrition cluster objective 1 and protection cluster objective 1. The services will be provided through 6 mobile health teams (MHT) in 4 priority districts: Arghestan, Khakrez, Maywand and Shahwalikote. The standard activities will be: 1. Improve essential live-saving trauma care activities in health facilities including through the provision of rehabilitative care and psychosocial support in emergencies. 2. Provide PHC services in underserved cluster designated ‘white areas’ as well as temporary and mobile services specifically initiated to address the needs of communities with high concentrations of returnees and IDPs. 3. Provision of Integrated Management of Acute Malnutrition (IMAM) for children 6-59 months, pregnant and lactating women in hard to reach, underserved areas where IDPs have yet to be assisted. 4. Provision of preventative services (Infant and Young Child Feeding promotion and counselling and micronutrient supplementation) for children 6-59 months, pregnant and lactating women in hard to reach, underserved where IDPs have yet to be assisted. 5. Mobile outreach protection services to women, men, girls and boys; principled referrals and psychosocial support to conflict affected people. 6. Provision of protection services (including health, psychosocial, legal and safety) to GBV survivors and children abused or exploited by armed groups and armed forces. During the needs assessment, AHDS had consultations with the stakeholders; the communities, local authorities, NGOs and UN agencies. The location for each MHT was chosen and updated in coordination with stakeholders. Further inputs and advices of the stakeholders are welcome; they will be used for further improvement of the project. Estimated direct beneficiary is 37,978 including 37,927 populations in the target communities and 51 staff. The MHTs will have properly trained staffed, required equipment and supplies, and ambulance for transfer of the victims. A Community Shura will be established for each MHT; members will be oriented about project objectives and activities, services available, early reporting mechanisms, timely transfer of the victims/survivors, and follow up. MOUs will be signed with the referral points (for consultation, referral, quick response and feedback). Project staff will participate in all meetings and other events initiated by Health, Nutrition and Protection clusters in Kandahar. The project is designed to contribute significantly to gender equality. Data and information will be segregated gender and age wise to ensure a good analysis of outputs and outcomes based on gender aspects. MoPH national waste management and infection prevention policies ensure minimizing environmental hazard. The services and staff will be managed in a very user friendly manner to avoid any direct or indirect harm. The total staff will be 51 including project manager, admin and finance officer, logistic officer and support staff in the office as well as 42 staff in the 6 MHTs. Each MHT will have: a doctor, a female midwife, a nutrition nurse, a female psychosocial counselor, a vaccinator, a driver and a guard. Two extra nurses will be on call to replace any staff on leave. The total required budget is USD $569,414. Exit: if the security becomes better, the catchment areas of these MHTs could be covered by BPHS. We hope that before end of this ERP the peace negotiations reach to a positive result. Integration to BPHS will be sought with GCMU and BPHS implementer.

Direct beneficiaries :

Men	Women	Boys	Girls	Total
8,004	8,356	10,999	10,619	37,978

Other Beneficiaries :

Beneficiary name	Men	Women	Boys	Girls	Total
Host Communities	7,088	7,425	9,788	9,450	33,751
Internally Displaced People	877	919	1,211	1,169	4,176
Other	39	12	0	0	51

Indirect Beneficiaries :

The whole population of the 4 target districts (Arghestan, Khakrez, Maywand and Shahwalikote) in Kandahar Province that are included in the priority list of CHF 2nd Allocation will benefit from the services. The capacities of the professional staff, support staff, and community elders involved in the process will be built up. The families of the staff and local markets will have economic gain from the new jobs created and purchases.

Catchment Population:

Estimated direct beneficiary is 37,978 including 37,927 populations in the target communities and 51 staff.

The population catchments areas is 37,927 including 4,176 IDPs; with following breakdown:

Population Men Women Boys Girls Total
Host 7088 7425 9788 9450 33751

IDP 877 919 1211 1169 4176

Total 7965
8344
10999
10619
37927

Living in conflict areas, the target population is prone to any misshapen. Prevailed poverty, conservative culture, men's domination, scarce support system and lack of public transportation are challenges for all victims/patients; however the delays, for any reason, cause deaths and complications in the emergencies.

Link with allocation strategy :

The "Health, Nutrition and Protection for Vulnerable" project is aimed to improve the wellbeing of 37,927 populations affected by conflict through improved access to basic health, nutrition and protection services targeting IDPs, returnees, and vulnerable host communities in 4 districts of Kandahar Province during coming 12 months.

The project will contribute to the SO-1 and SO-4 that include health cluster objectives 1 and 2, nutrition cluster objective 1 and protection cluster objective 1 that are:

• SO1: Immediate humanitarian needs of shock affected populations are met - including conflict and natural disaster affected and IDPs, refugees and returning Afghans from armed conflict.
• SO4: Humanitarian conditions in hard-to-access areas of Afghanistan are improved.
• Health Cluster Objective 1: Ensure access to emergency health services, effective trauma care and mass casualty management for shock affected people.
• Health Cluster Objective 2: Ensure access to essential basic and emergency health services for white conflict-affected areas and overburden services due to population movements.
• Nutrition Cluster Objective 2: The incidence of acute malnutrition is reduced through Integrated Management of Acute Malnutrition among boys, girls, and pregnant and lactating women.
• Protection Cluster Objective 1: Acute protection concerns, needs and violations stemming from the immediate impact of shocks and taking into account specific vulnerabilities, are identified and addressed in a timely manner.

An estimated direct beneficiary is about 37,978 including 37,927 people and 51 staff with 100% involved in this project. The beneficiaries living in the catchments areas include 33,751 host and 4,176 internally displaced people (IDP).

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
Dr Mohammad Fareed Asmand	Executive Director	fareed@ahds.org	0700284275
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BACKGROUND

1. Humanitarian context analysis

OCHA Afghanistan Weekly Field Report, 20 Aug 2017: from January to mid-August, 202,109 people fled their homes due to conflict. More than 32,000 displaced people have sought refuge in hard to reach areas. In total, 307,523 undocumented returnees have returned to Afghanistan in 2017. A joint assessment of displaced families is being conducted in Helmand, Kandahar, Uruzgan and Zabul provinces. More than 43,000 people are currently displaced in the Southern and South Eastern Region, 22% of the total displacements this year country-wide.

OCHA reports that between January and June, almost 33,000 war wounded patients were reported through First Aid Trauma Points (FATP) and specialised trauma care centres across the country – a 28 percent increase on the first six months of 2016 – with high combat areas Kandahar, Kunduz and Uruzgan recording the most incidences. At the same time, trauma care remains excluded from the Basic Package of Health Services (BPHS) package despite an ever-increasing demand for these services.

Access to life-saving and basic health services remains inadequate as a consequence of the defunct public health system and a conflict which is both intensifying in nature and expanding in geographic scope. Health indicators in these areas are particularly bad; women are twice as likely to die giving birth in Uruzgan and Helmand compared to the national average – already the third highest in the world – and 50 percent less likely to give birth in the presence of a skilled birthing attendant.

Afghanistan's nutrition situation continues to be negatively impacted by the conflict and decades of underdevelopment. Global acute malnutrition rates in children under 5 across three of the priority provinces –Uruzgan (21.6%), Kandahar (16.5%) and Kunar (16.2%) – breach emergency thresholds. Analysis of provision and coverage of integrated management of acute malnutrition (IMAM) services across the 45 priority districts, for example, highlight significant gaps in coverage of emergency nutrition response services. Currently, out of the 239 health facilities present only 115 (48%) provide services for the management of severe acute malnutrition (SAM) and 97 (41%) moderate acute malnutrition (MAM), leaving around 45 percent of children and nursing mothers in these areas without access to both preventive and curative lifesaving nutrition services.

Ongoing conflict throughout the first six months of 2017 has continued to take a considerable toll on the civilian population and exacerbate existing protection concerns while simultaneously generating new ones. Between January and June 2017, some 5,243 civilian casualties were recorded by the UNAMA Human Rights office. Both child and women casualties rose during the first half of 2017 with a 23 percent increase in women casualties and a nine percent increase in child deaths. In addition to inflicting significant physical injuries on the civilian population, the psychosocial trauma of war runs deep within the most vulnerable communities. Recent assessment data suggests that more than a third of children have been exposed to psychological distress due to loss of family and community members and the constant risk of death and injury.

Populations affected by conflict are also more likely to be exposed to multiple forms of gender based violence (GBV), including early and forced marriage, domestic and psychological and sexual abuse. Cultural norms and social stigma however, continue to inhibit health seeking behavior among GBV survivors.

The stakeholders in Kandahar are: OCHA, UNICEF, WHO, UNHCR, WFP, AHDS, BARAN, WADAN, Cordaid, Emergency, Handicap International, Healthnet-TPO, ICRC, Mercy Malaysia, MSF, and government directorates.

2. Needs assessment

AHDS team met with the stakeholders in Kandahar; Directorates of Public Health, Directorates of Economics, Governor Deputy, Provincial Shura, BPHS implementer, WHO, UNICEF and UNHCR representatives. Based on these meeting, a short list of potential places for intervention was prepared; considering running conflict, vulnerability and recent displacements. Rapid needs assessments were conducted involving community elders in the shortlisted areas using OCHA/IOM Emergency Rapid Assessment Form. The questionnaire focused on incident attracting humanitarian aid, population, vulnerable groups, potential hazards, health, water, sanitation, shelter, nutrition, agriculture, electricity, education, main needs, available humanitarian aid, recommended assistance.

Six areas in 4 priority districts of Kandahar were chosen: Amin Kala and Shego Godar in Arghestan, Lam in Khakrez, Elbak and Sozni Achakzo in Shahwalikot, and Sangber in Maywand.

High levels of insecurity and conflict, perpetuating civilian sufferings, were overall ranked highest in terms of critical lifesaving needs and vulnerabilities. Significant conflict caused evades of social services and displacement. Dispersed population pockets, lack of proper roads and lack of public transportation are limiting factors for access on top of ongoing conflicts.

About 37,927 people are in need of primary healthcare, about 2,000 conflict injuries are expected based on previous experience, estimated 2,880 female violence survivals will need protection support. Children are prone at ricks of diarrhea, respiratory infections and malnutrition. Kandahar SMART survey 2016 showed the overall GAM rate by WHZ 7.7% and SAM rate 1.1% for children 6□59 months; overall 8.1% of women of reproductive age (15□49 years old) had a MUAC measurement less than 21cms. The women are more prone to pregnancy and delivery risks, sexually transmitted diseases, pelvic problems, and musculoskeletal disorders due to bad living conditions and heavy works. The access is limited by lack of decision making authority of women in the family; gender based violence is a routine thread for women. Post trauma stress is prevalent among 70% of the population. Only 50% of the people have access to enough water, while access to potable water is further limited to 25%. The whole population specially men are exposed war injuries and land mines. According to the Healthnet TPO information 40% of the population is exposed to post trauma stress and about 40 cases of GBV are expected by each health facility on monthly basis.

Three cluster interventions (health, nutrition and protection) were selected based on AHDS and its old partners' expertise. AHDS is one of the pioneers in provision of health and nutrition including mental health and work with children. Since long time, AHDS has cooperating relationship with Healthnet TPO (in mental health) and Handicap (as referral point for disabled). AHDS is member of the Child Rights Advocacy Forum (CRAF) led by Save the Children International (SCI). AHDS is member of health and nutrition clusters. The services will seek technical support of Healthnet TPO, Handicap and Protection Clusters as well (especially UNFPA, UNICEF, WHO and UNHCR expertise).

The locations for MHTs are selected in the areas with no access to other facilities; they are 13-37km far from closest health facility. The teams will be based on a central location with higher density of population and move according to a defined schedule to the surrounding villages. MHT will provide regular services and follow up in each village of the target areas.

The internally displaced people (IDP) are scattered in the villages among the local residents. They share shelter and food; most of them work in the farms. Their children have access to primary education. Water sanitation and food security although bad are same as for the local residents. AHDS may consider advocacy in these field with interested organisations.

3. Description Of Beneficiaries

The “Health, Nutrition and Protection for Vulnerable” project is aimed to improve the wellbeing of 37,927 populations affected by conflict through improved access to basic health, nutrition and protection services targeting IDPs, returnees, and vulnerable host communities in 4 districts of Kandahar Province during coming 12 months.

The target priority districts are:
• Arghestan.
• Khakrez.
• Maywand.
• Shahwalikote.

The chosen white remote areas for mobile activities are:
• Amin Kala
• Shego Godar
• Lam
• Elbak
• Sozni Achakzo
• Sangber

These locations for MHT are selected in the areas with no access to other facilities; they are 13-37km far from closest health facility.

Direct beneficiaries under these groups include all women and men of all ages and children under eighteen. In addition to the beneficiaries in the communities, 51 job opportunities will be created by this project; so 51 staff are also directly benefit from the project. This means that total direct beneficiaries will be 37,978 (37,927 plus 51). Its segregation is summarized in the following table:

Population Men Women Boys Girls Total
Host 7088 7425 9788 9450 33751

IDP 877 919 1211 1169 4176

Staff 39 12 0 0 51

Total 8004
8356
10999
10619
37978

Majority of the population are residential Pashtuns, then Khochis, Tajiks, Baluches and the least one Hazaras. The main income sources are agriculture and horticulture followed by livestock and small businesses. The areas are very underdeveloped, majority of the people are poor. The culture and traditions are very conservative, patriarchy and male village Shura are the decision making mechanisms according to their own social justice norms. Poor living condition and lack of access to social services limits enthusiasm to gain information about issue like human, women and children right. Struggle for earning living stuff and keeping their village secure; push down the literal priority like education, development and equity from the list of priorities.

The children from age 7-10 start helping their fathers in agriculture and livestock business. Education for boys is acceptable, but for the girls it limits to reaching the teenage. People perception is that the situation is not secure enough for teenage girls to go to school. Furthermore, they think why a girl should be educated while the women are not responsible to finance families. But practically, there are women headed families although less in number, and women who are supporting family income by works like embroidery and sorting fresh and dry fruits.

The multi-cluster approach contributes to enhancing staff knowledge and skills. Community involvement in early warning, referral and follow up is another outcome of the project. Behaviour change is expected in the fields of personal hygiene, nutrition, early health seeking behavior, human rights and thinking out of the box. Jobs will be created for health and supports staff who will be employed in the MHTs. Project related procurements have economic impact in the communities.

Emergency PHC will be provided for all population, number of trauma cases is estimated based on previous experience, antenatal care will be provided for all pregnant women (4% of population) and vaccination will be provided for all under one children (4% of population) .

All under 5 children will be screened for acute malnutrition that is 18% of total population (6,827). According to Kandahar SMART survey 2016 expected SAM among under 5 children is 1.1% (67 cases), MAM is 8% (485 cases) and acute malnourished pregnant and lactating women is 8.1% (243 cases).

According to the Healthnet TPO information 40% of the population is exposed to post trauma stress (about 15,171) and about 40 GBV and child abuse cases are expected by each health facility on monthly basis (totally 2,910 cases). Proportion of GBV for women versus men is 100:2.

4. Grant Request Justification

The “Health, Nutrition and Protection for Vulnerable” project is aimed to improve the wellbeing of 37,927 populations affected by conflict through improved access to basic health, nutrition and protection services targeting IDPs, returnees, and vulnerable host communities in 4 districts of Kandahar Province during coming 12 months.

The districts are selected from the list of 45 prioritised district recommended by the clusters. Each location in each priority district is selected by remoteness, lack of services, presence of conflict in the area, and having recent IDPs. Direct beneficiaries under these groups includes all male and female of all ages with focus on women of reproductive health age (15-49) and children under five. Gender based violence survivors and people with physical and mental limitations or impairment will receive special attention while providing the selected services or referral to suitable centres.

Rapid needs assessments of the communities and repeated consultations were done with the stakeholders to ensure proper planning of really needed services fill the gaps and avoid duplication.

The planed project will contribute to the SO-1 and SO-4 that include health cluster objectives 1 and 2, nutrition cluster objective 1 and protection cluster objective 1. Looking the community needs and AHDS capacity, the following activities were selected from the clusters’ strategic response plans:

• Improve essential live-saving trauma care activities in health facilities and provision of rehabilitative care and psychosocial support in emergencies.
• Provide life-saving Primary Health Care services with mobile services and scaling up emergency obstetric and newborn care services.
• Provision of IMAM for children 6-59 months, pregnant and lactating women in hard to reach and underserved areas where IDPs have yet to be assisted.
• Provision of preventative services (Infant and Young Child Feeding promotion and counselling and micronutrient supplementation) for children 6-59 months, pregnant and lactating women in hard to reach and/or underserved areas where IDPs have yet to be assisted.
• Mobile outreach and static protection services to women, men, girls and boys; principled referrals and psychosocial support to conflict affected people to contribute to community based prevention and mitigation response mechanisms.
• Provision of protection services (including health, psychosocial, legal and safety) to GBV survivors and children abused or exploited by armed groups and armed forces.

Although the project is concerned about the IDPs and returnee, in reference to the SO4 “Humanitarian conditions in hard-to-access areas of Afghanistan are improved” the project will serve the local residence as well. These pockets of communities do not have access to such services due to remoteness of their geographic locations. The locations are selected in consultation with the clusters (in Kandahar) including BARAN the BPHS implementer, WHO, UNICEF, PHO and UNHCR.

AHDS goal is provision of humanitarian assistance and sustainable development for the people.

AHDS is present in Kandahar provide since 1995. Provision of healthcare services in conflict and fragile areas is the main expertise of AHDS. AHDS core competencies are in the fields of healthcare, nutrition, higher education for health staff, capacity building, child protection, emergency response, water and sanitation, and citizen’s charter (community development).

In 2015, AHDS successfully passed the due diligence, so registered with UNDP and OCHA as eligible organization for partnership/receiving fund. AHDS is registered with the European Commission (PADOR) and USAID (SAM) as qualified organization to receive direct fund.

5. Complementarity

AHDS presence in Kandahar and Uruzgan provinces since 1995 enabled it to build trust in the communities, attain enough experience in working in conflict zones and seeking alternatives for logistic supplies and supervision based on circumstances.

AHDS is partner with Healthnet TPO in another project with somehow similar activities submitted to CHF allocation for Uruzgan Province. It will be a golden opportunity to develop tools and training material together, share experiences between Kandahar and Uruzgan provinces, learn from each other and exchange technical support on timely manner as required.

AHDS is running Kandahar Institute of Health Sciences (KIHS) since 2004, which has Midwifery, Nursing, Laboratory Technician and Pharmacy Technician Schools. The proposed project will provide job opportunity for the graduates of this institute, while KIHS provides local health staff for the project to service the communities.

BARAN is BPHS implementer in Kandahar Province, the number of health facilities, type of services and budget ceiling is fixed in their contract, therefore, they cannot increase number of health facilities or types of interventions according the actual and newly emerging needs of the communities. This project can complement BPHS gaps in terms of geographic coverage and services needed in hard to reach areas. The people in selected areas of this proposed project do not have access to BPHS and nutrition services within two hours walking distance.

BARAN provides nutrition services as well in Kandahar. As mentioned, the target areas does not have easy access to that facilities, therefore, we planned to cover SAM and MAM among under five and acute malnutrition among PLW that are very prone to further morbidity and mortality. The complicated cases could be referred to BARAN health facilities and MoPH hospitals for stabilisation.

AHDS is providing another emergency health services by 2 MHTS in Maywand and Khakrez districts that is funded by WHO.

A project of Emergency Healthcare funded by OCHA (CHF allocation-1, 2016), which was providing services for the vulnerable in conflict areas by FATP in six districts of Kandahar (including Arghestan, Maywand and Shahwalikote districts) was ended on 9th July 2017. For sure, the conflict and need for emergency humanitarian interference is going on. The health, nutrition and protection services cannot be stopped until the situation is not improved.

LOGICAL FRAMEWORK

Overall project objective

To improve the wellbeing of 37,927 populations affected by conflict through improved access to basic health, nutrition and protection services targeting IDPs, returnees, and vulnerable host communities in 4 districts of Kandahar Province during coming 12 months.

HEALTH		
Cluster objectives	**Strategic Response Plan (SRP) objectives**	**Percentage of activities**
Objective 1: Ensure access to emergency health services, effective trauma care and mass casualty management for shock affected people	SO1: Immediate humanitarian needs of shock affected populations are met - including conflict and natural disaster affected and IDPs, refugees and returning Afghans from armed conflict	20
Objective 2: Ensure access to essential basic and emergency health services for white conflict-affected areas and overburden services due to population movements	SO4: Humanitarian conditions in hard-to-access areas of Afghanistan are improved	80

Contribution to Cluster/Sector Objectives : The proposed project will significantly contribute to the following health cluster objectives:

• SO1: Immediate humanitarian needs of shock affected populations are met - including conflict and natural disaster affected and IDPs, refugees and returning Afghans from armed conflict.
• SO4: Humanitarian conditions in hard-to-access areas of Afghanistan are improved.
• Health Cluster Objective 1: Ensure access to emergency health services, effective trauma care and mass casualty management for shock affected people.
• Health Cluster Objective 2: Ensure access to essential basic and emergency health services for white conflict-affected areas and overburden services due to population movements.

Six mobile health teams (MHT) will be established in remote areas of 4 prioritized districts including Maiwand, Khakrez, Shawalikot and Arghestan of Kandahar Province to provide trauma care and primary health care for the vulnerable population including women, children, IDP and returnees. The project is coordinated with Kandahar Provincial Public Health Directorate, WHO and BPHS implementer. In addition, it is coordinated with Handicap International and Healthnet TPO who can provide technical support in the fields of disability and psychosocial.

Disabled will be referred to Handicap International as required. HI will be asked to conduct on orientation workshop (their facilities, screening, need for referral, how to follow up etc.) for all the staff before starting work in the MHTs. Healthnet TPO will provide 5 days psychosocial and 5 days GBV training workshop for the staff.

Outcome 1

Improved access to and utilization of curative and preventive PHC services as well as trauma care by IDPs and conflict-affected populations in in 4 districts of Kandahar Province.

Output 1.1

Description

Increase access to life saving trauma care and primary healthcare service delivery points by establishment of 6 mobile health teams (MHT) for 37,927 people in prioritized districts of Kandahar Province.

The MHTs will serve in areas and surrounding villages of:
1. Amin Kala, Arghestan District.
2. Shego Godar, Arghestan District.
3. Lam area, Khakrez District.
4. Sangber area, Maywand District.
5. Elbak area, Shahwalikote District.
6. Sozni Achakzo, Shahwalikote District.

Emergency PHC will be provided for all population, number of trauma cases is estimated based on previous experience, antenatal care will be provided for all pregnant women (4% of population) and vaccination will be provided for all under eligible children (4% of population) .

One community midwife will be employed for each MHT with their Muharams to ease movement with the team to the target villages. Since the duration of the project is short, we will make sure that the midwives are experienced and trained on the task required in a MHT. Refresher training at the beginning will be provided for them before going to the field.

Each team with its Health Shura will develop its movement plan and maps within the target in communities.

Assumptions & Risks

During the rapid assessment the risk analysis of all districts were done in term of access, security and community negotiations.
AHDS has worked in all the districts of Kandahar province since 1995. During the past 22 years, we became very familiar with the people, terrains, most of community elders, traditions and sensitive issues for the people. AHDS has built enough trust among the communities having long term relations and interactions during tens of different projects implemented. AHDS has implemented projects related to health, nutrition, education, capacity building, water and sanitation and relief in Kandahar province. In over two decades, AHDS gained enough experience of working in conflict zones. In addition, AHDS has built good relations with other stakeholders in these two provinces like the provincial public health directorates, UN agencies and NGOs that are active in these provinces as well as the local governments.

Assumption:
• Receiving the fund on time.
• No big change in the political and security situation occur.
• Female staff is willing to travel with the MHT.
• The government and opposition support impartiality of the healthcare services.
• Cold chain and vaccines supply by REMT.

Risks:
• The unforeseen incidents of war.
• Armed conflicts on the way or target areas of the MHT.
• Interference of government security forces and or opposition armed men.

Mitigation:
• Ensure job opportunity for the Muharam of female staff.
• The staff will be well oriented on AHDS security policy.
• Orientation about the project and 4 humanitarian principles for the local provincial and local authorities as well as community elders in the target areas.
• In consultation with the communities take relevant measures to nullify or reduce the security risk for the MHTs staff and beneficiaries.
• Contacts will be kept with INSO and UN for awareness from potential treats and clashes which may happen in the target areas.
• Each MHT will make an evacuation plan with the community leaders in their movement areas, if necessary quick evacuation will be done.
• ICRC support will be requested if MHT is entrapped in a conflict.

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 1.1.1	HEALTH	SA2- Number of individuals receiving trauma care services	1,500	240	180	120	2,040
Means of Verification : Health facility registers, monitoring, monthly and quarterly narrative reports.							
Indicator 1.1.2	HEALTH	SA2- Number of conflict affected people in underserved areas served by emergency PHC and mobile services	7,965	8,344	10,999	10,619	37,927
Means of Verification : Health facility registers, monitoring, monthly and quarterly narrative reports.							
Indicator 1.1.3	HEALTH	SA2- Number of pregnant women in conflict affected and underserved areas receiving at least two antenatal care visits		1,517		0	1,517
Means of Verification : Health facility registers, monitoring, monthly and quarterly narrative reports.							
Indicator 1.1.4	HEALTH	Number of eligible children in conflict 'white areas' receiving measles vaccines (758 boys and 759 girls).					1,517
Means of Verification : Health facility registers, monitoring, monthly and quarterly narrative reports.							

Activities

Activity 1.1.1

Standard Activity : SA2- Improve essential live-saving trauma care activities in health facilities including through the provision of rehabilitative care and psychosocial support in emergencies;

• MOUs will be signed with referral points (surgery, mental health, disability, GBV protection, supplementary feeding).
• Six mobile health teams (MHT) will function on the passages were they can collect victims from conflict areas.
• Referral points will be identified; written protocols will be signed to ensure efficient referral, quick response and feedback.
• The MHT will be staffed and equipped according the standards, including access to ambulance.
• Training on triage and first aid will be provided for the staff (8 days including 3 days first aid and 5 days triage for doctors, nurses and midwives).
• Training on first aid will be provided for the drivers and guards (3 days training).
• Training on psychosocial support will be provided for the nurses, midwives and physicians (5 days training).
• Collect and stabilize victims from conflict areas.
• Report and quickly respond to any suspected outbreak (DEWS).

Activity 1.1.2

Standard Activity : Provide PHC services in underserved cluster designated 'white areas' as well as temporary and mobile services specifically initiated to address the needs of communities with high concentrations of returnees and IDPs;

• Employ necessary staff for the six mobile health teams (MHT)
• Hire vehicles for the mobile health teams (MHT).
• Provide necessary equipment for the MHT.
• Establish a community Health Shura for each health facility.
• Develop village visit timetables with Health Shuras for each MHT.
• Provide essential medicines, medical and non-medical supplies and equipment for the MHT.
• Establish referral system among the MHT and BPHS/ EPHS facilities.
• Provide antenatal and postnatal care for the mothers.
• Provide basic emergency obstetric and newborn care (EmONC) services.
• Provide vaccination for the children and child bearing age women.
• Provide family planning methods on request.
• Provide treatment of children sickness especially ARI, pneumonia and diarrheal diseases.
• Provide outpatient consultation and treatment of common diseases.
• Maintain ambulance/referral services.
• Coordinate with the stakeholders (Health cluster, PPHD, WHO, UNICEF, BARAN, Handicap, Community Shuras and Healthnet TPO).
• Regularly supervise the performance and outputs of the MHTs.
• Report the progress of works and health data on timely manner.

Additional Targets :

NUTRITION

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Objective 2: The incidence of acute malnutrition is reduced through Integrated Management of Acute Malnutrition among boys, girls, and pregnant and lactating women	SO1: Immediate humanitarian needs of shock affected populations are met - including conflict and natural disaster affected and IDPs, refugees and returning Afghans from armed conflict	100

Contribution to Cluster/Sector Objectives : The proposed project will significantly contribute to the following nutrition cluster objectives:
• SO1: Immediate humanitarian needs of shock affected populations are met - including conflict and natural disaster affected and IDPs, refugees and returning Afghans from armed conflict.
• Nutrition Cluster Objective 2: The incidence of acute malnutrition is reduced through Integrated Management of Acute Malnutrition among boys, girls, and pregnant and lactating women.

AHDS will implement IMAM services integrated within the 6 MHTs for 4 prioritized districts of Kandahar Province. Nutrition interventions (for SAM and IYCF) will be implemented in accordance with MoPH national nutrition guidelines. The interventions will be conducted in close collaboration with MoPH, UNICEF, WFP, BPHS implementer (BARAN) and the target communities.

Outcome 1

Improved access to quality IMAM services to acutely malnourished children and pregnant and lactating women among conflict affected populations in 4 prioritized districts of Kandahar Province.

Output 1.1

Description

Increase access to emergency nutrition services (IMAM including IYCF) provided though integrated OTP/TSFP with 6 mobile health teams (MHT) in prioritized districts of Kandahar Province.

• The output for Number of under 5 children screened for acute malnutrition is 18% of total population: 37927*18%=6827.
• The output for severely acutely malnourished (SAM) boys and girls 6-59 months according to Kandahar SMART survey 2016 is 1.1%, we planned for 2% to be ready for unexpected raise of cases: 37927*16%*2%=121.
• The output for moderate acutely malnourished (MAM) boys and girls 6-59 months according to Kandahar SMART survey 2016 is 8%: 37927*16%*8%=485.
• The output for acutely malnourished pregnant and lactating women according to Kandahar SMART survey 2016 is 8.1%: 37927*8%*8.1%=243.

The MHTs will provide integrated nutrition care with basic healthcare services in areas of:
1. Amin Kala, Arghestan District.
2. Shego Godar, Arghestan District.
3. Lam area, Khakrez District.
4. Sangber area, Maywand District.
5. Elbak area, Shahwalikote District.
6. Sozni Achakzo, Shahwalikote District.

The MHT will visit each target village in average on weekly basis; practically it depends on number of target villages in the catchments areas and distances from each other. The most frequently will be each 4 days for Shego Godar and each 9 days for Sangber area.

Each MHT is staffed with:
1. One doctor
2. One midwife
3. One nutrition nurse
4. One psychosocial nurse
5. One vaccinator
6. One driver
7. One guard

The selected areas do not have access to BPHS and nutrition services I two hours walking distance; therefore, we had to prioritise acute malnutrition cases to be reached by the mobile health teams.

Assumptions & Risks

During the rapid assessment the risk analysis of all districts were done in term of access, security and community negotiations.
AHDS has worked in all the districts of Kandahar province since 1995. During the past 22 years, we became very familiar with the people, terrains, most of community elders, traditions and sensitive issues for the people. AHDS has built enough trust among the communities having long term relations and interactions during tens of different projects implemented. AHDS has implemented projects related to health, nutrition, education, capacity building, water and sanitation and relief in Kandahar province. In over two decades, AHDS gained enough experience of working in conflict zones. In addition, AHDS has built good relations with other stakeholders in these two provinces like the provincial public health directorates, UN agencies and NGOs that are active in these provinces as well as the local governments.

Assumption:
• Receiving the fund on time.
• No big change in the political and security situation occur.
• Female staff is willing to travel with the MHT.
• The government and opposition support impartiality of the healthcare services.
• RUTF and super-cereal supplied by UNICEF/WFP.

Risks:
• The unforeseen incidents of war.
• Armed conflicts on the way or target areas of the MHT.
• Interference of government security forces and or opposition armed men.

Mitigation:
• Ensure job opportunity for the Muharam of female staff.
• The staff will be well oriented on AHDS security policy.
• Orientation about the project and 4 humanitarian principles for the local provincial and local authorities as well as community elders in the target areas.
• In consultation with the communities take relevant measures to nullify or reduce the security risk for the MHTs staff and beneficiaries.
• Contacts will be kept with INSO and UN for awareness from potential treats and clashes which may happen in the target areas.
• Each MHT will make an evacuation plan with the community leaders in their movement areas, if necessary quick evacuation will be done.
• ICRC support will be requested if MHT is entrapped in a conflict.

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 1.1.1	NUTRITION	SA2- Number of children 6-59 months screened for acute malnutrition at community and facility level and referred for treatment as needed in priority districts			3,427	3,400	6,827
Means of Verification : Facility register books, monitoring, monthly and quarterly reports.							
Indicator 1.1.2	NUTRITION	SA2- Number and proportion of severely acutely malnourished boys and girls 6-59 months admitted for treatment			60	61	121
Means of Verification : Facility register books, monitoring, monthly and quarterly reports.							
Indicator 1.1.3	NUTRITION	SA2- Number of boys and girls aged 0-59 months discharged cured from management of severe acute malnutrition programmes			60	61	121
Means of Verification : Facility register books, monitoring, monthly and quarterly reports.							
Indicator 1.1.4	NUTRITION	SA2- Number of acutely malnourished pregnant and lactating women admitted for treatment		243			243
Means of Verification : Facility register books, monitoring, monthly and quarterly reports.							
Indicator 1.1.5	NUTRITION	SA2- Number of boys and girls aged 6-59 months discharged cured from management of moderate acute malnutrition programmes			242	243	485
Means of Verification : Facility register books, monitoring, monthly and quarterly reports.							

Activities

Activity 1.1.1

Standard Activity : SA2- Provision of Integrated Management of Acute Malnutrition (IMAM) for children 6-59 months, pregnant and lactating women in hard to reach, underserved areas where IDPs have yet to be assisted.

• Admit and treat children aged 6 – 59 months with severe acute malnutrition (SAM) without medical complications in integrated mobile OTP.
• Refer critically ill severely malnourished children with medical complications to a stabilization center.
• Provide referral support for critically ill severely malnourished children with medical complications to the nearest stabilization center.
• Admit and treat children aged 6 – 59 months with moderate acute malnutrition (MAM) in integrated mobile OTP.
• Admit and treat pregnant and lactating women with acute malnutrition in integrated mobile OTP.
• Conduct regular joint supervision of all supported OTP sites to ensure quality of service delivery.
• Ensure uninterrupted supply of all the necessary food items, essential drugs and other supplies needed for the nutrition program.
• Conduct community outreach and home visit especially for defaulters and children not meeting the target weight.
• Conduct 2 rounds of de-worming campaigns targeting children aged 1-5 years to prevent micro nutrient deficiencies associated with intestinal worms.
• Refer complicated cases to stabilization center by BPHS implementer and PHO.
• Improve timely and accurate data collection and reporting.

Activity 1.1.2

Standard Activity : SA2- Provision of preventative services (Infant and Young Child Feeding promotion and counselling and micronutrient supplementation) for children 6-59 months, pregnant and lactating women in hard to reach, underserved where IDPs have yet to be assisted.

• Conduct IYCF counseling to women/caretakers of children in OTP during mobile team visits.
• Establish and support 12 IYCF mother support groups targeting mothers of children under 2 years.
• Conduct refresher training on IYCF to the health staff of the MHTs
• Distribute micronutrient supplement for under 5 year children, and lactating and pregnant women.
• Improve timely and accurate data collection and reporting of nutrition data from all sites through provision of data collection tools and training of nutrition staff on data management.

Additional Targets :

PROTECTION

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Objective 1: Acute protection concerns, needs and violations stemming from the immediate impact of shocks and taking into account specific vulnerabilities, are identified and addressed in a timely manner	SO1: Immediate humanitarian needs of shock affected populations are met - including conflict and natural disaster affected and IDPs, refugees and returning Afghans from armed conflict	100

Contribution to Cluster/Sector Objectives : The proposed project will significantly contribute to the following protection cluster objectives:
• SO1: Immediate humanitarian needs of shock affected populations are met - including conflict and natural disaster affected and IDPs, refugees and returning Afghans from armed conflict.
• Protection Cluster Objective 1: Acute protection concerns, needs and violations stemming from the immediate impact of shocks and taking into account specific vulnerabilities, are identified and addressed in a timely manner.
AHDS will implement post trauma psychosocial support, and protection for GBV and child abuse services integrated within the 6 MHTs for 4 prioritized districts of Kandahar Province. The mobile health teams (MHT) staffed with trained females will ensure equal access for women and girls, raise community awareness about protection of women and children, provide psychosocial counseling, clinically manage post trauma stress, GBV and child abuse survivors and refer them to Family Protection Centre (FPC) as required.
Community awareness will contribute to community behavior change. Presence of the services and follow up mechanism build trust among the vulnerable part of community to openly report the cases of violence and seek support.

The interventions will be in-line with CHF protection mainstreaming guidelines. The services will seek technical support of Healthnet TPO and Handicap International as well as Protection Cluster in Kandahar (especially UNFPA, UNICEF, WHO and UNHCR expertise). AHDS is member of the Child Rights Advocacy Forum (CRAF) coordinated by Save the Children International.

Outcome 1

Conducive protection environment is ensured for 37,927 people in 4 prioritized districts of Kandahar Province.

Output 1.1

Description

AHDS will provide psychosocial counseling for 15,171 general populations, support 500 injured people with post trauma stress (by counseling and referral to specialized centers), and provide protection services for 2,910 GBV and child abuse.
Protection services are considered in/through the mobile health teams (MHT) that are serving areas of:

1. Amin Kala, Arghestan District.
2. Shego Godar, Arghestan District.
3. Lam area, Khakrez District.
4. Sangber area, Maywand District.
5. Elbak area, Shahwalikote District.
6. Sozni Achakzo, Shahwalikote District.

The mobile health teams (MHT) staffed with trained females will:
• Ensure equal access for women and girls,
• Raise community awareness about protection of women and children,
• Provide psychosocial counseling,
• Clinically manage post trauma stress, GBV and child abuse survivors and
• Refer them to Family Protection Centre (FPC) as required.
• Follow up the violence survivors.

AHDS has 10 years of psychosocial counseling experience integrated into its BPHS projects. In partnership with IPSO, we had well trained PSS counselor who had one year training. In addition, the staff received short term refresher training courses by Healthnet TPO and AHDS Mental Health Officers.

Handicap International can advise our team about disabled vulnerabilities, when to refer to them and how to follow up, and how communities can protect them. The organisations involved in the Protection Cluster may advise and support our teams and/or survivors based on according to their expertise and facilities; depending on individual cases.

Assumptions & Risks

During the rapid assessment the risk analysis of all districts were done in term of access, security and community negotiations.
AHDS has worked in all the districts of Kandahar province since 1995. During the past 22 years, we became very familiar with the people, terrains, most of community elders, traditions and sensitive issues for the people. AHDS has built enough trust among the communities having long term relations and interactions during tens of different projects implemented. AHDS has implemented projects related to health, nutrition, education, capacity building, water and sanitation and relief in Kandahar province. In over two decades, AHDS gained enough experience of working in conflict zones. In addition, AHDS has built good relations with other stakeholders in these two provinces like the provincial public health directorates, UN agencies and NGOs that are active in these provinces as well as the local governments.

Assumption:
• Receiving the fund on time.
• No big change in the political and security situation occur.
• Female staff is willing to travel with the MHT.
• The government and opposition support impartiality of the healthcare services.

Risks:
• The unforeseen incidents of war.
• Armed conflicts on the way or target areas of the MHT.
• Interference of government security forces and or opposition armed men.

Mitigation:
• Ensure job opportunity for the Muharam of female staff.
• The staff will be well oriented on AHDS security policy.
• Orientation about the project and 4 humanitarian principles for the local provincial and local authorities as well as community elders in the target areas.
• In consultation with the communities take relevant measures to nullify or reduce the security risk for the MHTs staff and beneficiaries.
• Contacts will be kept with INSO and UN for awareness from potential treats and clashes which may happen in the target areas.
• Each MHT will make an evacuation plan with the community leaders in their movement areas, if necessary quick evacuation will be done.
• ICRC support will be requested if MHT is entrapped in a conflict.
• Healthnet TPO technical support will be requested, specially for staff training on GBV.

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 1.1.1	PROTECTION	SA2- Number of boys, girls, men and women receiving psychosocial support	3,186	3,338	4,399	4,248	15,171
Means of Verification : Facility register books, monitoring, monthly and quarterly reports.							
Indicator 1.1.2	PROTECTION	SA2- Number of GBV survivors receiving protection services (including health, psychosocial, legal and safety)	30	1,440	720	720	2,910
Means of Verification : Facility register books, monitoring, monthly and quarterly reports.							

Activities

Activity 1.1.1

Standard Activity : Mobile outreach protection services to women, men, girls and boys; principled referrals and psychosocial support to conflict affected people;

• Select locations for the health facilities and routes of movement that are away from actual or potential threats; especially the risk or threat of gender based violence (GBV), attacks from armed groups and land mines
• Orient the staff to treat the clients respectfully and inclusive of cultural and religious practices.
• Respect confidentiality and privacy of clients during consultations.
• Keep the identifiable information confidentiality unless consent has been given by the beneficiary.
• Consult with displaced and host communities about health needs so as to avoid community tensions that could lead to violence and harassment of one group or another.
• Employ female health staff members with skills and experience working with women and children.
• Train the staff on how to respond to the specific needs of victims of grave human rights violations, including rape and physical abuse.
• Assign qualified psychosocial workers to receive and counsel survivors of violations, especially when dealing with children and/or survivors of GBV.
• Put in place guidelines and mechanisms for monitoring and reporting instances of abuse and exploitation.
• Set up accessible, well understood mechanisms for suggestions and complaints.
• Monitor access, discrimination, and whether any services are being diverted.
• Strengthen coordination with Health Cluster at sub-national level to address GBV and child abuse as well.
• Coordinate with Protection and People with Special Need (PSN) network (headed by UNHCR) in Kandahar.
• Report and share protection concerns with the Protection cluster, including the GBV and Child Protection sub-clusters.

Activity 1.1.2

Standard Activity : SA2- Provision of protection services (including health, psychosocial, legal and safety) to GBV survivors and children abused or exploited by armed groups and armed forces;

• Train healthcare givers on identification and management of GBV (5 days course for doctor, nurse, PSS counselor and midwife with support of Healthnet TPO).
• Train the staff on PSS counseling and GBV (10 days training with support of Healthnet TPO).
• Include female PSS counselor in mobile health teams and to conduct blanket PSS sessions with target communities in general, women and girls in particular.
• Provide psychosocial counseling and health services to survivors as part of initial response.
• Distribute Dignity Kits for the GBV survivors.
• Work with pregnant to build strengths at the individual, relationship, and community levels that help them face and overcome trauma or adversity.
• Coordinate with the Kandahar Protection Cluster to establish case management committees (CMCs).
• Community mobilization through health committees that are established for each MHT.
• Include GBV in various community sessions/awareness.
• Coordinate with Family Protection Centre (FPC) in Kandahar City for referral and reporting.
• Refer GBV survivors to the organization who can provide legal assistance and specialized medical care.
• Follow up the referred survivors.

Additional Targets :

M & R

Monitoring & Reporting plan

The supervision and monitoring system is considered as an integrated reflection and communication system of the project. Based on the logical framework, a project M&R plan will be developed in participatory manner. This tool will enable us to set relevant project indicators, information gathering methods, information analysis and sharing to understand the project progress and results.

Considering the geographical condition and security situation, for supportive supervision and monitoring of the project activities, AHDS will consider vibrant management structure to be adjusted by changing security condition. Supportive supervision and monitoring of the project will be strengthened through below three main mechanisms:

• Strengthening of monitoring and supervision system based on experience.
• Data collection and information management.
• Information flow and beneficiary, staff and partners' feedback system.

The project will be furnished with monitoring and reporting tools using the ministry of public health (MoPH) NDSR, HMIS, EPI, RMNC, Nutrition databases, and Cluster Reporting Hubs. The staff will be trained on the use of the tools for self-monitoring. They will be responsible for daily supervision using the checklists, and sharing their findings with relevant supervisor during supervisory visits to discuss on how to address problems found. In the next supervisory visits, priority will be given to follow up of these plans. During the monthly meetings, everyone will present their monitoring findings and improvements.

The project will be monitored by staff from main office and Project Manager based in Kandahar Province. AHDS presence in Kandahar and Uruzgan provinces since 1995 enabled it to build trust in the communities and attain enough experience in working in conflict zones. Furthermore, the community members as access negotiators and community elder escorts enable our supervisors to visit all health facilities in each village.

The considered project manager has more than 10 years' experience of supervisory work in Kandahar Province. He has worked as a Trainer, Community Based Healthcare Officer, HMIS manager and Project Manager for health and nutrition projects. He has built trust among the communities all over Kandahar Province; he is capable to freely move in all the target areas for this project.

Remote monitoring will be used to make sure the MHTs are attending the villages according to the plan, by calling Health Shura members and other people in the target communities.

Health, Nutrition and Protection clusters' formats for reporting and security incidents forms will be used for data collection, quick alert and monitoring progress towards the indicators. Special attention is required on training the staff about protection and GBV reporting and follow-up system. With technical cooperation of Healthnet TPO and Handicap International, our project staff can provide quality training and supportive supervision for the staff of MHTs.

The health facility in-charges will record and make routine reports to the project manager on monthly basis, the data will be analysed together with the health facility in-charges, which will be reported to the partners and donors.

The emergency cases will be immediately reported using mobile phones. Considering the type and extend of case, AHDS will inform relevant stakeholders if joint immediate actions or close follow up are necessary.

The project will be monitored based on preliminary action-plan on monthly basis. The progress, deviations, shortfalls and challenges will be discussed at the field level as well as provincial level for on time corrective measures.

The technical progress and financial reports will be cross checked to analyse actual costs and cease any opportunity on timely manner to maximize quality of services for the people.

Quarterly technical and financial reports will be fed in CHF Afghanistan system before the set dates.

Workplan

Activitydescription	Year	1	2	3	4	5	6	7	8	9	10	11	12
Activity 1.1.1: • Admit and treat children aged 6 – 59 months with severe acute malnutrition (SAM) without medical complications in integrated mobile OTP. • Refer critically ill severely malnourished children with medical complications to a stabilization center. • Provide referral support for critically ill severely malnourished children with medical complications to the nearest stabilization center. • Admit and treat children aged 6 – 59 months with moderate acute malnutrition (MAM) in integrated mobile OTP. • Admit and treat pregnant and lactating women with acute malnutrition in integrated mobile OTP. • Conduct regular joint supervision of all supported OTP sites to ensure quality of service delivery. • Ensure uninterrupted supply of all the necessary food items, essential drugs and other supplies needed for the nutrition program. • Conduct community outreach and home visit especially for defaulters and children not meeting the target weight. • Conduct 2 rounds of de-worming campaigns targeting children aged 1-5 years to prevent micro nutrient deficiencies associated with intestinal worms. • Refer complicated cases to stabilization center by BPHS implementer and PHO. • Improve timely and accurate data collection and reporting.	2017											X	X
	2018	X	X	X	X	X	X	X	X	X	X		
Activity 1.1.1: • MOUs will be signed with referral points (surgery, mental health, disability, GBV protection, supplementary feeding). • Six mobile health teams (MHT) will function on the passages were they can collect victims from conflict areas. • Referral points will be identified; written protocols will be signed to ensure efficient referral, quick response and feedback. • The MHT will be staffed and equipped according the standards, including access to ambulance. • Training on triage and first aid will be provided for the staff (8 days including 3 days first aid and 5 days triage for doctors, nurses and midwives). • Training on first aid will be provided for the drivers and guards (3 days training). • Training on psychosocial support will be provided for the nurses, midwives and physicians (5 days training). • Collect and stabilize victims from conflict areas. • Report and quickly respond to any suspected outbreak (DEWS).	2017										X	X	X
	2018	X	X	X	X	X	X	X	X	X	X		
Activity 1.1.1: • Select locations for the health facilities and routes of movement that are away from actual or potential threats; especially the risk or threat of gender based violence (GBV), attacks from armed groups and land mines • Orient the staff to treat the clients respectfully and inclusive of cultural and religious practices. • Respect confidentiality and privacy of clients during consultations. • Keep the identifiable information confidentiality unless consent has been given by the beneficiary. • Consult with displaced and host communities about health needs so as to avoid community tensions that could lead to violence and harassment of one group or another. • Employ female health staff members with skills and experience working with women and children. • Train the staff on how to respond to the specific needs of victims of grave human rights violations, including rape and physical abuse. • Assign qualified psychosocial workers to receive and counsel survivors of violations, especially when dealing with children and/or survivors of GBV. • Put in place guidelines and mechanisms for monitoring and reporting instances of abuse and exploitation. • Set up accessible, well understood mechanisms for suggestions and complaints. • Monitor access, discrimination, and whether any services are being diverted. • Strengthen coordination with Health Cluster at sub-national level to address GBV and child abuse as well. • Coordinate with Protection and People with Special Need (PSN) network (headed by UNHCR) in Kandahar. • Report and share protection concerns with the Protection cluster, including the GBV and Child Protection sub-clusters.	2017											X	X
	2018	X	X	X	X	X	X	X	X	X	X		

Activity 1.1.2: • Employ necessary staff for the six mobile health teams (MHT) • Hire vehicles for the mobile health teams (MHT). • Provide necessary equipment for the MHT. • Establish a community Health Shura for each health facility. • Develop village visit timetables with Health Shuras for each MHT. • Provide essential medicines, medical and non-medical supplies and equipment for the MHT. • Establish referral system among the MHT and BPHS/ EPHS facilities. • Provide antenatal and postnatal care for the mothers. • Provide basic emergency obstetric and newborn care (EmONC) services. • Provide vaccination for the children and child bearing age women. • Provide family planning methods on request. • Provide treatment of children sickness especially ARI, pneumonia and diarrheal diseases. • Provide outpatient consultation and treatment of common diseases. • Maintain ambulance/referral services. • Coordinate with the stakeholders (Health cluster, PPHD, WHO, UNICEF, BARAN, Handicap, Community Shuras and Healthnet TPO). • Regularly supervise the performance and outputs of the MHTs. • Report the progress of works and health data on timely manner.	2017										X	X	X
	2018	X	X	X	X	X	X	X	X	X	X		
Activity 1.1.2: • Train healthcare givers on identification and management of GBV (5 days course for doctor, nurse, PSS counselor and midwife with support of Healthnet TPO). • Train the staff on PSS counseling and GBV (10 days training with support of Healthnet TPO). • Include female PSS counselor in mobile health teams and to conduct blanket PSS sessions with target communities in general, women and girls in particular. • Provide psychosocial counseling and health services to survivors as part of initial response. • Distribute Dignity Kits for the GBV survivors. • Work with pregnant to build strengths at the individual, relationship, and community levels that help them face and overcome trauma or adversity. • Coordinate with the Kandahar Protection Cluster to establish case management committees (CMCs). • Community mobilization through health committees that are established for each MHT. • Include GBV in various community sessions/awareness. • Coordinate with Family Protection Centre (FPC) in Kandahar City for referral and reporting. • Refer GBV survivors to the organization who can provide legal assistance and specialized medical care. • Follow up the referred survivors.	2017											X	X
	2018	X	X	X	X	X	X	X	X	X	X		
Activity 1.1.2: • Conduct IYCF counseling to women/caretakers of children in OTP during mobile team visits. • Establish and support 12 IYCF mother support groups targeting mothers of children under 2 years. • Conduct refresher training on IYCF to the health staff of the MHTs • Distribute micronutrient supplement for under 5 year children, and lactating and pregnant women. • Improve timely and accurate data collection and reporting of nutrition data from all sites through provision of data collection tools and training of nutrition staff on data management.	2017											X	X
	2018	X	X	X	X	X	X	X	X	X	X		

OTHER INFO

Accountability to Affected Populations

The target people were consulted for their needs and what is going to be planned during the rapid needs assessment. It is planned to establish community health committees (Shura) for each MHT in the main villages; usually the village local committees (Shura) take this responsibility. The members of Shura will be responsible to facilitate activities of the MHT, ensure security of the staff, transfer health messages to the villagers, prompt informing about any casualty and outbreak to the MHT staff, facilitate transportation means if required, and share concerns of the people with AHDS. In addition, the Health Shura is contact means between the people and MHT/AHDS office.

At the beginning, each MHT team should present the types of services can be provided for the people. Number, names, places and distances of all the villages in the catchment area will be listed. Then a timetable/calendar of village visits will be developed with the Health Shura for MHT roster.

The Health Shura members will be oriented on how to cooperate with the MHTs; early warning, rapid assessment, early transfer of the severe case, victims and violence survivors, and follow up.

The monthly health Shura meetings will be mainly used for two-way communication; reporting/information sharing to the Shura and receiving their feedbacks and recommendations. In case of any complaint, Shura members raise it in the monthly meetings, if not followed up, than they will share it with AHDS provincial office.

A complain mechanism will be established on how to complain to the head of MHT, or Health Shura. The aim is to ensure quality services are provided to the people with full respect to their dignity. Furthermore, the certain place/date of the MHT visit to each village of target community should be respected. Presence of female staff facilitates complaint reporting for the women and children.

In principle, emergency health/nutrition/protection services do not harm the people. The emergency services and staff will be managed in a very user friendly manner to avoid any direct or indirect harm to the communities and its environment. Local traditions will be considered and respected during services provision, follow up in the villages and transfer/referral of violence survivals to specialized centers.

Medical waste can harm if not disposed carefully. Waste reduction and disposal will be managed with high standard to minimize environment pollution and any possible risk for the children playing around the MHTs. The potential harm from medical waste and its impact on the environment will be minimized. Proper waste management according the MoPH national waste management policy ensures minimizing environmental hazard of the medical waste. AHDS will make sure that infection prevention measures are strictly considered in each health facility and waste management tools are available. The health facilities produce small amounts of sharps and organic waste with minimum environmental impact. High standards will be applied for the collection, separation and transfer of wastes. Sharps will be collected in proper paper boxes. The organic wastes like tissue remnants and placenta will be put in separate bags. Infected gauze and other material will have their own bags. Incinerator will used to disinfect and minimize wastes. Three different wells will be ready to bury sharps, ashes from the incinerator and tissues. The remnants of vegetable and foods will be buried in another place under earth to fertilize it. The facilities will not use solutions that have toxic vapors and make sure that harmful liquids do not go to the greens.

Implementation Plan

Governance: the project will be managed in decentralized manner by the project team based in Kandahar, where AHDS headquarter has facilitating and monitoring role.

Multi-cluster services: the MHTs will provide primary healthcare including treatment of acute malnutrition for target population. Furthermore, with close collaboration of Health Shura, it will provide psychosocial counseling for the post trauma stress, advocacy for human rights (with emphasis on women and child protection) and protection support for GBV survivors.

Community: channel of communication with beneficiaries is maintained through Health Shuras. This will allow for exchange of ideas, feedback and democratic control. The Health Shura will have monthly meeting to discuss current services, complaints and improvement opportunities.

Accessibility of services: a time-table for the geographical coverage of the villages and MHT movement map will be developed with Health Shuras in the target areas. AHDS will establish a patient-centered and service-minded culture of transparency and feedback. Average frequency of visit to each village will be on weekly basis; it may vary a little depending on number of villages for each MHT. Removing barriers for female users, minority groups and people with special health problems is necessary to enhance acceptability and actual use of the services; examples are presence of female staff, privacy and confidentiality.

Human resources: each MHT will have: a doctor, a female midwife, a nutrition nurse, a female psychosocial counselor, a vaccinator, a driver and a guard. Basic training, on job training, and supportive supervision ensure that people know what to do and how to behave with their clients.

Logistics: the primary process of patient-provider interaction can only function if the conditions are favorable, which means adequate work space, equipment, supplies, diagnostic and therapeutic facilities are available. Good support services are not only necessary for providing the patient with the best possible services, but also a critical factor in staff work satisfaction. The frequency of supply replenishment will be monthly with some flexibility depending on road access.

Referral: MOU with referral points identified for each service (surgery, mental health, disability, GBV protection, supplementary feeding) will be signed. The staff will communicate carefully about the condition and the services required on a referral slip and ask for feedback on the final diagnosis, case management and follow up needed.

Ambulance system: movement plan for the ambulances will be defined. The contact number of ambulances will be shared with MHT, nearby health facilities, and Health Shura members. Trustworthy private transport (introduced by Shura) we be called when the ambulance is not enough.

Disaster: A tailor made risk analysis and emergency preparedness plan will be in place to control outbreaks and emergencies. NDSR will be enforced through staff training, coordination with stakeholders, prompt reporting, case management, follow up and feedback.

Coordination: project onset, implementation and necessary amendment will be done in close coordination with the MoPH, Clusters and other stakeholders at the both provincial and national levels.

Reporting: MHT will report on monthly basis to AHDS provincial officer, quality of data will be checked, the reports will be analysed and feedback to MHT for corrective measures will be given. AHDS headquarter will compile field reports for quarterly reporting to the donor and partners.

Financial system: specific account number is designated for this project. AHDS' finance (as part of Operation Manual) is in line with the International Standards on Auditing (ISA). QuickBooks and spread sheets are in use for admin and finance management. AHDS main office does internal financial control. Independent chartered accountants are hired to do financial at the end of each fiscal year

Coordination with other Organizations in project area

Name of the organization	Areas/activities of collaboration and rationale
MoPH; provincial public health directorates	Planning, coordination, joint monitoring, referral, NDSR, links with local authorities, etc.
WHO	Guidelines, outbreaks, NDSR, additional emergency kits if needed.
UNICEF, WFP	Outbreaks, NDSR, vaccines, cold chain supply, nutrition supplies.
UNFPA	Guidelines, advises, advocacy.
UNHCR	Information about IDPs and returnees.
OCHA	Advises, advocacy.
WFP	Nutrition supplies
Kandahar Directorate of Women Affaires	Advises, referral, advocacy.
Healthnet TPO	Guidelines, training, advises.
Handicap International	Advises, referral.
BARAN (BPHS implementer)	Referral.
ICRC	Referral, security negotiations.
Community	Supports at the village level, information, facilitation, security, follow up.
INSO	Security news

Environment Marker Of The Project

A: Neutral Impact on environment with No mitigation

Gender Marker Of The Project

1-The project is designed to contribute in some limited way to gender equality

Justify Chosen Gender Marker Code

Healthcare and public nutrition services are very gender sensitive issues. In addition, general protection and protection for GBV survivors are also considered in the project. The project is designed to contribute significantly to gender equality. The gender issue was considered during the assessment phase done by AHDS. Fortunately, the targets, standards and guidelines for primary healthcare, nutrition and protection developed by MoPH and Humanitarian Clusters at each step/facility ensures gender mainstreaming. Following up of the guidelines and achieving the set targets are by themselves indicators of gender consideration. Data and information which will be collected and reported through this project will be segregated gender and age wise to ensure a good analysis of outputs and outcomes based on gender aspects.

Considering the conservative culture, it is not possible to have gender-mix Shura in the target area. Using the female staff, we can collect women concerns and recommendations. The MHTs will ensure that enough privacy is provided for the female. They will have the right to have their chaperons (muharam) with them in the clinic area as well as in the ambulance.

Protection Mainstreaming

In principle, emergency health/nutrition/protection services do not harm the people. The emergency health services and staff will be managed in a very user friendly manner to avoid any direct or indirect harm. Local traditions will be considered and fully respected. Careful consideration of the no discrimination policy of health sector and the four humanitarian principles guarantee the Do No Harm. Although, we never had any report of health staff with discriminative attitude in Afghanistan, still we will carefully monitor the MHTs and ask the beneficiaries (interviews & phone calls) for such an act. All the staff will be oriented on medical ethics, which strongly forbids any type of discrimination like tribe, sex, beliefs, orientations, age and so on. AHDS implements its human resource no discrimination policy for any employment and staff appraisal.

The project is basically planned to meet the needs of vulnerable with special focus on women and children. The locations chosen are inhabited by poor, remote and internally displaced people. Small portion of the beneficiaries could be better-off people.

No one will be asked about their religion, race, tribe and political affiliations. The poor will receive special attention; the priority will be given to them for example for use of ambulance. During the training, a medical ethics session will be conducted; the staff will learn how to deal respectfully with the patients and their caretaker at each stage.

The triage training will emphasize on prioritization of the most vulnerable people like disabled, women and children. A referral MOU will be signed with Handicap International that is providing services for the disabled. Hence, MOU is required for GBV survivors with Family Protection Centre (FPC) in Kandahar City and Kandahar Directorate of Women Affaires.

Community awareness and health & nutrition education sessions will be conducted to the people to get prime messages, become aware of risk factors, seek GBV prevention measures, understand importance of early health seeking behavior, make community based transportation mechanism for emergencies (in case the ambulance is overloaded), and advocacy for their health right.

Using the female staff, we can collect women concerns and recommendations. The MHTs will ensure that enough privacy is provided for the female. They will have the right to have their chaperons (muharam) with them in the clinic area as well as in the ambulance.

Community awareness about human rights and measures against GBV is crucial to ensure access of female to the services and protect them. A complain mechanism will be established on how to complain to the head of MHT, or Health Shura. The aim is to ensure quality services are provided to the people with full respect to their dignity. Presence of female staff facilitates complaint reporting for the women and children.

Gender is a sensitive issue in conservative cultures. The counselling and provision of protection services for GBV survivors should be communicated very carefully to avoid any misunderstanding. The do not harm approaches is very important here, any mistake may cause ban on MHT activities.

The Health Shuras will be encouraged to involve religious preachers (Mullah) in the Shura as member. They can talk about women rights in Islam and Hadiths that prohibit violence in the family. We cannot promise that during the project period protection mechanism can be established against GBV in the communities, but initial community mobilization and seeding steps would be initiated.

The government authorities and opposition will be contacted (mainly through the Health Shura) and oriented about the nature of the project and its lifesaving activities. As our past experience shows, it rarely happens that the armed forces stop a vehicle carrying medical supplies or patients. Rental vans equipped as ambulance will be used instead of attractive luxury ambulance to maintain low profile.

Country Specific Information

Safety and Security

Most of the target areas are relatively safe; means although located in conflict zone but have distance from the frontlines, except Khakrez District. Choosing the central locations and surrounding villages for movement together with the community members, we made sure that patients can be collected, stabilized and easily transferred to a higher level health facility (e.g. a hospital) if required.

The Health Shura takes responsibility for security of the MHTs and their staff as well. They will use their relations with local government authorities as well as opposition.

Healthcare projects and health staff are acceptable and respected by the government, local communities and opposition. The government authorities will be briefed about the project, impartiality, fair treatment of the beneficiaries regardless their affiliations. Cooperation of local authorities is crucial for impartial treatment of the victims, which is responsibility of health staff. The health staff must not be accused for resuscitation of “enemies”.

In addition, community members will negotiate with opposition whenever necessary. The project should not be seen as a governmental initiative at disposal of national armed forces. It should be clear for all the conflicting parties that the MHTs are at disposal of the local citizens regardless their sex, race, faiths and political affiliations.

ICRC had helped us in the past to solve issues with Taliban. We may need mediation of ICRC if community trials do not work timely. Although, ICRC Kandahar has limited its operations recently, but has not announced yet to close down its Office.

The unforeseen incidents of war might not be avoidable, but we will make sure to do not endanger the lives of project staff and beneficiaries at any circumstance. The staff will be well oriented on AHDS security policy which is available in national language. Contacts will be kept with INSO and UN for awareness from potential treats and clashes which may happen in the target areas. Relevant measures will be taken to nullify or reduce the risk for the MHTs and their staff. Each MHT will make an evacuation plan with the community leaders in their area, if necessary quick evacuation will be done.

The timetable of MHT visits to the villages (movement map) could be flexible according the security situation special active fighting. Decision will be made after contacting Health Shura. The communities will be informed about changes in the schedule in advance.

Access

The target communities are already consulted about access issue. Community elders assured that the MHTs can operate in the selected areas and people can utilize the provided services responding to their needs. Government officials agreed with the necessity of work in these areas and types of services planned under this project. Community elders are sure that the opposition will not interrupt health and nutrition services; if any misunderstanding rises, they can negotiate with them.

A central place will be chosen as MHT station in each 6 target area from where it will travel to cover all target villages. This place should be the safest and highly populated village among all the villages in the catchment area. Although visit timetable for villages will be pre-determined, access of the roads and feasibility of the people gathering to seek services will be checked on daily bases with Health Shura members.

The impartiality nature of the project will be explained to the government authorities and opposition (mainly through the Health Shura). AHDS will make sure that the MHT routes of movement are safe and acceptable for armed forces (both government and opposition). In uncertain areas support of the target community as escorting MHT will be requested.

The considered project manager has more than 10 years’ experience of supervisory work in Kandahar Province. He has worked as a trainer, Community Based Healthcare Officer, HMIS manager and Project Manager for health and nutrition projects. He has built trust among the communities all over Kandahar Province; he is capable to freely move in all the target areas for this project. The main office team is also able to monitor the selected target areas.

The health staff although not local, has gained quite enough respect and dignity among the authorities, local people and even the opposition as impartial services providers. Afghanistan never had any health staff with discriminative attitude; still we will carefully monitor the MHTs and ask the beneficiaries (interviews & phone calls) for such an act.

Gender is a sensitive issue in conservative cultures. The counselling and provision of protection services for GBV survivors should be communicated very carefully to avoid any misunderstanding. The do not harm approaches is very important here, any mistake may cause ban on MHT activities.

AHDS was the prime rehabilitation initiator and provider of primary health care and later on BPHS in Kandahar. During the past 22 years, we became very familiar with the people, terrains, most of community elders, traditions and sensitive issues for the people. AHDS has built enough trust among the communities having long term relations and interactions during tens of different projects implemented. In over two decades, AHDS gained enough experience of working in conflict zones.

In addition, AHDS has built good relations with other stakeholders in these two provinces like the provincial public health directorates, UN agencies and NGOs that are active in these provinces as well as the local governments.

AHDS has implemented projects related to health, nutrition, education, capacity building, water and sanitation and relief in Kandahar Province. AHDS is currently running the Institute of Health Sciences (KIHS), Mor Birth Center and Emergency Health Services for White Conflict-Affected Areas in Kandahar Province.

AHDS has implemented a number of emergency projects funded by OHCA, WHO, Cordaid and ECHO (in partnership with Save the Children) for many years in Kandahar Province.

The non-government groups (opposition) will be contacted by the Health Shuras. Health Shura will orient them about the project, type of services and beneficiaries. The MHTs will function neutrally; serving all the clients without asking who are they and belong to which side.

BUDGET

Code	Budget Line Description	D / S	Quantity	Unit cost	Duration Recurrance	% charged to CHF	Total Cost
1. Staff and Other Personnel Costs							
1.1	President	S	1	4,000.00	12	20.00	9,600.00
	President salary is charged in percentage as 20%, as he guides and supervise over all planning and execution of technical and financial activities of the programs, make sure the projects are inline with AHDS vision and mission detailed in the strategic plan. The salary is based on on AHDS salary scale, which is in line with Government's Approved NTA scale (National Technical Assistant salary scale). Currently this salary is based on NTA+AHDS Salary on Grade A/8 (Which is Afs. 284,444/- and we made it fixed amount of US$ 4,000/-.						
1.2	Executive Director	S	1	3,137.00	12	20.00	7,528.80
	Salary of Executive Director is charged in percentage as 20%, as he manage day to day planning and execution of technical and financial activities of the projects, coordinates with stakeholders (like OCHA. Clusters, MoPH) and approve the reports. The salary is based on on AHDS salary scale, which is in line with Government's Approved NTA scale (National Technical Assistant salary scale). Currently this salary is based on NTA+AHDS Salary on Grade A/4, which is Afs. 213,333/-						
1.3	Program Focal Point/Technical /Monitoring & Evaluation Officer	S	1	1,641.00	12	25.00	4,923.00
	This position is based in main office in Kabul, and is responsible for monitoring and supervision of the project sites and health facilities, and project activities as training reporting with donor and/field and on job guidance in both provinces of Kandahar and Urozgan. This position is charged 20% in this project.						
1.4	Head of Finance	S	1	1,882.00	12	20.00	4,516.80
	Finance head who is charged 20% in this project will be responsible for over all financial management of the project related issues, preparing donor reports, attending meetings						
1.5	Head of Control/Audit	S	1	1,118.00	12	25.00	3,354.00
	Internal Control/Audit is charged 20% in this project and is responsible for overall checking financial, HR and logistic documents of the project and ensures donor and internal AHDS rules and policies are in place.						
1.6	Admin Officer	S	1	809.00	12	25.00	2,427.00
	The percentage charged for this position is as he is responsible for all administrative and HR related issues of the project in Kabul level and support either on site or by distance to project team.						
1.7	Finance Officer	S	1	892.00	12	20.00	2,140.80
	Finance Officer charged 20% is handling day to day transactions of the project and making entries to system and controls budget and provides support to field staff.						
1.8	Inventory/Logistic Officer	S	1	708.00	12	50.00	4,248.00
	This position is responsible for overall supplies of the proejct outside the province and coordinates with project staff on the supply related issues with regular travels to project.						
1.9	Retirement/Severneth-Pay Contribution	S	1	40,667.00	1	18.00	7,320.06
	Ref Boq 1.9: As per Government labor law and AHDS' internal policy, we are issuing staff yearly severenth pay. The total amount of Afs. 2,765,330/- is annual salary cost of AHDS' permanent staff, and this amount should be charged to projects as per our board of directors decision between 18-35% on each project. (The calculation is pasted as per accurate and % is decreased to meet earlier submitted forecast).						
1.10	Project Manager	D	1	897.00	12	70.00	7,534.80
	Program Manager is full time dedicated position for this project who is based in Kandahar with frequent trips to sites and is overall responsible for planning, coordinating, implementation and reporting of the project issues to main office and is in coordination with donor. He also coordinates with finance and program teams and provides needed advise. His salary is 70% in this project as currently it is charged in other project as well, and the remaining 30% will be covered from that project during both projects life.						
1.11	Admin/Finance	D	1	700.00	12	70.00	5,880.00
	This is a full time dedicated position to CHF project, responsible for all accounting, cash related issues and expenses, replying feedbacks of main office and donors and controls programs activities against provided budget and sends documents to main office on monthly basis both in soft and hard formats. He also monitors project activities to ensure transparency and reports both to program manager and Kabul finance department. His salary is 70% in this project as currently it is charged in other project as well, and the remaining 30% will be covered from that project during both projects life.						
1.12	Guards	D	2	220.00	7	100.00	3,080.00
	Guard is budgeted as full time dedicated person in provincial office in order to maintain the office secure and meet the day to day running tasks of the project and office colleagues. It is budgeted 7 months as is already covered in another project the earlier months.						

1.13	Cleaner	D	1	220.00	7	100.00	1,540.00
	Cleaner is budgeted as full time dedicated person in provincial office for keeping the office and departments clean and help in day to day running tasks of the departments and project. He also is responsible for assisting cook and serving tea to guests on official meetings. It is budgeted 7 months as is already covered in another project the earlier months.						
1.14	Driver	D	1	270.00	7	100.00	1,890.00
	Drivers as other support staff is budgeted in provincial level in Kandahar to facilitate in the transportation of the involved project staff to sites, meetings and other official commutes. It is budgeted 7 months as is already covered in another project the earlier months.						
1.15	Doctor (MD) for MHTs	D	6	500.00	12	100.00	36,000.00
	Per MHT there will be 1 MD Doctor means 6 in total MHTs. The salary of this position is based on NSP and HC, and they will be working in CHCs in Urozgan and will provide trauma care, referral services, follow up of treated patients, response to emergencies and participate in responses to mass casualties.						
1.16	Nurse/Nutrition Consular	D	8	340.00	12	100.00	32,640.00
	Per HMT there will be one 1 Nurses/nutrition consular, and 2 extra for all 6 MHTs, as in case of any one on leave the tasks will cover 2 extra budgeted nurses as support to each MHTs. The salary of this position is based on NSP and HC, and they will be working in MHT and will provide trauma care, referral services, nutrition consultations, follow up of treated patients, response to emergencies and participate in responses to mass casualties. Per MHT there will be 1 nurses.						
1.17	Midwives	D	7	500.00	12	100.00	42,000.00
	One Extra Midwives is budgeted that in case of any other midwives are in leave this position will cover the gap., rest all MHTs has one Midwife per facility. The salary of this position is based on NSP and HC, and they will be working in MHT and will provide maternal health related and trauma care, referral services, follow up of treated patients, response to emergencies and participate in responses to mass casualties.						
1.18	Psychosocial Counselor	D	6	500.00	12	100.00	36,000.00
	This position is responsible for providing consoling on Post trauma stress, GBV and child abuse, protection and gender violence in each MHTs as per description of the program.						
1.19	Vaccinator	D	6	138.00	12	100.00	9,936.00
	This position if providing needed vaccination services in each MHTs.						
1.20	Guards/Cleaners	D	6	220.00	12	100.00	15,840.00
	One Guard/cleaner will be working in each MHTs as dedicated staff providing support staff and cleaning and taking care of the site, necessary guidance to patients.						
	Section Total						**238,399.26**
2. Supplies, Commodities, Materials							
2.1	Medicine & Consumables	D	6	670.00	12	100.00	48,240.00
	This line is budgeted for the supply of medicines and consumables which are delivered on a monthly basis to MHTs. The cost has been estimated according to past consumption. A detailed list of drugs and consumables are also available as per BoQ 2.1.						
2.2	Nutrition Related Medicine	D	1	8,076.00	1	100.00	8,076.00
	As per Bo! 2.2						
2.3	Health Education Materials	D	6	100.00	12	100.00	7,200.00
	We budgeted Afs. 5 per poster to be printed. and this amount comes from calculating cost of printing materials (i.e. 7 type posters each 200 copies) <6800/7/200> . This line is budgeted for health education materials/posters and other awareness session to help both staff and beneficiaries get knowledge for common health related issues.						
2.4	Supply Delivery (form MO)	D	1	882.00	3	100.00	2,646.00
	This budget line is the estimated cost of supplies from Kabul to Projects site on quarterly basis, and usually some items/medicines and supplies are not available in provinces and/or are at high cost, therefore, it is needed to be procured from Kabul and sent to projects. Approximate cost of Afs. 60,000/supply/quarter is budgeted. (Afs. 60,000 =. @ US$ 68 / quarter per supply/truck up to Kandahar. It's the estimated current cost one truck can transport supply from Kabul to Kandahar.)						
2.5	Supply Delivery (Within Province)	D	1	882.00	12	100.00	10,584.00
	This budget line is the estimated cost of supplies from within provinces to projects sites. Approximate cost of Afs. 60,000/shipment/car/MHTs for monthly including dignity kits and nutrition supplies.						
2.6	Trainings	D	1	11,065.00	1	100.00	11,065.00
	As per BoQ 2.6 and this is to confirm that prices as per policy and actual expenditure.						

2.7	Dignity Kits	D	240	21.00	12	100.00	60,480.00
	As per BoQ 2.7. Kits to be distributed to women and girls for GBV (Gender based violence) survivors. The support letters for the need of these are already submitted in first draft.						
	Section Total						**148,291.00**
3. Equipment							
3.1	None Medical Equipment's	D	6	1,698.00	1	100.00	10,188.00
	This line includes purchase of needed equipment's for MHTs as per BoQ No. 3.1						
3.2	Medical Equipment	D	6	1,268.00	1	100.00	7,608.00
	The medical equipment is necessary for 6 MHTs as per BoQ No. 3.2						
3.3	Community Awareness	D	6	50.00	12	100.00	3,600.00
	Monthly community awareness gathering costs.						
	Section Total						**21,396.00**
4. Contractual Services							
4.1	Rental (MHT Sites/Houses)	D	6	162.00	12	100.00	11,664.00
	This budget line is for rental of sites for 6 MHTs in Kandahar.						
4.2	Office Rent (Kandahar)	S	1	515.00	12	50.00	3,090.00
	This budget line is for partial cost of office rental in Kandahar where all management of the project will be carried out.						
4.3	Office Rent (Kabul)	S	1	1,100.00	12	17.00	2,244.00
	This budget line is for partial cost of Main Office rental in Kabul.						
4.4	Vehicle Rental	D	6	809.00	12	100.00	58,248.00
	This budget line is for rent of 6 vehicles 1 per each MHT which will include driver's/vehicle fuel/maintenances expenses as well. The cost is calculated i.e Afs. 55,000/vehicle						
	Section Total						**75,246.00**
5. Travel							
5.1	Travel Allowance/Accommodation (Main Office Supervision)	D	1	103.00	6	100.00	618.00
	This budget is for travel related cost from main office for supervision of program admin/finance to projected site. costs include periderm as per AHDS policy Afs. 1000/day/person. (for 7 days in 2 months) the cost is converted @ Afs. 68 = US$ 1.						
5.2	Transport (Air/Road) (Main Office Supervision)	D	1	200.00	6	100.00	1,200.00
	This budget is for travel related cost from main office for supervision of program admin/finance to projected site. costs include US $ Approx. 200/round trip/person from Kabul to Project site (Kandahar/Urozgan)						
5.3	Travel Allowance/Accommodation (Project Site)	D	1	176.00	6	100.00	1,056.00
	This budget line is for accommodation and periderm of cost of person traveling to field from Project site (Kandahar facilities) as per AHDS Policy. i.e. Afs. 12000/2 months is forecasted. @ Rate of Afs. 68 = US$ 1						
5.4	Transport (Air/Road) (Project Site)	D	1	209.00	6	100.00	1,254.00
	This budget line is for transportation cost of person traveling to field from Project site (Kandahar) and/or Kabul Estimated Afs. 4000 @ 68 = US$ is as per current market transportation cost. And US$ 200 for Kabul travels including Perdiems of US$ 100/						
	Section Total						**4,128.00**
6. Transfers and Grants to Counterparts							
NA	NA	NA	0	0.00	0	0	0.00
	NA						
	Section Total						**0.00**

7. General Operating and Other Direct Costs							
7.1	Other running cost (communication and stationeries, etc.)	D	8	300.00	12	100.00	28,800.00
	The quantity shows 6+2 (8) means 6 for MHTs and 2 for Offices Kandahar and Kabul. This line is for any other possible expenses related to project as stationery cost for 6 MHTs (Stationery items include pen, pencils, white paper, stapler, staples, calculator, erasers, marker pen, stamp pad etc) and General running cost of HFs includes cleaning materials and items related in health facilities (electric bulb, lock, socket, tea, candies etc) and communication costs internet/phone. This also includes water and electricity/lighting system for facilities.						
7.2	Other (Fuel for Generator/Maintenance if the vehicle is provided by NGO)	D	2	588.00	12	40.00	5,644.80
	Only 40% charges and this line include generator fuel, vehicle maintenance and other associated costs. these vehicles will also be used for official trips, monitoring and supervision sites. i.e. Afs. 40,000/months.						
7.3	Maintenance	D	6	44.00	12	100.00	3,168.00
	This budget line is for repair and maintenance of cost of equipment/furniture of both office and MHTs.						
7.4	Winter heating	D	7	74.00	3	100.00	1,554.00
	This budget line is allocated for winterization and heating cost of 6 MHTs and Office in Kandahar during three months of winter season.						
7.5	Financial Services/Bank Charges	D	1	103.00	12	100.00	1,236.00
	This line is used for Bank charges of fund from Main office to projects and for staff salary transfer and any other banking fees related to project. Based on other projects expenditure, we predicted Afs. 7000/months for this budget lines. It is charged based on actual project expenses not extra amount is charged.						
	Section Total						**40,402.80**
SubTotal			370.00				**527,863.06**
Direct							476,470.60
Support							51,392.46
PSC Cost							
PSC Cost Percent							7.00
PSC Amount							36,950.41
Total Cost							**564,813.47**

Project Locations

Location	Estimated percentage of budget for each location	Estimated number of beneficiaries for each location					Activity Name
		Men	Women	Boys	Girls	Total	
Kandahar -> Kandahar	7	9				9	
Kandahar -> Shahwalikot	31	3,381	3,536	4,655	4,495	16,067	Activity 1.1.1 : • MOUs will be signed with referral points (surgery, mental health, disability, GBV protection, supplementary feeding). • Six mobile health teams (MHT) will function on the passages were they can collect victims from conflict areas. • Referral points will be identified; written protocols will be signed to ensure efficient referral, quick response and feedback. • The MHT will be staffed and equipped according the standards, including access to ambulance. • Training on triage and first aid will be provided for the staff (8 days including 3 days first aid and 5 days triage for doctors, nurses and midwives). • Training on first aid will be provided for the drivers and guards (3 days training). • Training on psychosocial support will be provided for the nurses, midwives and physicians (5 days training). • Collect and stabilize victims from conflict areas. • Report and quickly respond to any suspected outbreak (DEWS). Activity 1.1.1 : • Admit and treat children aged 6 – 59 months with severe acute malnutrition (SAM)

							without medical complications in integrated mobile OTP. • Refer critically ill severely malnourished children with medical complications to a stabilization center. • Provide referral support for critically ill severely malnourished children with medical complications to the nearest stabilization center. • Admit and treat children aged 6 – 59 months with moderate acute malnutrition (MAM) in integrated mobile OTP. • Admit and treat pregnant and lactating women with acute malnutrition in integrated mobile OTP. • Conduct regular joint supervision of all supported OTP sites to ensure quality of service delivery. • Ensure uninterrupted supply of all the necessary food items, essential drugs and other supplies needed for the nutrition program. • Conduct community outreach and home visit especially for defaulters and children not meeting the target weight. • Conduct 2 rounds of de-worming campaigns targeting children aged 1-5 years to prevent micro nutrient deficiencies associated with intestinal worms. • Refer complicated cases to stabilization center by BPHS implementer and PHO. • Improve timely and accurate data collection and reporting. Activity 1.1.1 : • Select locations for the health facilities and routes of movement that are away from actual or potential threats; especially the risk or threat of gender based violence (GBV), attacks from armed groups and land mines • Orient the staff to treat the clients respectfully and inclusive of cultural and religious practices. • Respect confidentiality and privacy of clients during consultations. • Keep the identifiable information confidentiality unless consent has been given by the beneficiary. • Consult with displaced and host communities about health needs so as to avoid community tensions that could lead to violence and harassment of one group or another. • Employ female health staff members with skills and experience working with women and children. • Train the staff on how to respond to the specific needs of victims of grave human rights violations, including rape and physical abuse. • Assign qualified psychosocial workers to receive and counsel survivors of violations, especially when dealing with children and/or survivors of GBV. • Put in place guidelines and mechanisms for monitoring and reporting instances of abuse and exploitation. • Set up accessible, well understood mechanisms for suggestions and complaints. • Monitor access, discrimination, and whether any services are being diverted. • Strengthen coordination with Health Cluster at sub-national level to address GBV and child abuse as well. • Coordinate with Protection and People with Special Need (PSN) network (headed by UNHCR) in Kandahar. • Report and share protection concerns with the Protection cluster, including the GBV and Child Protection sub-clusters. Activity 1.1.2 : • Train healthcare givers on identification and management of GBV (5 days course for doctor, nurse, PSS counselor and midwife with support of Healthnet TPO). • Train the staff on PSS counseling and GBV (10 days training with support of Healthnet TPO). • Include female PSS counselor in mobile health teams and to conduct blanket PSS sessions with target communities in general, women and girls in particular. • Provide psychosocial counseling and health

							services to survivors as part of initial response. • Distribute Dignity Kits for the GBV survivors. • Work with pregnant to build strengths at the individual, relationship, and community levels that help them face and overcome trauma or adversity. • Coordinate with the Kandahar Protection Cluster to establish case management committees (CMCs). • Community mobilization through health committees that are established for each MHT. • Include GBV in various community sessions/awareness. • Coordinate with Family Protection Centre (FPC) in Kandahar City for referral and reporting. • Refer GBV survivors to the organization who can provide legal assistance and specialized medical care. • Follow up the referred survivors. Activity 1.1.2 : • Conduct IYCF counseling to women/caretakers of children in OTP during mobile team visits. • Establish and support 12 IYCF mother support groups targeting mothers of children under 2 years. • Conduct refresher training on IYCF to the health staff of the MHTs • Distribute micronutrient supplement for under 5 year children, and lactating and pregnant women. • Improve timely and accurate data collection and reporting of nutrition data from all sites through provision of data collection tools and training of nutrition staff on data management. Activity 1.1.2 : • Employ necessary staff for the six mobile health teams (MHT) • Hire vehicles for the mobile health teams (MHT). • Provide necessary equipment for the MHT. • Establish a community Health Shura for each health facility. • Develop village visit timetables with Health Shuras for each MHT. • Provide essential medicines, medical and non-medical supplies and equipment for the MHT. • Establish referral system among the MHT and BPHS/ EPHS facilities. • Provide antenatal and postnatal care for the mothers. • Provide basic emergency obstetric and newborn care (EmONC) services. • Provide vaccination for the children and child bearing age women. • Provide family planning methods on request. • Provide treatment of children sickness especially ARI, pneumonia and diarrheal diseases. • Provide outpatient consultation and treatment of common diseases. • Maintain ambulance/referral services. • Coordinate with the stakeholders (Health cluster, PPHD, WHO, UNICEF, BARAN, Handicap, Community Shuras and Healthnet TPO). • Regularly supervise the performance and outputs of the MHTs. • Report the progress of works and health data on timely manner.
Kandahar -> Khakrez	16	1,045	1,091	1,436	1,386	4,958	Activity 1.1.1 : • MOUs will be signed with referral points (surgery, mental health, disability, GBV protection, supplementary feeding). • Six mobile health teams (MHT) will function on the passages were they can collect victims from conflict areas. • Referral points will be identified; written protocols will be signed to ensure efficient referral, quick response and feedback. • The MHT will be staffed and equipped according the standards, including access to ambulance. • Training on triage and first aid will be provided

for the staff (8 days including 3 days first aid and 5 days triage for doctors, nurses and midwives).
• Training on first aid will be provided for the drivers and guards (3 days training).
• Training on psychosocial support will be provided for the nurses, midwives and physicians (5 days training).
• Collect and stabilize victims from conflict areas.
• Report and quickly respond to any suspected outbreak (DEWS).
Activity 1.1.1 : • Admit and treat children aged 6 – 59 months with severe acute malnutrition (SAM) without medical complications in integrated mobile OTP.
• Refer critically ill severely malnourished children with medical complications to a stabilization center.
• Provide referral support for critically ill severely malnourished children with medical complications to the nearest stabilization center.
• Admit and treat children aged 6 – 59 months with moderate acute malnutrition (MAM) in integrated mobile OTP.
• Admit and treat pregnant and lactating women with acute malnutrition in integrated mobile OTP.
• Conduct regular joint supervision of all supported OTP sites to ensure quality of service delivery.
• Ensure uninterrupted supply of all the necessary food items, essential drugs and other supplies needed for the nutrition program.
• Conduct community outreach and home visit especially for defaulters and children not meeting the target weight.
• Conduct 2 rounds of de-worming campaigns targeting children aged 1-5 years to prevent micro nutrient deficiencies associated with intestinal worms.
• Refer complicated cases to stabilization center by BPHS implementer and PHO.
• Improve timely and accurate data collection and reporting.
Activity 1.1.1 : • Select locations for the health facilities and routes of movement that are away from actual or potential threats; especially the risk or threat of gender based violence (GBV), attacks from armed groups and land mines
• Orient the staff to treat the clients respectfully and inclusive of cultural and religious practices.
• Respect confidentiality and privacy of clients during consultations.
• Keep the identifiable information confidentiality unless consent has been given by the beneficiary.
• Consult with displaced and host communities about health needs so as to avoid community tensions that could lead to violence and harassment of one group or another.
• Employ female health staff members with skills and experience working with women and children.
• Train the staff on how to respond to the specific needs of victims of grave human rights violations, including rape and physical abuse.
• Assign qualified psychosocial workers to receive and counsel survivors of violations, especially when dealing with children and/or survivors of GBV.
• Put in place guidelines and mechanisms for monitoring and reporting instances of abuse and exploitation.
• Set up accessible, well understood mechanisms for suggestions and complaints.
• Monitor access, discrimination, and whether any services are being diverted.
• Strengthen coordination with Health Cluster at sub-national level to address GBV and child abuse as well.
• Coordinate with Protection and People with Special Need (PSN) network (headed by UNHCR) in Kandahar.
• Report and share protection concerns with the Protection cluster, including the GBV and Child

							Protection sub-clusters. Activity 1.1.2 : • Train healthcare givers on identification and management of GBV (5 days course for doctor, nurse, PSS counselor and midwife with support of Healthnet TPO). • Train the staff on PSS counseling and GBV (10 days training with support of Healthnet TPO). • Include female PSS counselor in mobile health teams and to conduct blanket PSS sessions with target communities in general, women and girls in particular. • Provide psychosocial counseling and health services to survivors as part of initial response. • Distribute Dignity Kits for the GBV survivors. • Work with pregnant to build strengths at the individual, relationship, and community levels that help them face and overcome trauma or adversity. • Coordinate with the Kandahar Protection Cluster to establish case management committees (CMCs). • Community mobilization through health committees that are established for each MHT. • Include GBV in various community sessions/awareness. • Coordinate with Family Protection Centre (FPC) in Kandahar City for referral and reporting. • Refer GBV survivors to the organization who can provide legal assistance and specialized medical care. • Follow up the referred survivors. Activity 1.1.2 : • Conduct IYCF counseling to women/caretakers of children in OTP during mobile team visits. • Establish and support 12 IYCF mother support groups targeting mothers of children under 2 years. • Conduct refresher training on IYCF to the health staff of the MHTs • Distribute micronutrient supplement for under 5 year children, and lactating and pregnant women. • Improve timely and accurate data collection and reporting of nutrition data from all sites through provision of data collection tools and training of nutrition staff on data management. Activity 1.1.2 : • Employ necessary staff for the six mobile health teams (MHT) • Hire vehicles for the mobile health teams (MHT). • Provide necessary equipment for the MHT. • Establish a community Health Shura for each health facility. • Develop village visit timetables with Health Shuras for each MHT. • Provide essential medicines, medical and non-medical supplies and equipment for the MHT. • Establish referral system among the MHT and BPHS/ EPHS facilities. • Provide antenatal and postnatal care for the mothers. • Provide basic emergency obstetric and newborn care (EmONC) services. • Provide vaccination for the children and child bearing age women. • Provide family planning methods on request. • Provide treatment of children sickness especially ARI, pneumonia and diarrheal diseases. • Provide outpatient consultation and treatment of common diseases. • Maintain ambulance/referral services. • Coordinate with the stakeholders (Health cluster, PPHD, WHO, UNICEF, BARAN, Handicap, Community Shuras and Healthnet TPO). • Regularly supervise the performance and outputs of the MHTs. • Report the progress of works and health data on timely manner.
Kandahar -> Maywand	15	767	801	1,053	1,016	3,637	Activity 1.1.1 : • MOUs will be signed with referral

							points (surgery, mental health, disability, GBV protection, supplementary feeding). • Six mobile health teams (MHT) will function on the passages were they can collect victims from conflict areas. • Referral points will be identified; written protocols will be signed to ensure efficient referral, quick response and feedback. • The MHT will be staffed and equipped according the standards, including access to ambulance. • Training on triage and first aid will be provided for the staff (8 days including 3 days first aid and 5 days triage for doctors, nurses and midwives). • Training on first aid will be provided for the drivers and guards (3 days training). • Training on psychosocial support will be provided for the nurses, midwives and physicians (5 days training). • Collect and stabilize victims from conflict areas. • Report and quickly respond to any suspected outbreak (DEWS). Activity 1.1.1 : • Admit and treat children aged 6 – 59 months with severe acute malnutrition (SAM) without medical complications in integrated mobile OTP. • Refer critically ill severely malnourished children with medical complications to a stabilization center. • Provide referral support for critically ill severely malnourished children with medical complications to the nearest stabilization center. • Admit and treat children aged 6 – 59 months with moderate acute malnutrition (MAM) in integrated mobile OTP. • Admit and treat pregnant and lactating women with acute malnutrition in integrated mobile OTP. • Conduct regular joint supervision of all supported OTP sites to ensure quality of service delivery. • Ensure uninterrupted supply of all the necessary food items, essential drugs and other supplies needed for the nutrition program. • Conduct community outreach and home visit especially for defaulters and children not meeting the target weight. • Conduct 2 rounds of de-worming campaigns targeting children aged 1-5 years to prevent micro nutrient deficiencies associated with intestinal worms. • Refer complicated cases to stabilization center by BPHS implementer and PHO. • Improve timely and accurate data collection and reporting. Activity 1.1.1 : • Select locations for the health facilities and routes of movement that are away from actual or potential threats; especially the risk or threat of gender based violence (GBV), attacks from armed groups and land mines • Orient the staff to treat the clients respectfully and inclusive of cultural and religious practices. • Respect confidentiality and privacy of clients during consultations. • Keep the identifiable information confidentiality unless consent has been given by the beneficiary. • Consult with displaced and host communities about health needs so as to avoid community tensions that could lead to violence and harassment of one group or another. • Employ female health staff members with skills and experience working with women and children. • Train the staff on how to respond to the specific needs of victims of grave human rights violations, including rape and physical abuse. • Assign qualified psychosocial workers to receive and counsel survivors of violations, especially when dealing with children and/or survivors of GBV. • Put in place guidelines and mechanisms for monitoring and reporting instances of abuse and exploitation.

							• Set up accessible, well understood mechanisms for suggestions and complaints. • Monitor access, discrimination, and whether any services are being diverted. • Strengthen coordination with Health Cluster at sub-national level to address GBV and child abuse as well. • Coordinate with Protection and People with Special Need (PSN) network (headed by UNHCR) in Kandahar. • Report and share protection concerns with the Protection cluster, including the GBV and Child Protection sub-clusters. Activity 1.1.2 : • Train healthcare givers on identification and management of GBV (5 days course for doctor, nurse, PSS counselor and midwife with support of Healthnet TPO). • Train the staff on PSS counseling and GBV (10 days training with support of Healthnet TPO). • Include female PSS counselor in mobile health teams and to conduct blanket PSS sessions with target communities in general, women and girls in particular. • Provide psychosocial counseling and health services to survivors as part of initial response. • Distribute Dignity Kits for the GBV survivors. • Work with pregnant to build strengths at the individual, relationship, and community levels that help them face and overcome trauma or adversity. • Coordinate with the Kandahar Protection Cluster to establish case management committees (CMCs). • Community mobilization through health committees that are established for each MHT. • Include GBV in various community sessions/awareness. • Coordinate with Family Protection Centre (FPC) in Kandahar City for referral and reporting. • Refer GBV survivors to the organization who can provide legal assistance and specialized medical care. • Follow up the referred survivors. Activity 1.1.2 : • Conduct IYCF counseling to women/caretakers of children in OTP during mobile team visits. • Establish and support 12 IYCF mother support groups targeting mothers of children under 2 years. • Conduct refresher training on IYCF to the health staff of the MHTs • Distribute micronutrient supplement for under 5 year children, and lactating and pregnant women. • Improve timely and accurate data collection and reporting of nutrition data from all sites through provision of data collection tools and training of nutrition staff on data management. Activity 1.1.2 : • Employ necessary staff for the six mobile health teams (MHT) • Hire vehicles for the mobile health teams (MHT). • Provide necessary equipment for the MHT. • Establish a community Health Shura for each health facility. • Develop village visit timetables with Health Shuras for each MHT. • Provide essential medicines, medical and non-medical supplies and equipment for the MHT. • Establish referral system among the MHT and BPHS/ EPHS facilities. • Provide antenatal and postnatal care for the mothers. • Provide basic emergency obstetric and newborn care (EmONC) services. • Provide vaccination for the children and child bearing age women. • Provide family planning methods on request. • Provide treatment of children sickness especially ARI, pneumonia and diarrheal diseases. • Provide outpatient consultation and treatment of common diseases.

							• Maintain ambulance/referral services. • Coordinate with the stakeholders (Health cluster, PPHD, WHO, UNICEF, BARAN, Handicap, Community Shuras and Healthnet TPO). • Regularly supervise the performance and outputs of the MHTs. • Report the progress of works and health data on timely manner.
Kandahar -> Arghestan	31	2,802	2,928	3,855	3,722	13,307	Activity 1.1.1 : • MOUs will be signed with referral points (surgery, mental health, disability, GBV protection, supplementary feeding). • Six mobile health teams (MHT) will function on the passages were they can collect victims from conflict areas. • Referral points will be identified; written protocols will be signed to ensure efficient referral, quick response and feedback. • The MHT will be staffed and equipped according the standards, including access to ambulance. • Training on triage and first aid will be provided for the staff (8 days including 3 days first aid and 5 days triage for doctors, nurses and midwives). • Training on first aid will be provided for the drivers and guards (3 days training). • Training on psychosocial support will be provided for the nurses, midwives and physicians (5 days training). • Collect and stabilize victims from conflict areas. • Report and quickly respond to any suspected outbreak (DEWS). Activity 1.1.1 : • Admit and treat children aged 6 – 59 months with severe acute malnutrition (SAM) without medical complications in integrated mobile OTP. • Refer critically ill severely malnourished children with medical complications to a stabilization center. • Provide referral support for critically ill severely malnourished children with medical complications to the nearest stabilization center. • Admit and treat children aged 6 – 59 months with moderate acute malnutrition (MAM) in integrated mobile OTP. • Admit and treat pregnant and lactating women with acute malnutrition in integrated mobile OTP. • Conduct regular joint supervision of all supported OTP sites to ensure quality of service delivery. • Ensure uninterrupted supply of all the necessary food items, essential drugs and other supplies needed for the nutrition program. • Conduct community outreach and home visit especially for defaulters and children not meeting the target weight. • Conduct 2 rounds of de-worming campaigns targeting children aged 1-5 years to prevent micro nutrient deficiencies associated with intestinal worms. • Refer complicated cases to stabilization center by BPHS implementer and PHO. • Improve timely and accurate data collection and reporting. Activity 1.1.1 : • Select locations for the health facilities and routes of movement that are away from actual or potential threats; especially the risk or threat of gender based violence (GBV), attacks from armed groups and land mines • Orient the staff to treat the clients respectfully and inclusive of cultural and religious practices. • Respect confidentiality and privacy of clients during consultations. • Keep the identifiable information confidentiality unless consent has been given by the beneficiary. • Consult with displaced and host communities about health needs so as to avoid community tensions that could lead to violence and harassment of one group or another. • Employ female health staff members with skills

							and experience working with women and children. • Train the staff on how to respond to the specific needs of victims of grave human rights violations, including rape and physical abuse. • Assign qualified psychosocial workers to receive and counsel survivors of violations, especially when dealing with children and/or survivors of GBV. • Put in place guidelines and mechanisms for monitoring and reporting instances of abuse and exploitation. • Set up accessible, well understood mechanisms for suggestions and complaints. • Monitor access, discrimination, and whether any services are being diverted. • Strengthen coordination with Health Cluster at sub-national level to address GBV and child abuse as well. • Coordinate with Protection and People with Special Need (PSN) network (headed by UNHCR) in Kandahar. • Report and share protection concerns with the Protection cluster, including the GBV and Child Protection sub-clusters. Activity 1.1.2 : • Train healthcare givers on identification and management of GBV (5 days course for doctor, nurse, PSS counselor and midwife with support of Healthnet TPO). • Train the staff on PSS counseling and GBV (10 days training with support of Healthnet TPO). • Include female PSS counselor in mobile health teams and to conduct blanket PSS sessions with target communities in general, women and girls in particular. • Provide psychosocial counseling and health services to survivors as part of initial response. • Distribute Dignity Kits for the GBV survivors. • Work with pregnant to build strengths at the individual, relationship, and community levels that help them face and overcome trauma or adversity. • Coordinate with the Kandahar Protection Cluster to establish case management committees (CMCs). • Community mobilization through health committees that are established for each MHT. • Include GBV in various community sessions/awareness. • Coordinate with Family Protection Centre (FPC) in Kandahar City for referral and reporting. • Refer GBV survivors to the organization who can provide legal assistance and specialized medical care. • Follow up the referred survivors. Activity 1.1.2 : • Conduct IYCF counseling to women/caretakers of children in OTP during mobile team visits. • Establish and support 12 IYCF mother support groups targeting mothers of children under 2 years. • Conduct refresher training on IYCF to the health staff of the MHTs • Distribute micronutrient supplement for under 5 year children, and lactating and pregnant women. • Improve timely and accurate data collection and reporting of nutrition data from all sites through provision of data collection tools and training of nutrition staff on data management. Activity 1.1.2 : • Employ necessary staff for the six mobile health teams (MHT) • Hire vehicles for the mobile health teams (MHT). • Provide necessary equipment for the MHT. • Establish a community Health Shura for each health facility. • Develop village visit timetables with Health Shuras for each MHT. • Provide essential medicines, medical and non-medical supplies and equipment for the MHT. • Establish referral system among the MHT and BPHS/ EPHS facilities.

							• Provide antenatal and postnatal care for the mothers. • Provide basic emergency obstetric and newborn care (EmONC) services. • Provide vaccination for the children and child bearing age women. • Provide family planning methods on request. • Provide treatment of children sickness especially ARI, pneumonia and diarrheal diseases. • Provide outpatient consultation and treatment of common diseases. • Maintain ambulance/referral services. • Coordinate with the stakeholders (Health cluster, PPHD, WHO, UNICEF, BARAN, Handicap, Community Shuras and Healthnet TPO). • Regularly supervise the performance and outputs of the MHTs. • Report the progress of works and health data on timely manner.

Documents

Category Name	Document Description
Project Supporting Documents	AHDS Endorsement Letter by APC.pdf
Project Supporting Documents	AHDS LFA approval by HC.pdf
Project Supporting Documents	AHDS Endorsement Letter by NC.pdf
Project Supporting Documents	AHDS Em Rapid Assessment.pdf
Budget Documents	CHF-2AHDS budget and all BoQOctober3.xlsx
Budget Documents	NTA - AHDS Scale.xlsx
Grant Agreement	AHDS - 6817 - GA - Signed by HC.pdf
Grant Agreement	AHDS - 6817 - GA - Signed by HC and IP.pdf