OCHA Coordination Saves Lives

Project Proposal

Requesting Organization :	Action Contre la Faim
Allocation Type :	2017 2nd Standard Allocation

Primary Cluster	Sub Cluster	Percentage
NUTRITION		20.00
PROTECTION	Gender Based Violence	13.00
FOOD SECURITY AND AGRICULTURE		19.00
WATER, SANITATION AND HYGIENE		23.00
COORDINATION AND COMMON SERVICES		25.00
		100

Project Title :	Integrated Emergency Response to Conflict Affected Internally Displaced People (IDPs) and Host communities in Lashkargah District, Helmand province, with multi-sectoral and coverage assessments in hard to reach provinces in Afghanistan
Allocation Type Category :	

OPS Details

Project Code :		**Fund Project Code :**	AFG-17/3481/SA2/N-APC-FSAC-WASH-CCS/INGO/6749
Cluster :		**Project Budget in US$:**	1,619,973.93
Planned project duration :	12 months	**Priority:**	
Planned Start Date :	01/11/2017	**Planned End Date :**	31/10/2018
Actual Start Date:	01/11/2017	**Actual End Date:**	31/10/2018

Project Summary :	In line with the HRP 2017 and the 2nd allocation strategic priorities, ACF proposes to launch an intervention targeting the most vulnerable IDPs, host communities and institutions in improving access to services and timely humanitarian response in Lashkargah district, Helmand. ACF aims also to enhance coordinated needs assessments in Afghanistan through integrated multi sectoral assessments in the hard to reach provinces of Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul. The first part of the proposed action is an integrated WASH, Nutrition, Health, FS and MHCP approach aimed at addressing the underlying cause of child deaths in the area (diarrheal diseases, treatment of acute malnutrition). The overall objective and approach envisioned both fits in ACF mission strategy, which is geared towards reducing morbidity and mortality amongst U5 children, and support integrated programming. The focus on WASH, Nutrition, FS and Protection in addition to aligning with national humanitarian priorities, corresponds to ACF fields of expertise. ACF is internationally recognized for its technical know-how and field experience in successfully implementing integrated projects with specific expertise on Nutrition, WASH, MHCP and FS. In country, ACF is one of the leading members of the WASH and Nutrition Clusters. In addressing malnutrition ACF directly implement IMAM activities. Two mobile teams will be deployed covering 14 sites, conduct screening of U5 children, and treat SAM children. More over the mobile team activity includes treating of MAM children, IMNCI and Acute Malnourished PLW. The teams will also provide health education, IYCF messages and psychosocial counseling to mothers and caretakers. To increase access to safe drinking water, ACF will work in both IDPs, institutions and host communities for the construction of new water points or the rehabilitation of the existing boreholes. ACF will also distribute BioSand Filters to the HH settled in areas to safe drinking water with reported case of diarrhea and the water quality is poor / not respecting the minimum quality standards. ACF will distributed hygiene kits for women and girls reflecting mainstreamed protection principles where distributions are sensitized to minimize risks of GBV. With the ongoing conflict in Helmand, many people including children are displaced and have settled in the provincial capital Lashkargah and as a result, many schools are overcrowded. The children are at risk of contracting diarrhea diseases due to poor hygiene and sanitation. For maximum impact on reducing the incidence of diarrheal diseases, the project will also work towards sustainable positive behavior changes in care practices related to personal hygiene with a strong focus on hand-washing with soap. ACF will use various “dissemination stations”, as many entry points for transmission of knowledge on optimal hygiene practices, in a bid to reach out to the largest population. Community leaders will be actively involved in the process to act as “education stations” to support durable behavior change. These dissemination stations will also be utilized as distribution points for GBV messages to generate awareness and link to available community services. The proposed intervention seeks to provide FS survival assistance through unconditional cash distribution to food insecure prolonged IDP HH affected by conflict disaster enduring prolonged periods of displacement (6 months to 2 years) and with it, enhanced vulnerability. The cash distribution will be based on guideline on FSAC cluster food basket and the FSAC Cluster HRP guidance. The 2nd part of the project aims to support the Clusters and BPHS IPs in addressing current humanitarian data gaps and making informed strategic programming decisions. It shall be done through the conduction of 8 multi-sectoral assessments (SMART – Nutrition, Health, FSL and WASH), 2 Rapid SMART and 2 SQUEAC in the targeted provinces.

Direct beneficiaries :

Men	Women	Boys	Girls	Total
5,474	5,017	17,030	20,360	47,881

Other Beneficiaries :

Beneficiary name	Men	Women	Boys	Girls	Total
Host Communities	4,198	4,045	14,479	17,861	40,583
Internally Displaced People	1,050	900	2,551	2,499	7,000
Other	226	72	0	0	298

Indirect Beneficiaries :

Population living in villages adjacent to the targeted villages will benefit from the nutrition, WASH and MHCP activities through transmission of information on the IYCF messages and hygiene messages from their peers. The food security and livelihood activities indirectly benefits/contributes to the economy of the local food suppliers and traders. The project will also support indirectly local Hawala suppliers, as they will be contracted by ACF for cash distribution. Moreover, the beneficiaries might share the assistance with their relatives.
The children under five and pregnant and lactating women screened during integrated SMART, Rapid SMART surveys or SQUEAC assessments will benefit indirectly from the project. Local health authorities will benefit from accurate and updated data to support an effective and consistent allocation of resources and programming.
Local government authorities will indirectly benefit from the intervention in gaining evidence-based understanding of the nutrition, health, WASH and food security situation of their provinces. Other partners operating in the areas will also have access to the results of these surveys and evaluations and benefit from the availability of multi-secretarial data, even if not working in the field of nutrition or health.
ACF estimates that about 2,000 individuals living in villages near the targeted villages in Helmand will benefit indirectly from the construction of WASH facilities, protection and nutrition services. In addition, vulnerable households with extended families will also benefit indirectly from the cash assistance by sharing the cash or the food purchased through the cash assistance delivered.

Catchment Population:

The catchment population of this project will be IDPs (recently less than six months), protracted IDPs (more than six months and less than 2 years) and host communities. In addition some of the population in the catchment area will benefits form water points rehabilitation/constructed where ever their water sources are not functional.
The catchment population of the project will also depend on the catchment population of the targeted districts for the SMART and SQUEAC surveys, and of the zones where the Rapid SMARTs will be conducted. The coverage of the surveys/assessment, and actual catchment population will be defined for each province at the beginning of the assessment, depending on the number of districts covered. The intended planned catchment population for a SMART and SQUEAC can be considered to be the entire population living in a selected province, while for a Rapid SMART it will be the entire population living in the selected zone where the assessment is conducted.

Link with allocation strategy :

The proposed project aligns with the 2017 humanitarian response plan strategic objective #1, #2, #3 and #4 life-saving activities in underserved and hard to reach areas where there are severe needs" through provision of integrated Nutrition, WASH, Food Security and Protection interventions mainstreaming protection across the sectors, and assessments in hard to reach provinces. The first part of the project will be in Lashkargah, the capital of Helmand Province and has been identified as one of the hard to reach areas in Afghanistan. The project is strategically focused in Lashkargah district because most IDPs and returnees continue to come in due to the ongoing conflict in the various parts of the province. As for the second part, the assessments will be implemented in the provinces of Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul.
The project will more specifically address the nutrition cluster strategic objective 2, the incidence Acute Malnutrition reduced among boys, girls, pregnant and lactating women" through providing Integrated Management of Acute Malnutrition (IMAM) for children 6 to 59 months and pregnant and lactating women, then by implementing proactive strategies at mobile clinic and at community level with promotion on the 1000 days (including Infant and Young Child Feeding - IYCF) and micronutrient supplementation, Integrated Management of new natal and child illness and core care practice. Integrated psychosocial team in Nutrition will also implement psychosocial counselling activity and reach Protection sectoral objectives namely mitigating risks through nutrition, health and psychosocial humanitarian intervention. The WASH interventions address the cluster strategic objective 1 and 2 through the provision of safe drinking water to water-stressed communities and institutions (schools and Health facilities) and coordinated efforts to improve hygiene and sanitation practices in communities and schools.
The food security intervention addresses the cluster strategic objective 2 ensure continued and regular access to food during lean season for severely food insecure refugees and prolonged IDPs through provision of cash assistance to meet their immediate food needs. The protection intervention designed according to sectors specific protection actions addresses protection cluster strategic objective 2 evolving protection concerns, needs and violations are monitored, analyzed, and responded to upholding fundamental rights and restoring the dignity and well-being of vulnerable shock affected populations. And 3, Support the creation of a protection-conductive environment to prevent and mitigate protection risks, as well facilitate an effective response to protection violations through mainstreamed and integrated protection activities throughout Nutrition/Health, FSL and WASH.
The assessment activities will address the first objective of the Enabling Action envelope, "Strengthen humanitarian actor's response through the coordinated multi-sector assessments to inform humanitarian programming, strategic decision-making and improve understanding of critical humanitarian needs".

Sub-Grants to Implementing Partners :

Partner Name	Partner Type	Budget in US$
AADA	National NGO	40,279.00
ORCD/MRRCA	National NGO	20,139.50
PUI	International NGO	20,139.50
Cordaid/AHDS	National NGO	35,686.00
OHPM	National NGO	40,279.00
ORCD	National NGO	35,686.00
		192,209.00

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

Other Funding Source	Other Funding Amount

Organization focal point :

Name	Title	Email	Phone
Kinga KOMOROWSKA	Country Director	cd@af.missions-acf.org	0799566128
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BACKGROUND

1. Humanitarian context analysis

In Afghanistan, almost one third of the population (9.3 million people) are in need of humanitarian assistance, a 13% increase from last year. Access remains a concern for humanitarian organizations, in some part of the country such as Faryab or Paktika, no humanitarian assessments have been able to take place. Moreover, according to 2017 HRP and HNO rates of infant and maternal mortality remain among the highest in the world at 73/1000 live births and 327/100,000 live births respectively and severe acute malnutrition (SAM) has breached emergency thresholds in 20 of 34 provinces. About 1.8 million people require treatment for acute malnutrition.
Displacement due to conflict continued in 2017, with 68,370 IDPs in the first quarter. A rising insurgency and increased insecurity are exacerbating existing humanitarian needs while simultaneously generating new ones. The number of IDPs located in hard-to-reach areas has continued to grow, today constituting 23% (15,730) of the newly displaced caseload in 2017 (OCHA 2017). More than 50% of those displaced are reported to be children who face particular risk of abuse and exploitation as well as interrupted school attendance and harmful child labour, requiring targeted protective services in response. In addition to being left bereft of their assets and belongings, populations affected by conflict are also exposed to multiple forms of gender based violence, including early and forced marriage, domestic and psychological and sexual abuse, affecting displaced and host communities alike.

The new IDPs in the Southern region account for more than 40% (27,700) of the overall total so far in 2017. Located in the southern region of Afghanistan, at the border with Pakistan, Helmand province is characterized by harsh geological conditions (arid zone), and high levels of insecurity. Owing to poor natural resources endowment, widespread insecurity and low access to services, Helmand is a very high priority province in the HRP 2017. Women are twice as likely to die giving birth in Helmand compared to the national average – already the third highest in the world (HRP 2017). Integrated (IPC): Based on IPC analysis of 2016, this province has fallen in phase 3 (crises) of IPC.

According to SFSA 2017, 30% of Helmand population have poor or borderline food consumption, and based on combined rCSI and FCS, Helmand has 32% severely or moderately food insecure population, furthermore Helmand is the province with the higher share of food expenditure (52%). According to the livelihood coping strategies, Helmand is the third province with higher number of household using crises or emergency strategies, about 15% of households are using crisis strategies and 32% are using emergency strategies.

Despite acute needs, the humanitarian presence in Helmand remains limited: according to 2017 HRP, Helmand is one of the less supported provinces in terms of humanitarian actors - when compared to the population in need. The report indicated Helmand as one of the four provinces with high risk of rapid displacement, or urban center failure, representing that province has high risk for fall of a district or provincial center causing mass displacement. The same report also indicated that Helmand has the highest number of IDP displaced in hard-to-reach areas. In this highly contested province, only few humanitarian organizations have succeeded to establish and to deliver assistance. Beyond Lashkargah city and surrounding districts, humanitarian access remains very limited; which severely undermines the capacity of actors to reach out to the most vulnerable. Compounded with insecurity-induced restrictions on population freedom of movement, this limited outreach of humanitarian assistance has left a large proportion of the population in a situation of despair.

2. Needs assessment

Helmand is characterized by protracted conflict that has been stemming the displacement of population from their homeland, loss of assets and death. Influx of IDPs in Lashkargah created pressure on the water, health/nutrition and education services. ACF SQUEAC survey (March 2017) confirmed high demand of nutrition/health service in the district, overall coverage of 35.6% (24% to 49.3%) using single coverage estimate which was below the SPHERE thresholds for rural areas (>50% and >70% urban). It means that more than 50% of SAM cases are not able to access OPD-SAM treatment services. Even though ACF has supported the HF staffs in training to improve the quality of service, influx of IDPs over stretched the HF that need additional staffs and supplies. Some barriers that contributed for low coverage were: long waiting in HF, travelling long distance walk to HF, lack of CHW attached to the areas, and a strict culture preventing some women from being able to go to HF without Mahram. A Rapid SMART (Aug. 2016) disclosed combined GAM and SAM prevalence at 24.9% and 7.4%. On the current CHF project maternal nutrition status of reproductive age with MUAC <230 mm was at 28.4%. The number of admission during the mobile clinic activities confirmed high prevalence of SAM in the area. Access to safe and clean water and general hygiene conditions is very low (ACF WASH needs Assessment in Lashkar Gah June 2017). The main drinking water sources are unprotected open well, river and springs; most wells are non-functional. 75% of the women are using old clothes, none are using sanitary pad and most of them are washing hand with only water during menstruation. Moreover, ACF KAP survey (Sept. 2016) discloses that 61.6% U5 children were affected by diarrhoea within two weeks of the interview and highlights that only 50% of HH know how to prevent it. Poor hygiene practices and lack of hygiene knowledge have been observed, 23% of open defecation, only 65.9% of surveyed people are washing their hand after using the toilet and only 34.5% are using soap and water for hand washing.
ACF WASH survey conducted in schools of Lashkargah (May 2017) indicated that WASH facilities are in poor status and are not sufficient for current school population. In 12 schools surveyed 54% of boreholes are non-functional. The sanitation facilities in the school are pit latrines that are either full or not functional. ACF HEAT assessment (June-July 2017) assessed prolonged IDP HHs in Lashkargah district disclosed alarming food insecurity among them:
- 16% of the surveyed HH heads are females, 6% are 60 or above, 1% are under 18 yo. 4% are permanently disabled with limited or no capacity to work.
- 79% have incomes below the food basket identified by FSAC (Food basket cost of 2,100 Kcal/person/day is 6,147 AFN/90$).
- 80% are poor, 8% are borderline and 11% have acceptable FCS.
- Based on combined FCS and rCSI, 82% endure high levels of food deprivation, 8% experience medium levels and 10% experience low food deprivation, in general most of the HHs were effectively unable to satisfy their food needs.
- 92% have no food stock and 93% have contracted debts.
- 74% have confirmed difficulties of not having cash to buy food and other essentials. These HHs have used various livelihoods coping strategies (begging and daily labor).
- 99% do not intend to go back to their place of origin.
There is a lack of capacity and quality information to properly analyze the priorities and design humanitarian action to meet needs with proper allocation of scare resources in Afghanistan. Both HRP process and response to humanitarian emergencies are weakened by information gaps, lack of confidence in available data and divergent approaches to identify and categorize needs. This challenge is cross-cutting and contributes to the risk of misguiding policy- makers, donors and implementing partner decisions, increasing the probability of inappropriate or inefficient allocation of resour

3. Description Of Beneficiaries

The primary beneficiaries of this project are IDPs and Acute malnutrition beneficiaries under 5 and PLW with acute malnutrition admission criteria, from the 14 mobiles sites. Bracelets will be use to avoid double admission with the HFs. Every children U5 who needs IMNCI consultation will receive it at the mobile clinics. 3,000 mothers with children U5 will be trained on how to measure the MUAC of their children. CHW and FHAG will be trained on 1000 days messages and how to measure the MUAC and edema. Mother with children U2 will benefit from cooking demonstrations, and all caretakers at mobile clinics will benefit of education session on the 1000 days. The targeted beneficiaries of the project are living in the semi-urban area of Lashkargah with limited access to safe and clean water and poor hygiene conditions. 36,564 individuals will benefit from the WASH activities. They will be from the most vulnerable IDPs, host communities and institutions in Lashkargah district of Helmand province.
Direct beneficiaries for cash intervention will be food insecure prolonged IDP households in Lashkargah city of Helmand province affected by conflict disaster enduring prolonged periods of displacement (6 months to 2 years) and mostly recorded by ACF as part of its Emergency Response Mechanism project, which it implements in Helmand province.
To ensure that the most vulnerable households within the protracted IDP population are prioritized and reached by this assistance, ACF will develop a vulnerability scoring system to assign gradual weights based on the severity of each of these vulnerability criteria and their impact on the nutritional security of affected households. The pre identified criteria for selecting prolonged vulnerable IDP households for CBI is as followings:
1. Status (displaced for more than 6 months up to 2 years),
2. Size and composition of the family (large HHs with more than 8 members)
3. Female/disabled/headed HHs
4. HHs with no working age adults
5. Sources of income (no income or earning main income from either borrowing, casual unskilled non-construction labor, begging, casual construction labor, small business, or others non-specified jobs used as proxy indicator for poverty)
6. HHs with more than 2 children under 5 years old
7. HH with more than 1 pregnant woman
8. High rCSI of 18 or above scores/ or using more than one food base coping strategy
9. HHs with poor food consumption score
10. HHs living in shelter with mud walls and tarpaulin roof, or households living in tents
Direct beneficiaries of the assessment intervention will be the Clusters (Nutrition, WASH, FSAC and Health), who will benefit from the availability of updated and quality data (all reports will be shared through the Clusters). BPHS, EPHS and NGO partner staff will also benefit from the project as they will be trained and capacitated on how to conduct integrated SMART surveys, Rapid SMART Assessments and SQUEAC.
For calculation of beneficiary figures, ACF used the standard team composition for a SMART: 25 persons per SMART survey, 24 persons for Rapid SMART and 25 per SQUEAC which is 298 in total. The teams will be trained by ACF technical staff on how to conduct SMART, Rapid SMART or SQUEAC.
ACF will highly recommend, where possible, to have female staff in the team, to reach women in the communities more easily, and ease the administration of questionnaires on infant and young child feeding practices. The actual number of women per SMART team is highly dependent on the context, and the capacity of partners to hire females having access to the field in difficult/insecure environments.
The total number of beneficiaries has been calculated to avoid double counting (see attachment), the following are included : 1,353 SAM U5, 2,706 MAM U5, 6,260 IMNCI, 25,381 beneficiaries of hygiene promotion in schools, 4,130 ind. (BSF distribution), 7,053 men and women from water access, 10% of FSL activities, 298 BPHS IP members trained.

4. Grant Request Justification

With the financial support of CHF, since 2014 ACF works to improve the assessment of the most vulnerable populations and evaluating the access and coverage of IMAM. In an effort to strengthen BPHS IPs capacities to ensure sustainability, all assessments are conducted in partnership with BPHS IPs or nutrition partners with ACF providing technical and financial support. ACF proposes a follow-up to the ongoing CHF grant to conduct additional integrated SMART, SQUEAC and Rapid surveys for emergency-affected populations, with a strong focus on IDPs, to continue addressing the information gap, enhance the information sharing and, training to BPHS partner staff in targeted provinces of Afghanistan.

The humanitarian needs in terms of WASH, nutrition, food security and mental health/protection in Lashkargah district are very high. The incoming of the new IDPs every time exerts pressure on the existing water sources that are easily damaged and needs rehabilitation. The influx of people leads to increase in waste generated at the HH level which contributed environmental pollution, source of infection, spread of diseases and death of children who are the most vulnerable under such situation. The health and nutrition service delivery by the BPHS partner at the HF is overstretched and lack of outreach services unable to meet essential daily needs including nutrition and overall health services of the increased IDP population. IDPs have lost their assets and livelihoods and lack of employment opportunity in Lashkargah makes them highly food insecure and leads to children to be malnourished.

ACF proposed lifesaving interventions provision of nutrition and health service by deploying two mobile clinics in the villages far from the HF and screening of U5 children, treatment of SAM children, MAM children and PLW those who meet the admission criteria. SAM children with complicated illness will be referred to Boost hospital for In-patient services. In addition, children with illness will be treated according to the disease diagnosed by doctors in the mobile teams. Health education and IYCF messages sessions to the mother and caretakers during screening with internal referral made by ACF psychosocial counselling team integrated with health and nutrition where necessary. Mothers will be trained on MUAC measurement for early detection of malnutrition in their home. WASH intervention activities included ensure access to safe and clean drinking water through construction/rehabilitating of water points, distribution of BSF, rehabilitation of latrines in schools and conducting of hygiene sessions, distribution of hygiene kits and setting up WSUCs.

The food security component of the proposed program seeks to provide emergency survival food security support for vulnerable prolonged IDP HHs affected by conflicts and displaced to Lashkargah city. These HHs were identified as extremely food insecure and ill prepared to face upcoming winter season and very likely to resort to negative or destructive coping strategies which could eventually affect their food security, malnutrition, morbidity and mortality status in longer term. ACF will identify the most vulnerable protracted IDPs through HEAT assessment tool, using the above-mentioned vulnerability criteria (see Description of Beneficiaries).

Since 2015, ACF has physical presence and acceptance in proposed intervention areas (Lashkargah) with fully functional base, expatriates, and project and support staff. ACF is currently implementing different emergency projects (WASH, Nutrition, CBI and MHCP) funded by Global Alliance Canada, CHF and ECHO. ACF brought a technical expertise, recognized internationally, that none of the NGOs possessed there. ACF positioning in priority sectors, without overlapping with present actors, helped leveraging great support from partners on the ground. Therefore, ACF is best placed to implement an appropriate and efficient response to the current emergency needs.

5. Complementarity

The project will complement with the ongoing CHF funded integrated nutrition and WASH project which targeted the prolonged IDP households in Mukhtar camp through rehabilitation of water points, construction of sanitation pit, hygiene promotion sessions, distribution of hygiene kit and Bio Sand Filter in village where the main water source is river or unprotected water points. This project will end in September 2017.

The proposed action will complement with the ongoing ACFs Global Alliance Canada (GAC) funded integrated WASH and nutrition project which is implemented in south and eastern villages at the outskirt of Lashkargah town supporting IDPs and host communities, through construction /rehabilitation water points, hygiene promotion and treatment of Severe Acute Malnourished children and health education and direct SAM treatment and IMCI by mobile clinic. Having the proposed project will improve the coverage of wash service to areas that are not covered by ongoing project mainly in the part of Mukhtar IDP camp and western part of Lashkargah city.

Additionally the project will complement and create synergy with ongoing Emergency Response Mechanism project funded by ECHO that addresses the immediate food and non-food items needs of the households displaced by ongoing conflict in less than six month period. During ERM screening U5 children and PLW are secerned and referred to IMAM services.

Moreover, the project complements CHF supported food security project that meets the food need of prolonged IDPs through the cash assistance by reaching more prolonged IDPs that were not assisted by the ongoing project.

The project will complement two CHF funded projects, conducted in other provinces to enhance coordinated humanitarian assessments, data quality, sharing and utilization for humanitarian response planning in Afghanistan. It will also be complementary with the WHO and UNICEF established National Nutrition Surveillance System along with community-based sentinel sites, mass screenings, admission data from feeding centers, data from health clinics, and repeated anthropocentric surveys (SMART) are one of the (possible) components of a national nutrition surveillance system. Provided that they are conducted on a regular basis, and respect high quality standards, SMART surveys feed national nutrition surveillance systems through the production of population-representative estimates of prevalence of under-nutrition. In early 2014, UNICEF, WHO and PND, with the financial support of Global Affairs Canada, launched a National Nutrition Surveillance System (NNSS). While still being refined by partners, the methodology retained for the NNSS builds upon health facility and community based data, serving as early warning to be complemented by other information systems, including population-based nutrition surveys. Thanks to the comparison of data, ACF's integrated SMART surveys conducted under this CHF project will help the NNSS to reach the most accurate estimation of levels of malnutrition across the country. To ensure complementary, ACF Nutrition Surveillance manager will be actively coordinating with NNSS stakeholders to participate in NNSS meetings, and provide technical support when and where needed.

LOGICAL FRAMEWORK

Overall project objective

To contribute to the reduction of child morbidity and mortality associated with under nutrition among U5 children and PLW through integrated WASH, Nutrition, Protection and Food security interventions in Lashkargah district and to strengthen coordinated needs assessments as well as the capacity of nutrition stakeholders to conduct multi-sectoral assessments in hard to reach provinces of Afghanistan

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 project contributes to the cluster objectives by first providing Integrated Management of Acute Malnutrition (IMAM) for children 6 to 59 months and pregnant and lactating women, then by implementing proactive strategies at mobile clinic and at community level with promotion on the 1000 days (including Infant and Young Child Feeding - IYCF) and micronutrient supplementation and cooking presentation.
Due to the conflict, many people are displaced from unreached area. The health facilities are overcrowded and many children coming from unreached area do not benefit from treatment. The mobile clinics will go in different sites and treat children not reached by Health Facilities treatment. The main objective of this project will be to dispense Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) treatment services to children and pregnant and lactating women. The second important component will be on prevention through different activities by diffusing IYCF messages to the lactating mothers and pregnant women focusing on 1,000 days at mobile clinics and at community level by promoters, Community Health Workers (CHW), Family Health Action Group (FHAG) and also through radio.
ACF is currently leading the ERM assessments in Helmand province within the ECHO-funded ERM consortium as well as within the wider framework of the Joint Assessment Team responding to internal displacement caused by conflicts and/or natural disasters. These data will inform ACF mode of intervention (direct or referral), as well as community mobilization strategy within the communities where these IDPs are seeking refuge.
ACF supports an average of 300 SAM children per week through mobile clinics (with CHF found) and currently facilitates Health Facilities (with Global Affairs Canada fund) through technical support including core care practices and technical reflection of implications of Gender Based Violence (GBV) on mother's capacity to provide self-care and care for children including early detection of malnutrition. However, the ongoing CHF project will end in September 2017 but the IDP influx remains significant and health facilities are already overcrowded. Needs are therefore increasing.
Thus, the aim is to continue the activities of 2 mobile clinics providing services in minimum 14 sites in Mukhtar camp and outside of the camp, in sites far from health facilities, where there are needs. The 14 sites selected by ACF for the mobile clinic activities are : Farahian, Haji Noor, Haji Ghafoor, Haji Agha, Haji Amanullah, Mir Wali, Majeed Khan, Haji Nadar, Haji Baqi, Haji Abdula aka, Haji Akhtar, Mohammad Village, Karam Khan, Haji Abdullah jan and Haji Abdul mohammad. Due to security reasons or if ACF receives a request from the DoPH then some changes could be done accordingly. ACF will adapt to the needs during the project.
ACF aims to improve the care quality for children under 5 in health and care of acute malnutrition with IMCI consultation, SAM treatment for children under 5 and include MAM and PLW with acute malnutrition. According to the SQUEAC done in March 2017, one of the major barriers to access is the absence of Mahram to accompany women, as well as distance, and no MAM and PLW treatment services at mobile clinics.
Besides providing life-saving services to malnourished children, these mobile teams will be used by ACF as a pilot program to support advocacy towards national nutrition and health stakeholders for access and coverage of expansion of nutrition services. The same evidence based advocacy will be built into the proposed intervention with regards to human resources, and the need to increase BPHS staffing.

Outcome 1

Improved quality of care and gender sensitized access to IYCF, health and IMAM services for prevention and treatment of acute malnutrition, increased acceptance of new care practices in Lashkargah district

Output 1.1

Description

Improved quality of care and gender sensitized access to IYCF, IMNCI and IMAM services for prevention and treatment of acute malnutrition, and increased acceptance of new care practices in Lashkargah district

Assumptions & Risks

Political situation in the country and the region allows ACF to implement its program
Security remains manageable enough for project implementation
No force major natural disasters and disease outbreaks during the project implementation
No major economic crises
No major fluctuation in the exchange rate
Resources are available in the country or can be relatively easily imported
Community members are willing to participate and remain involved
Relevant national and local authorities approve and support the project implementation
Targeted communities understand the mandate of ACF, accept their presence on the area, and actively participate in the project
Relevant authorities (government and non-government) accept their presence on the area, and actively participate in the project

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	NUTRITION	SA2- Number and proportion of severely acutely malnourished boys and girls 6-59 months admitted for treatment			487	866	1,353
Means of Verification : Statistic report form, monthly activity progress report							
Indicator 1.1.10	NUTRITION	Number of caretakers or pregnant women who attend an IYCF, care practice session at the mobile clinic					4,230
Means of Verification : Mobile clinic register, monthly activity progress report. In the number of females some of them can be girls who are with their sibling. 4,230 females							

Indicator 1.1.11	NUTRITION	Number of cooking demonstrations conducted including follow up discussion sessions					100
Means of Verification : Promoters report Activity progress report							
Indicator 1.1.12	PROTECTION	Percentage of activities reflecting integration between ACF sectors on this program					100
Means of Verification : Activity progress report All activities (100%) under Nutrition, FSL and WASH are integrated with MHCP through different strategies; either with integrated flying officer from the MHCP department in each sector to ensure that WASH, FSL and Nutrition objectives are fulfilled because there is qualitative attention to a minimum mitigate access risks for women and girls with regards these services.							
Indicator 1.1.2	NUTRITION	SA2- Number and proportion of moderately acutely malnourished boys and girls 6-59 months admitted for treatment			1,218	1,488	2,706
Means of Verification : Statistic report form, Monthly activity progress report							
Indicator 1.1.3	NUTRITION	Number of new IMCI consultation conducted					6,260
Means of Verification : Mobile clinic register, monthly activity progress report							
Indicator 1.1.4	NUTRITION	SA2- Number of acutely malnourished pregnant and lactating women admitted for treatment		1,270			1,270
Means of Verification : Mobile clinic register, monthly activity progress report							
Indicator 1.1.5	NUTRITION	SA2- Number of boys and girls aged 0-59 months discharged cured from management of severe acute malnutrition programmes			365	650	1,015
Means of Verification : Statistic report form, monthly activity progress report							
Indicator 1.1.6	NUTRITION	SA2- Number of boys and girls aged 6-59 months discharged cured from management of moderate acute malnutrition programmes			914	1,116	2,030
Means of Verification : Statistic report form, Monthly activity progress report							
Indicator 1.1.7	PROTECTION	SA2- Number of GBV survivors receiving protection services (including health, psychosocial, legal and safety)		120		120	240
Means of Verification : ACF activity Reports, referrals to ACF psychosocial counselling team, psychosocial BNF database and reports							
Indicator 1.1.8	PROTECTION	Percentage of Nutrition beneficiaries assessed on mental heath and care practices					50
Means of Verification : Statistic report form, Monthly MHCP register, monthly activity progress report 50% of nutrition beneficiaries are estimated to be reached under this indicator based on current statistics available from ongoing integrated Nutrition and MHCP activities in Helmand. At present with 2 staff integrated within Nutrition following mobilization period are able to reach 20% of beneficiaries under assessment. With increased numbers of MHCP staff and developed experience, 50% reach is anticipated.							
Indicator 1.1.9	NUTRITION	Number of mother trained on measurement of MUAC and edema					3,000
Means of Verification : Attendance sheet of training; training assessment							

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.

Screening, referral and treatment of SAM and MAM children and malnourished PLW through mobile clinics integrated with psychosocial support and care practices

ACF will directly implement mobile nutrition services in IDP Mukhtar settlement and in other villages outside the camp, composed of one supervisor (medical doctor), two certified Nurses/midwifes, 2 measurers/screeners, 1 for health education and 1 psychosocial officer with the aim of (i) conducting passive case finding of SAM-MAM children (in support to CHWs that ACF will train and supervise), and (ii) delivering SAM, MAM and acute malnutrition PLW treatment at community level integrating psychosocial support and care practices to account for the many barriers including potential social norms acting as barriers (e.g. Mother's in law not supporting exclusive breastfeeding sessions) to accessing such services identified in Helmand.
Mother's in law have been consistently identified during Helmand based GBV workshop and Ghor based Gender Analysis lead by ACF Gender/GBV expert to be consistent triggers in GBV at home level.
Acute malnourished children with medical complications and/or poor appetite who require intensive care it will be referred to an inpatient facility and receive follow up treatment at mobile clinics.

During the consultation child measurement, appetite test, medical consultation, postnatal depression assessment (where needed), assessment of understanding of care practices (where needed), observation of mother-child relationship, distribution of medical and nutritional treatment in line with the national guideline, and referred to any psychoeducation or counselling groups where needed. ACF will be entirely accountable for the performance of this team, and report on the number of children screened, admitted, and OTP and basic general and psychosocial health performance indicators (i.e. number of medical consultations, psychosocial assessments, GBV referrals, cured rate, defaulter rate, progression in care practices, and death rate).

Activity 1.1.2

Standard Activity : Not Selected

Integrated IMNCI services for children through mobile clinics

The mobile teams will also provide medical treatment for children affected by common and basic illnesses who do not need to be referred to an inpatient facility, and engage the local partner in order to facilitate the referral of children needing admission in therapeutic feeding units or pediatric wards. From the actual project in Helmand, an average of 2 consultations per child per year will be done.

Activity 1.1.3

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.

IYCF message given through mobile clinics

The current majority of admissions into nutrition programs are children aged 2 years or less. There is a gap on the successful dissemination of key messages on the 1,000 days (7 ENA, including IYCF). ACF integrated programming will strengthen the methodology for dissemination through more participatory and psychosocial methods and the purposive targeting of key groups including husbands, fathers and mothers-in-law as a mitigation strategy against GBV at household level where otherwise the mother trained would be entirely responsible for transferring knowledge to the household and sustaining IYCF related household behavior change. These messages will be delivered during specialized psychoeducation sessions on care practices during mobile clinic activity.
The messages will include topics on maternal and personal health care, infant and young child feeding including exclusive breastfeeding, and health care complemented with corresponding topics on mother self-care (using this specific module as a means of distribution on GBV awareness), mother-child attachment, balance food preparation and person and home hygiene. A system of messages, building on previous sessions, will be organized every week targeting all caretakers accessible including those with the child independent form IMCI consultation or nutrition program.
Addressing the Mental Health Gap in education and training from a global mental health and psychosocial services (MHPSS) perspective, during follow up, if the mother requests or indicates further supports/training is needed. Or if integrated Health, Nutrition and Psychosocial team identify additional or ongoing need, further appropriate support by specialized education will be provided. Where the ongoing need or additional need is rapidly contributing to infant's reduced or stagnant weight, the infant will be referred to the therapeutic feeding unit at the hospital immediately, while the mother is supported.

Activity 1.1.4

Standard Activity : Not Selected

Implementation of integrated programming

Mental Health and Care Practices (MHCP) department will conduct coordinated implementation of integrated programming with psychosocial and care practices components and conduct trainings and program design support for any implementing actor on psychosocial counselling services including the support for integrated psychosocial officer in Water, Sanitation and Hygiene (WASH), Emergency, Monitoring, Evaluation, Accountability and Learning (MEAL) and Food Security and Livelihood (FSL) departments.

Activity 1.1.5

Standard Activity : Not Selected

Conducting psychosocial education and/or counselling sessions

Workshops employing adult education models will roll out staged modules on psychosocial and care practices, and protection to local partners and/or coordinated agencies operating in the area. To maximize learning and development for participants, numbers of participants per workshop will be capped at 20 participants per group, with a ratio of 2 trainers to 20 participants.
To support the move of the theoretical training content to practical application at field level, ACF master trainers will also train all APA managers in a two-day orientation training on the core components partner, coordinated and ACF staff are inducted on. On-the-job mentoring and support for facilities and healthcare providers who have received training will then be implemented. Each facility where the partner is providing psychosocial counselling that has been trained will be visited at least twice for comprehensive post-training follow-up, mentoring and on-the-job training during the project. Following post training visits and midline project evaluation (as part of a broader monitoring, evaluation, learning and accountability plan), ACF master trainers will also organize refresher trainings for a percentage of trained staff targeting those who receive the lowest marks during post-training visits across the two provinces.

In addition, where cases of GBV are identified, a response team integrated within the Health team made up of psychosocial counselling staff managed by the psychosocial coordinating officer will provide group and individual counselling at field level securely with best practice responses including 1) warmth and acceptance, 2) emotional and practical support within a safe environment, 3) technical understanding of psychological impact of GBV, 4) validation on all reactions – no reaction is wrong or maladaptive, 5) believing the story, 6) confidentiality, 7) technical support on medical and legal supports, and 5) control over their process and choice. This team will also link with advocacy and accompaniment to clinics, police, court, referral to other agencies and finally coordination with those agencies and partners completing workshops with ACF (this coordination list is not limited to these actors and may include any actors under the World Health Organization/ Ministry of Public Health (WHO/MoPH) upcoming capacity building of Health Facility staff on GBV).

GBV is defined here as violence that involves men, women, boys and girls where the violence is perpetrated because the target belongs to the gender group e.g. she is beaten because she is a woman, or the violence affects a particular gender groups disproportionately e.g. during a conflict, victim ratio is 20:80 men to women. WHO Classifications of GBV include Rape, Sexual assault, Physical assault, Forced marriage, Denial of resources, and/or Psychological/emotional abuse.

Activity 1.1.6

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.

7 Essential Nutrition Actions (ENA) are given by promoters through the community HH by HH (house to house approach)

1000 days (including IYCF messages), Nutrition cluster and PND are working towards harmonization of approaches to IYCF promotion. While ENA is one of the recommended approaches, it would be worthwhile to highlight that ENA will be implemented in harmony with national IYCF strategy (work in progress) and counseling package and not in parallel.
ACF recognizes a cultural barrier significant in limiting humanitarian access to the majority of primary care givers; female members of the household whole household role includes the responsibility for children (ACF Gender Analysis 2017) who often cannot leave their homes without permission from the head of the family – husband, father/father in law or at times mother in law. The transmission of the 1000 days message and how it can contribute to reducing emergency needs by the use of door-to-door promoters. The promoters will be females to transmit messages to the females at household (HH) level, further sensitizing information transmission, and will be technically trained on sensitivity and whole household engagement where possible by the integrated psychosocial officer within ACF Nutrition team. Community Health Workers and Family Health Action Groups are at the forefront of the MoPH community outreach strategy, and have a key role to play in the expansion of coverage of nutrition services. Acknowledging this, ACF will seek to enhance their capacity to conduct screening and referral (for Community Health Workers), and promotion of Essential Nutrition Actions (for Family Health Action Groups), as well as ensure active supervision/monitoring - seen as instrumental to boost their motivation and performance. While supporting Community Health Supervisors (CHS) to monitor CHWs and FHAGs, ACF will also get directly involved into supervising them.

As part of its integrated approach, ACF will also be working with CHWs and FHAGs, HF staff and community leaders on GBV, core care practices, hygiene education and WASH-related topics. The aim is to foster broader understanding of targeted child illnesses, and the linkages between the two (i.e. the vicious diarrhea-malnutrition cycle) and between care practices that can either exacerbate or mitigate targeted child illnesses. Community base nutrition program (CBNP) recently reviewed by the PND will be used to train the CHW and FHAG. Working through these actors, as well as community leaders, possess the advantages of strengthening (i) recognition of community members who are perceived as legitimate sources of knowledge and skill in passing on such key nutrition messages, (ii) adaptability of the messages to local circumstances and norms; linked with other activities above, community actors are in best position to tailor the messages to their specific audience ensuring messages are processed, understood and applied correctly at a fundamental level, and (iii) outreach through these different actors to facilitate ACF's humanitarian access to reach a larger percentage of the community than direct ACF to Community sensitization allows.

Activity 1.1.7

Standard Activity : Not Selected

Screening through Mother led MUAC strategy

Mothers with children under 5 years old will be trained on how to conduct the measurement of MUAC and edema as early detection signs of malnutrition. Training mothers on early warning signs of health issues has a strong evidence base, specifically for ACF and the successful sustainable treatment of malnutrition; the demand and coverage of the nutrition program increases. The rationale for ACF aiming to teach mothers how to perform MUAC is to achieve an early diagnosis of SAM, which if acted upon in a timely manner would decrease mortality and morbidity related to malnutrition, reduce program costs due to shorter treatment times, lower the proportion of children requiring expensive in-patient care for SAM with complications.
The aim is to keep the structure at community level, going through CHW and FHAG. They will be trained on the mother strategy and it will be the first step. Instead of the CHW go house to house doing screening (which in reality is not done), the mother will come to see the CHW and FHAG to receive confirmation of the diagnostic and if it is not the case to receive a refreshment on the MUAC and edema technique.
For the mothers, the training will focus on three key execution strategies (i) training of mothers through door to door visits by Family Hygiene Action Groups members and (ii) organized group training of mothers during mass community sensitization and demonstration exercises in the settlements for WASH and nutrition messages (e.g. cooking demonstrations) (iii) use of media to pass messages to maintain the regularity of the screening activities (radio spot messages and posters). In order to minimize false referrals by mothers ACF will establish a control mechanism where there will be a multi-step screening and identification of malnourished cases before admission to the nutrition program. The first step being the mother's screening of their own child, the second step if possible the mother will see the CHW or FHAG of the villages to confirm the detection and refer to the mobile clinic or HF and the third step is the verification of the child's MUAC and WHZ by a screener from the mobile team before admission to the program. The ability of mothers to assess the nutrition status of their children is also considered to have a positive deviance effect on the community's understanding and appreciation of the nutrition program. ACF expects that by mothers gaining knowledge on how to the nutrition status of their own children coupled with key sensitization on IYCF and proper hygiene they will understand better the importance of proper nutrition and diet as a measure of avoiding their children from being malnourished. This in effect will influence the mothers feeding practices and lead to adoption of better feeding practices and improved health seeing behavior.
At the mobile clinics and at the community a regular evaluation on the quality of MUAC screening will be done. If the quality screening done by the mother is low, a refreshment training will be done.

Activity 1.1.8

Standard Activity : Not Selected

Cooking demonstration for mothers/caregivers of children U2

More than 80% of admissions to OPD are between 6 and 24 months (ACF program in Lashkagah). As a measure of sustainable intervention in this area and to be able to effectively support the primary caregiver whose role is solely linked to malnutrition management at the household/family level, ACF will actively implement cooking demonstrations in coordination with the cooking demonstrations implemented by the BPHS, as recommended by the Public Nutrition Department (PND). Where possible, ACF will partner with the BPHS on a series of the same demonstration to ensure coherency and consistency in messaging. Cooking demonstrations will emphasize on the complementary feeding from 6 to 24 months following exclusive breastfeeding, thus reinforcing this core message also. It will demonstrate how to prepare a complementary feeding with available seasonal food on the market-using balanced diet recipes suited to the developmental stage of the child. More specifically, a number of cooking demonstrations will be conducted for mothers of children under 2 years old under MAM treatment during to their IMCI consultation. During the demonstration, psychosocial health education session will also be integrated. At the mobile clinic level, at each site, cooking demonstrations will be conducted once a month and purposive targeting will ensure that each caretaker supported under different components of this program in the program will benefit from the demonstration. The demonstration will be adapted to the seasonal food, covering the 4 seasons and the needs on micronutrient. All feedback will be incorporated into adapting the suitability of the cooking demonstrations to each target audience to build a sustainable environment to facilitate the targeted sustainable behavior changes and mitigate any GBV triggers as previously discussed potentially found in focusing all knowledge transfer on one mother per household without support mother in law.

Activity 1.1.9

Standard Activity : Not Selected

Radio messages

In link with the different activities addressed above, the team will organize radio broadcast. The different topics will address messages on detection and prevention of malnutrition.
They will include detection by MUAC, IYCF, maternal health, micronutrients, care practice messages.

Additional Targets :

PROTECTION

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Objective 3: Support the creation of a protection-conducive environment to prevent and mitigate protection risks, as well as facilitate an effective response to protection violations	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	50
Objective 2: Evolving protection concerns, needs and violations are monitored, analysed, and responded to upholding fundamental rights and restoring the dignity and well-being of vulnerable shock affected populations	SO4: Humanitarian conditions in hard-to-access areas of Afghanistan are improved	50

Contribution to Cluster/Sector Objectives : Helmand is in need of humanitarian actors for multi-sectoral, mainstreaming of AoRs protection activities, and integrated and mainstreamed protection and is one of the four provinces with high risk of rapid displacement, or urban centre failure, representing that province has high risk for fall of a district or provincial centre causing mass displacement with implicated multi sectoral vulnerabilities on WASH, Health, Nutrition and Protection – notably gender based violence (GBV). Helmand has got the highest number of IDPs in to hard-to-reach areas thus reflecting protection concerns on issues inhibiting health seeking behaviours, including but not limited to GBV risk exposure. In this highly contested province, only few humanitarian organizations have succeeded to establish and to deliver assistance. Beyond Lashkargah city and surrounding districts, humanitarian access remains very limited; which severely undermines the capacity of actors to reach out to the most vulnerable communities. Insecurity-induced restrictions on population's freedom of movement has limited outreach of humanitarian assistance has left a large proportion of the population in dire need in mainstreamed and integrated protection. The proposed project aligns with the allocation on the protection sector as the IDPs and returnees are faced with increased risks and vulnerabilities to multiple forms of GBV including violence against women, domestic violence, sexual abuse and forced marriage in early childhood. By mainstreaming activities, the profile of protection on GBV will be lowered and more succinctly and sustainably implemented, with operational processes ensuring the affected population can access effective and appropriate humanitarian assistance in safety and dignity, without experiencing discrimination or unintended harmful consequences. The proposed project also aligns with the 1st GBV key action for WASH to identify safety and security risks for women and girls relevant to WASH systems to ensure location, design and maintenance/follow up truly maximise safety and security of women and girls in addition to young boys. At a minimum women and girls will be facilitated to participate in integrated WASH and Protection committees for the purposes of assessment, design, implementation and follow up feedback utilising psychosocial support and communication strategies to accurately reflecting do no harm (in terms of psychosocial sensitivity) to identify determinants of GBV and social stigmas that once reflected in design will help reduce exposure to GBV and enable increased access to WASH services. Protection within WASH will specifically address special needs of girls and women in identified gender based violence through assessments and promote community accepted orientation on care practices. Integrated psychosocial team in Health and Nutrition will also implement psychosocial counselling activity and reach Protection sectoral objectives namely mitigating risks through health, nutrition and psychosocial humanitarian interventions. ACF through mobile currently facilitates HFs through technical support including core care practices and technical reflection of implications of GBV on mother's capacity to provide self-care and care for children including early detection of malnutrition. Mobile clinics provide services and improve the quality care for children U5 in health and care of acute malnutrition with IMCI consultation, SAM treatment for children U5 and treat PLW with acute malnutrition. All activities and all others are mainstreamed or integrated but anchored to Protection and relevant sectoral objectives as explicated below with all activities reflected in ACF's other LFAs for coherency, overall meeting SMART criteria through specific definitions, measurement techniques, with achievable timelines that are practically actionable, realistically attainable and grounded in past ACF community relationships.

Outcome 1

Mobile outreach and static protection services mainstreamed within multiple sectors are provided to women, men, girls and boys

Output 1.1

Description

Populations affected by conflict have improved access to response modalities that reduce risk of exposure to serious risk

Assumptions & Risks

Political stability in the country and in the province
Security remains stable enough for project implementation
No force major natural disasters and disease outbreaks during the project implementation
No major economic crises
No major fluctuation in the exchange rate
Resources are available in the country or can be relatively easily imported
Community members are willing to participate and remain involved
Relevant national and local authorities approve and support the project implementation

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	WATER, SANITATION AND HYGIENE	Number of men, women, boys and girls beneficiaries have access to safe and clean protected water sources free of E.Coli.					11,327
Means of Verification : Baseline and final KAP surveys ACF field monitoring reports ACF activities reports Water Quality analysis reports The integrated PSS officer will ensure that all gender groups are reached by integrating female protection strategies and child protection strategies as outlined in protection LFA. 3,624 men, 3,429 women, 2,509 boys and 1,765 girls.							
Indicator 1.1.2	WATER, SANITATION AND HYGIENE	SA2- Number of people in need with access to at least 15lpcd of drinking water	3,624	3,429	2,509	1,765	11,327
Means of Verification : Baseline and final KAP surveys ACF field monitoring reports including psychosocial inputs, ACF activities reports Water Quality analysis reports							
Indicator 1.1.3	WATER, SANITATION AND HYGIENE	Number of WSUCs established or re-activated in selected villages comprising of men and women					105
Means of Verification : ACF activities report							
Indicator 1.1.4	PROTECTION	SA2- Number of boys, girls, men and women receiving psychosocial support	100	550	388	550	1,588
Means of Verification : Assessment reports, ACF activities report, Psychosocial reports							
Indicator 1.1.5	WATER, SANITATION AND HYGIENE	Percentage of completed KAP surveys including gender and age disaggregation					100
Means of Verification : Questionnaire, trainings database and final reports							
Indicator 1.1.6	WATER, SANITATION AND HYGIENE	Number of women safely and correctly using the menstrual hygiene kits distributed					2,647
Means of Verification : ACF distribution Reports, KAP survey Reports, sensitization reports							
Indicator 1.1.7	WATER, SANITATION AND HYGIENE	Number of gender sensitized hygiene promotion sessions conducted					560
Means of Verification : ACF activity reports							
Activities **Activity 1.1.1**							
Standard Activity : SA2- 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 mainstreamed mobile outreach protection services There is a notable lack of research on the links between WASH and GBV, therefore, an ACF WASH KAP will also explore lack of access to WASH and increased vulnerability to physical violence, early marriages, access to education. The surveyors will mostly be women, facilitating women and children's participation will promote claimed rights on WASH access and mitigated GBV. Women's involvement and children's involvement in data provision and subsequent decision making based on this data is critical to their empowerment. Informed mobilisation of communities and the selection of sites linked to women and girls protection and dignity, ACF will ensure equal participation from different gender groups in the location, design and maintenance of WASH facilities to ensure women are not overburdened with these roles, facilitate different gender groups to identify the full scope of risky hygiene practices and their subsequent community appropriate mitigation, and advocate to ensure a gender balance in committees. Results of all committee findings including lessons learned and best practices will be member checked with Health Facility management staff, Schools directors, and community members. Water stressed site selections will be coordinated with Department of Women's Affairs which currently leads in different provinces on interventions for the reduction of GBV, we well as transparency and respect of local culture and norms. Training for schoolteachers, community leaders, Community Development Councils and health Workers will lead to increased outreach of health and hygiene promotion, as ACF will work with authorities to supervise, monitor and support aforementioned actors for sensitizing pupils/students and the community members on personal and environmental hygiene in both communities and schools. Supported by active supervision, provision of IEC material, and refresher/on-the-job training. Increasing the frequency of outreach of hygiene promotion sessions in schools and at community levels.							
Activity 1.1.2							
Standard Activity : SA2- 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 mainstreamed static protection services

During Construction/Rehabilitation of water sources in schools, health facilities and communities, reflecting GBV action for WASH 3, the location of the water points will be in areas that are accessible and safe for all, to that end the decision regarding the location of the new water points will actively involve discussion with all members of the community, and in general no more than 500 meters from households. Due consideration to safety and protection of users (e.g. ideally located in close to mosques or in the centre of villages to ensure safety of those responsible for water collection – essentially women and children). Before rehabilitation or construction of the water points, ACF will facilitate a community with members to have their inputs in the issues concerning the rehabilitation or construction of the water point. ACF will use its WASH team of female staff to go to selected households to collect view of women, who are restricted from attending community meetings. Hiring local people as daily workers will also contribute to supporting community members' income and purchasing power. All the construction/rehabilitation of water points will be monitored by ACF, Shuras and CDCs; as well as provincial technical bodies PRRD (Provincial Rural Rehabilitation and Development) in addition to the Head of the Department of Woman's affairs in order to ensure the quality of the works and respect of MRRD standards and maintained equity of access for women and girls. At the end of the project, all the structures will be formally handed over to the communities, in the presence of relevant local authorities, again supported by the Department of Woman's Affairs. With this support, mainstreamed violence prevention messages on water sources in schools, health facilities and communities, will develop dignity and safety standards specific to each space e.g. different standards for young girls in schools compared to PLWs in health facilities. Conducting Hygiene promotion sessions (for boys and girls) in Schools, ACF reorganizes that to ensure sustainability of the WASH programs in schools, the involvement of national authorities, community leaders, communities and parents is crucial. ACF will not only construct/rehabilitate WASH facilities in the most vulnerable schools but will also work the provincial department of education to ensure impactful hygiene promotion sessions in the schools. ACF will conduct special sessions and with different styles for each the different age groups. The mainstreamed topics during the various sessions for students will include care practices on safe handling of drinking water, safe disposal of wastewater, safe disposal of human excreta, disposal of solid waste, household sanitation and food hygiene and personal hygiene. These topics will be taught using participatory methods where students actively identify the reasons for these care practices and what supports they need at home and community level to have sustainable practice. Integrated WASH and psychosocial programming will also facilitate children's involvement in youth hygiene clubs within and outside the school; in turn supported by community leaders and committees. To support hygiene promotion in the schools, IEC (materials posters and leaflets) will be distributed and followed up, in order to see how they implement hygiene sessions and provide advise where needed. Linking with above activities, special sessions will also be delivered to teachers to deliver Menstrual Hygiene management clues and advises in a sensitive and objective manner as per context of the project area, with follow up OTJ and supervision – addressing the international MHGap on limited follow up to sensitive topics of training leading to limited impact.

Outcome 2

Integrated services implemented within Nutrition actions and protection assessments in consultation with the APC

Output 2.1

Description

Conflict affected population access protection services including psychosocial

Assumptions & Risks

Political stability in the country and in the province
Security remains stable enough for project implementation
No force major natural disasters and disease outbreaks during the project implementation
No major economic crises
No major fluctuation in the exchange rate
Resources are available in the country or can be relatively easily imported
Community members are willing to participate, accept the involvement of women and children, and remain involved at each stage of the project
Relevant national and local authorities approve and support the project implementation

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 2.1.1	PROTECTION	Percentage of Nutrition beneficiaries assessed on mental heath and care practices					50

Means of Verification : Statistic report from,
Monthly MHCP register - Mental Health and Care Practices Department of ACF is the department integrating psychosocial support and care practices with Nutrition and Health department of ACF
Monthly activity progress report

50% of nutrition beneficiaries are estimated to be reached under this indicator based on current statistics available from ongoing integrated Nutrition and MHCP activities in Helmand. At present with 2 staff integrated within Nutrition following mobilization period are able to reach 20% of beneficiaries under assessment. With increased numbers of MHCP staff and developed experience, 50% reach is anticipated.

Indicator 2.1.2	PROTECTION	SA2- Number of GBV survivors receiving protection services (including health, psychosocial, legal and safety)		120		120	240

Means of Verification : ACF activity Reports, referrals to ACF psychosocial counselling team, psychosocial BNF database and reports

Activities

Activity 2.1.1

Standard Activity : SA2- Integrated protection services implemented within the actions of other Clusters and protection assessments in consultation with the APC.

Integrated protection services within mobile outreach services
During screening and treatment of PLW affected by malnutrition through mobile clinic integrated with psychosocial support and care practices ACF will directly implement mobile nutrition services in IDP Mukhtar settlement and in other villages outside the camp. The intervention team will be composed of 1 supervisor (medical doctor), 2 certified Nurses/midwifes, 2 measurers/screeners, 1 for health education and 1 flying psychosocial officer with the aim of delivering SAM, MAM and acute malnutrition PLW treatment at community level. The flying officer will integrate psychosocial support and care practices to account for the many barriers including potential social norms acting as barriers e.g. Mother's in law not supporting exclusive breastfeeding sessions have been consistently identified during Helmand based GBV workshop and Ghor based Gender Analysis lead by ACF Gender/GBV expert to be consistent triggers in GBV at home level. During the consultation child measurement, appetite test, medical consultation, postnatal depression assessment (where needed), assessment of understanding of care practices (where needed), observation of mother-child relationship, distribution of medical and nutritional treatment in line with the national guideline, and referred to any psychoeducation or counselling groups including ACF's counselling team and he broader services available. Integrated services will also address gaps in current standalone nutrition interventions. There is a gap on the successful dissemination of key messages on the 1000 days. ACF using integrated programming will strengthen the methodology for dissemination through more participatory and psychosocial methods and the purposive targeting key groups including husbands, fathers and mothers-in-law as a mitigation strategy against GBV at household level where otherwise the mother trained would be entirely responsible for transferring knowledge to the HH and sustaining IYCF related household behavior change. These messages will be delivered during specialized psychoeducation sessions on care practices during mobile clinic activity. They will include the topics on maternal and personal health care, IYCF including exclusive breastfeeding, and health care complimented with corresponding topics on mother self-care (using this specific module as a means of distribution on GBV awareness), mother-child attachment, food preparation and person and home hygiene. A system of messages, building on previous sessions, will be organized every week targeting all caretakers accessible including those with the child independent form IMNCI consultation or nutrition program. Addressing the Mental Health Gap in education and training from a global mental health and psychosocial services (MHPSS) perspective, during follow up, if the mother requests or indicates further supports/training is needed, or if integrated, Nutrition and Psychosocial team identify additional or ongoing need, further appropriate support by specialized education will be provided. Where the ongoing or additional need is rapidly contributing to infant reduced or stagnant weight, the infant will be referred to the therapeutic feeding unit at the hospital immediately, while the mother is supported.

Activity 2.1.2

Standard Activity : Not Selected

Implementation of GBV action for WASH 2 through the use of formative research

In addition to the PSS counsellors and mainstreamed actions, a flying team of psychosocial officers will promote qualitative interactions with beneficiaries including specific GBV actions. In the WASH sector, the flying officer will implement GBV action for WASH 2 - the informed mobilisation of communities and the selection of sites linked to women and girls' protection and dignity. This officer will respond to GBV related socio cultural issues related to blocked access to resources identified in ongoing Nutrition activities in the province. The flying PSS officer within the WASH team will reach out to female community members at house-to-house level with female WASH promotors to ensure equal participation from different gender groups in the location, design and maintenance of WASH facilities. To ensure women are not overburdened with additional roles gender daily calendars will be generated as part of a broader formative research to identify barriers to mobilisation, facilitate different gender groups to identify the full scope of risky hygiene practices and their subsequent community appropriate mitigation, and conduct sensitisations with community leaders and Mullahs to advocate for an authentic gender balance in committees participation. In communities identified as water-stressed, the flying officer will promote site selection in coordination with CDC and PRRD to guarantee full involvement of communities and key focal community engaged authorities including the Department of Women's Affairs, which currently leads in different provinces on interventions for the reduction of GBV, we well as transparency and respect of local culture and norms. In this way, GBV is proactively reduced by ensuring sites selected do not present GBV related risks for women, girls or boys.

Activity 2.1.3

Standard Activity : Not Selected

Conduct GBV focused formative research using construction/rehabilitation of water sources in schools, health facilities and communities as a means of introduction

In addition, reflecting GBV action for WASH 3, the location of the water points will be in areas that are accessible and safe for all, to that end the decision regarding the location of the new water points will actively involve discussion with all members of the community, and in general no more than 500 meters from households. In addition, reflecting GBV action for WASH 3, the location of the water points will be in areas that are accessible and safe for women and girls, to that end the decision regarding the location of water points will be identified through formative research where female participation is central. This formative research will focus on GBV and all related issues within the province. Female led analysis of barriers to safe access to water points as well as sanitation facilities will identify determinants to GBV risks, and identify solutions to minimise distress at community level in past WASH actions in other emergencies where women and girls have reported latrines as areas for GBV and conflicts at water sources. ACF's flying PSS officer within the WASH team of female staff to go to selected households to collect views of women, who are restricted from attending community meetings to enable women's participation in bodies that can oversee proper use and maintenance of WASH facilities. The flying Support PSS officer positioned within WASH will support qualitative interactions and facilitate sensitized responses through focus formative research including focus group discussions; key informant interviews and iterative analyses overall leading to informed behaviour change communications; women to women engagement and male to male engagement. .

Activity 2.1.4

Standard Activity : Not Selected

Implementation of proactive and reactive strategies using establishment/reinforcement of WSUCs, mechanics and caretakers as means of distribution

ACF flying officer within the WASH team in collaboration with the psychosocial counselling team will utilise WSUCs (and CDCs) as a means of distribution on GBV. This integrated team will disseminate information on all agencies available resources within the local community related to GBV. This team will also facilitate proactive design and/or jointly selecting with members of the affected population regarding GBV anti violence messages from the cloud repository on IEC materials available for Asia Foundation and Women for women international. These messages will be made available at water points, focus groups, health facilities, the Department of Women's Affairs and other locations where groups gather, with messages aligned to different gender communication levels e.g. more visually orientated and simplified communication strategies for children. Similarly, the establishment of WSUCs can provide a community supported and sensitized distribution mechanism for reactive support to GBV cases. WSUCs will introduce psychosocial counselling services for GBV cases, sensitization sessions for disaggregated gender groups on GBV issues related to water access including general workshops on social and cultural issues in personal and community hygiene that can lead to GBV and related protection concerns for different community members.

Activity 2.1.5

Standard Activity : Not Selected

Provision of gender sensitized hygiene promotion sessions and distribution of menstrual hygiene kits to women and girls

Distribution of menstrual hygiene kits with beneficiaries will also be facilitated by the flying psychosocial officer in WASH and Nutrition teams to address issues of stigma hosting of women's support groups conducted prior to distribution of menstrual hygiene kits; and assessment and analysis' contribution to local social, cultural and institutional context. This distribution directly accesses the female population, which are directly affected by stigma triggered GBV in relation to menstruation. This activity will therefore reflect outcomes and findings of the formative research in relation to choice of sanitary protection as a personal decision, influence of cultural acceptability and user preferences. It is critical that this programme will support women and girls by involving them in the planning discussions and decisions about the materials and/or products to be supported, facilitated by the integrated PSS officer within WASH. At the same time, the GBV counselling group who will respond to any psychological barriers identified to using sanitary products will also support this activity. ACF has been distributing similar kits in many province of Afghanistan, along with sensitization around menstruation. While having received positive feedback from women targeted under precedent projects, ACF would like to collect stronger evidence on the impact of providing sensitization around menstruation hygiene, as well as hygiene kits. The WASH integrated psychosocial officer collaborating strongly with the WASH female Hygiene Expert to carry an in depth evaluation with female beneficiaries of this specific activity; disseminating findings and subsequent best practice to the WASH Cluster and other ACF partners. Reflecting on current gender analysis and past findings, will link directly with key decision makers at the household level (identified during KAP) who can facilitate behaviour changes on sensitive topics like menstruation management. As with other points of community engagement under this project, this point of community contact will also be used to disseminate information and sensitisation on GBV, thus further ensuring the sustainability of key messaging on the issue, and contributing to lifting the 'veil' on GBV. To account for the hygiene needs of men and women, ACF will also distribute standard hygiene kits following comprehensive baseline assessment on cultural acceptance and hygiene need of kit items. While this is not a GBV dignity kit distribution, as a mitigation strategy for violence against women, hygiene kits following the WASH cluster approved content, will be distributed following sensitization and promotion with community leaders, WSUCs and household members. WASH integrated psychosocial officer collaborating strongly with WASH female Hygiene Expert will do in depth evaluation with female beneficiaries of this specific activity; disseminating findings and subsequent best practice with relevant stakeholders. Reflecting on current gender analysis and past findings, will link directly with key decision makers at the household level (identified during KAP) who can facilitate behaviour changes on sensitive topics like menstruation. This point of community contact will also be used to disseminate information and sensitisation on GBV including psychosocial counselling groups, thus further ensuring the sustainability of key messaging on key issues for women and girls.

Activity 2.1.6

Standard Activity : Not Selected

Conduct Hygiene promotion sessions (for boys and girls) in schools

ACF recognizes that to ensure sustainability of the WASH programs in schools, the involvement of national authorities, community leaders, communities and parents is crucial. ACF will not only construct/rehabilitate WASH facilities in the most vulnerable schools but will also work the provincial department of education to ensure impactful hygiene promotion sessions in the schools. ACF will conduct special sessions and with different styles for each the different age groups. The topics during the various sessions for students will include care practices on safe handling of drinking water, safe disposal of waste water, safe disposal of human excreta, disposal of solid waste, household sanitation and food hygiene and personal hygiene, and be taught using participatory methods where students actively identify the reasons for these care practices and what supports they need at home and community level to have sustainable practice. Integrated WASH and psychosocial programming will also facilitate children's involvement in youth hygiene clubs within and outside the school; in turn supported by community leaders and committees. To support hygiene promotion in the schools, IEC (materials posters and leaflets) will be distributed and followed up, in order to see how they implement hygiene sessions and provide advise where needed. Linking with above activities, special sessions will also be delivered to teachers to deliver Menstrual Hygiene management clues and advises in a sensitive and objective manner as per context of the project area, with follow up OTJ and supervision – addressing the international MHGap on limited follow up to sensitive topics of training leading to limited impact.

Activity 2.1.7

Standard Activity : Not Selected

Mobile outreach protection services to women, men, girls and boys: Conducting psychosocial education at health facility and community levels

Workshops employing adult education models will roll out staged modules on psychosocial and care practices, and protection to local civic organizations and/or coordinated agencies operating in the area. To maximize learning and development for participants, numbers of participants per workshop will be capped at 20 participants per group, with a ratio of 2 trainers to 20 participants. To support the move of the theoretical training content to practical application at field level, ACF master trainers will also train all civil organizations in a two-day orientation training on the core components partner, coordinated and ACF staff are inducted on. On-the-job mentoring and support for facilities and healthcare providers who have received training will then be implemented. Each facility who have received training will be visited at least twice for comprehensive post-training follow-up, mentoring and on-the-job training during the project. Following post training visits and midline project evaluation (as part of a broader monitoring, evaluation, learning and accountability plan), ACF master trainers will also organize refresher trainings for a percentage of trained staff targeting those who receive the lowest marks during post-training visits across the two provinces. The mothers/mothers in law will meet in open area and in a big group prior to and following sessions to discuss their expectations and experiences of the demonstrations with adequate time for open secure discussion to ensure transfer of knowledge and as a comprehensive effort to sustain food preparation practices without creating risks for women and simultaneously being responsive to any protection concerns; all feedback will be incorporated into adapting the suitability of the cooking demonstrations to each target audience to build a sustainable environment to facilitate the targeted sustainable behavior changes and mitigate any GBV triggers as previously discussed potentially found in focusing all knowledge transfer on one mother per household without support mother in law.

Activity 2.1.8

Standard Activity : Not Selected

Mobile outreach protection services to women, men, girls and boys: Conducting psychosocial counselling for GBV and other protection concerns

Where cases of GBV are identified, a response team integrated within the Nutrition team made up of psychosocial counselling staff managed by the psychosocial coordinating officer will provide group and individual counselling at field level securely with best practice response including 1) warmth and acceptance, 2) emotional and practical support within a safe environment, 3) technical understanding of psychological impact of GBV, 4) validation on all reactions – no reaction is wrong or maladaptive, 5) believing the story, 6) confidentiality, 7) technical support on medical and legal supports, and 5) control over their process and choice. This team will also link with advocacy and accompaniment to clinics, police, court, referral to other agencies and finally coordination with those agencies and partners completing workshops with ACF (this coordination list is not limited to these actors and may include any actors under the WHO/MoPH upcoming capacity building of Health Facility staff on GBV).

Additional Targets :

FOOD SECURITY AND AGRICULTURE

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Objective 2: Ensure continued and regular access to food during lean season for severely food insecure people, refugees and prolonged IDPs at risk of hunger and acute malnutrition	SO3: The impact of shock induced acute vulnerability is mitigated in the medium term	100

Contribution to Cluster/Sector Objectives : The proposed project is aligned with the allocation priority FSAC cluster objective 2: “Ensure continued and regular access to food during lean season for severely food insecure people, refugees and prolonged IDPs at risk of hunger and acute malnutrition” and SO4: “Humanitarian conditions in hard-to-access areas of Afghanistan are improved”. More specifically, it aims at pursuing 2017 HRP SO3: “The impact of shock induced acute vulnerability is mitigated in the medium term” by providing direct assistance through cash-based interventions to protracted IDPs, with support from mainstreamed protection principles of Do No Harm, dignity and respect, therefore preventing a further deterioration in their situation in the absence of progress on government effort towards durable solutions.

Prolonged IDPs in Lashkargah have limited access to labor opportunities – being unable to find employment, due to their rural skillset and low literacy rate and are mostly reliant on limited casual labor. Women in particular find it very difficult or are not permitted to work to supplement their household income or support their families in the case of female-headed households. Rates of severe food insecurity have been found to be extremely high among these groups and their food security and livelihood situation will be worsened during coming winter season. The proposed intervention is directly contributing to the FSAC targeting severely food insecure and acute shock-affected vulnerable people, specifically through life saving intervention targeting prolonged IDPs. FSAC’s priority is to provide timely food assistance during winter to respond to acute and seasonal chronic food insecurity. Since FSAC prioritized the Cash programming in areas where markets are functional and reliable cash transfer mechanisms are available, therefore the proposed intervention is fully aligned with FSAC programing prioritization.

Outcome 1

Targeted prolonged IDPs households of Lashkargah district (Helmand province) affected by conflict receive timely cash assistance to cover their immediate food needs, to ensure a minimum of their food security condition

Output 1.1

Description

1,000 conflict affected food insecure prolonged IDPs households of Lashkargah district in Helmand province receive the equivalent of 180 USD as cash assistance to cover their needs for two months

Assumptions & Risks

Security does not deteriorate and allows access to beneficiaries
Security does not deteriorate economic and physical access to local markets
Government authorities and communities support the project while respecting ACF charter
No natural disaster or disease outbreak during project implementation
Targeted communities actively participate and contribute to the project

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	FOOD SECURITY AND AGRICULTURE	SA2- Number of new and prolonged IDPs assisted on time with cash	3,601	3,399			7,000
Means of Verification : Baseline food security survey/ (HEAT) report Cash distribution lists							
Indicator 1.1.2	FOOD SECURITY AND AGRICULTURE	SA2- Number of cash interventions followed up with post distribution monitoring as per CHF requirements	2	0	0	0	2
Means of Verification : Cash post distribution report PCDM report Please refer to the total number only. Number of men/women/girls/boys is not relevant here.							
Indicator 1.1.3	FOOD SECURITY AND AGRICULTURE	SA2- Reduction in percentage of prolonged IDP households with poor Food Consumption Score					70
Means of Verification : PCDM report							

Activities

Activity 1.1.1

Standard Activity : Not Selected

MoUs with local authorities (DoRR) on project

ACF will develop and sign a mutual MoU with assigned rules and responsibilities of DoRR and ACF for the selection of beneficiaries and cash distribution.

Activity 1.1.2

Standard Activity : Not Selected

Selection and registration of food insecure beneficiaries based on assigned criteria
Having identified the need for cash assistance, in response ACF will start the process of screening the prolonged IDPs households and selecting the most vulnerable and eligible prolonged IDPs households for this assistance. The process will be started with screening internal lists (as part of the ERM project). ACF team will do cross check individually, through household visit and administration of HEAT questionnaire based on which ACF will extract the final list of beneficiary households. The cash assistance will be delivered for food insecure prolonged IDPs households' targeted based on vulnerability criteria. To target the prolonged food insecure conflict induced IDPs households who have been staying in Helmand, ACF will apply vulnerably scoring technical using weigh for each vulnerability criteria identified. Then the data collection will be carried out on paper and enter into excel data base, analysis and scoring will be conducted to identify the eligible beneficiaries.
The pre identified criteria for selecting prolonged vulnerable households is as followings:
1. Status (displaced for more than 6 months up to 2 years),
2. Size and composition of the family (large households with more than 8 members)
3. Female/disabled/headed households
4. Households with no working age adults
5. Sources of income (no income or earning main income from either borrowing, casual unskilled non-construction labor, begging, casual construction labor, small business, or others non-specified jobs used as proxy indicator for poverty)
6. Households with more than 2 children under 5 years old
7. Household with more than 1 pregnant woman
8. High rCSI of 18 or above scores/ or using more than one food base coping strategy
9. Household with poor food consumption score
10. Households living in shelter with mud walls and tarpaulin roof, or households living in tents
11. Household with less than 3 weeks food stock
12. Households with more than 1 elderly person
13. Households with more than 1 disabled person
14. Households with more than 1 chronically ill person

Activity 1.1.3

Standard Activity : SA2- Cash assistance to severely food insecure prolonged IDPs located within the 45 hard to reach districts. Findings of relevant assessments undertaken within the past 6 months will be a prerequisite for funding and must be submitted along with the proposal.

Cash assistance to food insecure prolonged IDP HH in Lashkargah district, Helmand province

Once the eligible beneficiaries based on vulnerability scoring techniques are identified for this intervention, ACF will disburse the cash in two months.
The market systems continue to function in targeted area of Helmand. Cash has been proven an effective tool to deliver aid in a way that empowers vulnerable people to meet their needs with mainstreamed protection supported by an integrated psychosocial officer to ensure more flexibility, dignity and choice. In addition, cash transfer programming supports local markets and stimulate trade. ACF has advocated for the use of cash transfers as an emergency response and have been appropriate and successful due to its suitability in terms of community acceptance, market access and capacities, and availability of various transfer mechanisms. However, ACF is aware and commits to mitigate risks women and girls where cash is distributed.
ACF has a long experience and experienced staff in CBI sector. Moreover, ACF implemented numerous projects in different provinces of Afghanistan. In order to avoid duplication, ACF will consult and coordinate with DoRR and active NGOs in Helmand. Furthermore, ACF has maintained and strengthened regular coordination and communication with OCHA regional offices, regional/national clusters and other partners working in Helmand.
The new field staff to be recruited will undergo series of training and orientations on the project objectives and technical inputs, including protection in emergency and mainstreamed protection in FSL. ACF will hire female staff to be engaged in the fieldwork and conduct the beneficiary verification and post distribution monitoring surveys (PDM will be led by an independent MEAL unit, with the assistance of female project staff) to mitigate exposure to risks for women and girls during data collection thus ensuring the female voice is represented and integrated to program activities. Traditional beliefs are very strong in the rural population in Helmand, male staff cannot survey and contact female member of households. ACF has been conducting market surveillance under ERM and CHF project in Helmand province concerning supply and price conditions that has confirmed the availability of food and NFIs. As items were found to be available in sufficient quantity and at affordable prices. Lashkargah, being the province capitals, host a major market that continues to function even during massive conflict around Lashkargah city. This led to the adoption of a CBI approach for the IDPs against in-kind assistance. The CBI modality chosen for this intervention is DIRECT CASH to be provided to the beneficiaries using the existing Hawala system. There will be two tranches for cash distribution for each beneficiary household selected: The cash distribution will take place after beneficiaries are identified based on assigned vulnerability criteria and vulnerability scoring techniques. ACF has aligned the amount to the FSAC standard package of 2,100 Kcal/person/day (i.e.180 USD per HH for a total of 2 months covered). The cash will be distributed in two installments covering their 2 months food needs. 1,000 food insecure prolonged conflict IDPs households of Helmand will benefit from this UCT activity. Delivery of cash to the beneficiaries will be through the existing Hawala system (with presence of ACF staffs), an informal remittance system, prevalent and effective in the country and in Helmand province. ACF has been using the Hawala system since 2008. A distribution plan will be developed to include the scheduling, cash distribution points taking careful consideration on security, mitigate risks, and not to disrupt market prices. ACF will be conducting monthly price monitoring on the markets to monitor the impact of the intervention and potential inflation of prices.

Activity 1.1.4

Standard Activity : Not Selected

Post cash distribution monitoring survey

One month after the distribution of cash, ACF MEAL team will carry a Post Cash Distribution Monitoring on a representative, randomly selected sample of beneficiaries in the area of the project. An independent MEAL unit will lead post-distribution monitoring, with the assistance of female project staff. The PDM will assess beneficiary satisfaction towards (i) the quantity of cash received, (ii) the timeliness of the distribution, (iii) the organization of the distribution, (iii) the cash usage, (iv) complaints and concern of beneficiaries. Results will be used to evaluate the quality of targeting (the level of use of the cash can be used as proxy indicator to understand whether the project effectively targeted the most vulnerable prolonged IDPs households), effectiveness of the intervention in responding to priority needs of targeted families (same comment), and support a short lesson learnt document to serve for future implementation of similar project.
For PDM, 106 beneficiaries, representing 10% of the targeted beneficiaries as representative sample, will be selected for the interview. The sample size was drawn using a confidence level of 95% and a confidence interval of 9. This is the minimum percentage that ACF will include in the sampling for the PDMs to be conducted.
A baseline survey will be conducted during the beneficiary selection in order to determine the current food security situation and conditions of the population. A Final survey together with PDM will be undertaken to compare with the baseline data, and to measure the impact of the project on beneficiaries. The baseline and final survey will contains food security indicators (i.e. FCS, rCSI and food stock).

ACF has already started utilizing the PDM tool recently created by the Afghanistan Cash Voucher Working Group, endorsed by the ICC, and will submit a PDM report to the CHF and further sharing with the Afghanistan Cash Voucher Working Group and the Clusters.

Activity 1.1.5

Standard Activity : Not Selected

Monthly market monitoring survey

ACF will be conducting monthly price monitoring on the markets to monitor the impact of the intervention and potential inflation of prices.

ACF has been conducting market surveillance under ERM and CHF project in Helmand province with regards to supply and price conditions which has confirmed the availability of food and NFIs. As items were found to be available in sufficient quantity and at affordable prices. Lashkargah, being the province capitals, host a major market that continues to function even during massive conflict around Lashkargah city. This led to the adoption of a Cash Based Intervention approach for the IDPs against in-kind assistance.

Activity 1.1.6

Standard Activity : Not Selected

Establish beneficiary and stakeholder feedback and complaint mechanism

As a part of its general policy, ACF will establish a feedback mechanism to enable beneficiaries to make a suggestion or make complaints. ACF will introduce a range of ways that is contextually feasible including introduction of a telephone complaint line, feedback e-mail address for stakeholder and beneficiaries, and interviews with beneficiaries. MEAL Department will oversee and the establishment and/or management of the feedback mechanism to ensure that a more formalized system of asking, receiving, processing and responding to the feedback and complaints is, independently, in place.
The feedback mechanism well be clearly communicated to staffs, communities and government institutions about why ACF has a feedback mechanism, what it is for and how it works. As such, information sharing about the feedback mechanism will be integrated into the community mobilization of the project. Similarly, MEAL Department will communicate with the target groups about their right to complain and raise their concern how we work. The department will also discuss what constitutes an ACF related and non-ACF related feedback/complaints and how ACF will deal with feedback and complaints.
In addition, ACF MEAL department will conduct regular individual face-to-face meeting during monitoring visits at community levels. This will allow beneficiaries with no access to phone or being illiterate to provide their feedback.
As with all feedback mechanisms established, every effort will be made to prevent harm and unintended negative consequences on those making complaints, protect confidentiality and encourage reporting of complaints and concerns in a safe environment.

Additional Targets :

WATER, SANITATION AND HYGIENE		
Cluster objectives	**Strategic Response Plan (SRP) objectives**	**Percentage of activities**
Objective 1: Ensure timely access to a sufficient quantity of safe drinking water, use of adequate and gender sensitive sanitation, and appropriate means of hygiene practices by the affected population	SO4: Humanitarian conditions in hard-to-access areas of Afghanistan are improved	55
Objective 2: Ensure timely and adequate access to WASH services in situations (returnees transit points, health centers, therapeutic feeding centers, schools, etc.) affected by emergencies	SO4: Humanitarian conditions in hard-to-access areas of Afghanistan are improved	45

Contribution to Cluster/Sector Objectives : According to 2017 HRP, Helmand is one of the less supported provinces in terms of humanitarian actors compared to the population in need. The report indicated Helmand as one of the four provinces with high risk of rapid displacement or urban centre failure, the province has high risk for fall of a district or provincial centre causing mass displacement. The same report also indicated that Helmand has the highest number of IDPs in hard-to-reach areas. In this highly contested province, only few humanitarian organizations have succeeded to establish and to deliver assistance. Beyond Lashkargah city and surrounding districts, humanitarian access remains very limited; which severely undermines the capacity of actors to reach out to the most vulnerable communities. Compounded with insecurity-induced restrictions on population's freedom of movement, this has left a large proportion of the population in a situation of despair. The project aligns with the allocation on theme (strategic priority) #1 "life-saving activities in underserved and hard to reach areas where severe needs". The project is strategically focused in Lashkargah District because the majority IDPs and returnees continue to come in as result of the ongoing conflict in the various parts of the province. It will more specifically address the WASH Cluster strategic priority #3, "Response to WASH needs of the communities hosting the conflict affected IDPs and returnees whose water and sanitation needs are increased due to IDPs and returnees (and available WASH resources are stretched) exposing the communities to risk of waterborne diseases' in areas affected by ongoing conflict" for which Helmand is a priority. Through the provision of safe drinking water to water-stressed communities, and coordinated efforts to improve hygiene practices in communities and schools, ACF intends to contribute to reducing incidence of water borne diseases most especially amongst children under 5 - which in Helmand province stands as the main cause of child morbidity. The project will be in line with WASH cluster priority activities that will include HH water treatment, safe storage solutions, rehabilitation of water points and hygiene promotion to ensure sufficient quantity of safe drinking water and appropriate means of hygiene practices. The project will contribute to the following outcome indicators of the WASH envelope: -Number of people in intervention areas provided with access to at least 15L per capita per day of drinking water – Number of people in intervention areas provided with access to a place to wash hands with soap, - proportion of institutions in need with gender sensitive access to appropriate WASH facilities. As indicated above, Lashkargah as an urgent area for humanitarian response also applies under the protection sector as IDPs and returnees are faced with increased risks and vulnerabilities to multiple forms of GBV including violence against women, domestic violence, sexual abuse and forced marriage. The project also aligns with the 1st GBV key action for WASH to identify safety and security risks for women and girls relevant to WASH systems to ensure location, design and maintenance/follow up truly maximise safety and security of women and girls in addition to young boys. Women and girls will be facilitated to participate at least in integrated WASH and Protection committees for the purposes of assessment, design, implementation and follow up feedback utilising psychosocial support and communication strategies to accurately reflecting do no harm (in terms of psychosocial sensitivity) to identify determinants of GBV and social stigmas that once reflected in design will help reduce exposure to GBV and enable increased access to WASH services. Finally, integrated protection within WASH will specifically address special needs of girls and women to protectively respond to identified GBV through these assessments and promote community accepted orientation on care practices.

Outcome 1

To improve access to safe and clean water in vulnerable IDPs, Host communities and selected schools and health facilities in Lashkargah district, Helmand province

Output 1.1

Description

Women and girls are able to access new water points and rehabilitated water points in safety and security

Assumptions & Risks

Political stability in the country and in the province
Security remains stable enough for project implementation
No force major natural disasters and disease outbreaks during the project implementation
No major economic crises
No major fluctuation in the exchange rate
Resources are available in the country or can be relatively easily imported
Community members are willing to participate and remain involved
Relevant national and local authorities approve and support the project implementation

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 1.1.1	WATER, SANITATION AND HYGIENE	Number of men, women, boys and girls beneficiaries with access to safe and clean protected water sources free of E.Coli.					11,327
Means of Verification : Baseline and final KAP surveys ACF field monitoring reports ACF activities reports Water Quality analysis reports 3,624 men, 3,429 women, 2,509 boys and 1,765 girls; for a total of 11,327 beneficiaries.							
Indicator 1.1.2	WATER, SANITATION AND HYGIENE	SA2- Number of people in need with access to at least 15lpcd of drinking water	3,624	3,429	2,509	1,765	11,327

Means of Verification : Baseline and final KAP surveys
ACF field monitoring reports including psychosocial inputs,
ACF activities reports
Water Quality analysis reports

Indicator 1.1.3	WATER, SANITATION AND HYGIENE	Number of Households using correctly household water treatment systems (Bio Sand Filters) distributed and having safe drinking water					590

Means of Verification : ACF distribution and post monitoring reports
KAP survey

Indicator 1.1.4	WATER, SANITATION AND HYGIENE	Number of WSUCs established or re-activated in selected villages comprising of men and women					105

Means of Verification : ACF activities report

Indicator 1.1.5	PROTECTION	Percentage of boys, girls, men and women receiving psychosocial support					60

Means of Verification : Assessment reports, ACF activities report, Psychosocial reports
Within the current activities in Helmand, the introduction of psychosocial activities is currently reaching 15% of total beneficiaries under Nutrition using 1 PSS officer per mobile group. With the increase in staff and developed expertise over the last 5 months, this is expected to increase by 300% i.e. increase to reaching 60% of beneficiaries.

Activities

Activity 1.1.1

Standard Activity : Not Selected

Mobilization of the communities, selection of sites in schools and villages, and signing of MoU with the respective ministry and with each selected villages of Lashkargah district

During project inception, a technical assessment of all existing water sources of the selected area will be carried out, in order to acquire deep knowledge about quantity and quality of water available to population, functionality and condition of water points (hand pump, apron, and surrounding area), habits of people with regards to fetching water, water chain and conservation (containers cleanness, transport, water use). In assessing these, due attention will be reflected on women and children's roles as primary collectors of water, the safety of water collection points including shade where there are queues. Facilitated by an integrated psychosocial officer in the WASH sector per base to reflect GBV action for WASH 2 - the informed mobilisation of communities and the selection of sites linked to women and girls protection and dignity, ACF will ensure equal participation from different gender groups in the location, design and maintenance of WASH facilities to ensure women are not overburdened with these roles in addition to the typical gender daily calendar, facilitate different gender groups to identify the full scope of risky hygiene practices and their subsequent community appropriate mitigation, and advocate to ensure a gender balance in committees – to be comprised of 50% women. Results of all committee findings, lessons learned from earlier water point constructions, and best practices will be member checked with Health Facility (HF) management staff, schools directors, and community members, and a final dissemination to all groups for last inputs before construction begins.
In communities identified as water-stressed, site selection will be done jointly with CDC and PRRD to guarantee full involvement of communities and key focal community engaged authorities including the Department of Women's Affairs, which currently leads in different provinces on interventions for the reduction of GBV, as well as transparency and respect of local culture and norms. Upon selection of sites, a MoU will be signed with each community in order to clarify and acknowledge roles and responsibility of each party to the project with particular focus on clear definitions of integrated roles. Local authorities and technical bodies of Helmand Province (PRRD) will be invited during discussions with the communities regarding the MoU and the project action plan.

Activity 1.1.2

Standard Activity : Household water treatment, water trucking, safe storage solutions, rehabilitation of emergency boreholes and hygiene promotion to ensure sufficient quantity of safe drinking water and appropriate means of hygiene practices for returnees and host communities in areas of high return;

Construction/Rehabilitation of water sources in schools, health facilities and communities

The construction/rehabilitation of 21 water sources will take in consideration the characteristics of underground water, and will cover schools, HF and most vulnerable IDPs and host communities with lack or poor access to safe and clean water. The intervention will focus on the rehabilitation of existing water points, according to needs (e.g. physical condition of the water point), suitability of access for different gender groups, and priority ranking of the institutions depending on the number of students. Where no water point exists in the school compound, a new bore well will be constructed. In HF, ACF will rehabilitate the existing water sources, install a solar powered submersible pump for water pumping and ensure that water is available in the key areas including the delivery rooms, toilets, hand washing stations and the clinical laboratory. The design and construction of the water points will be done in consultation with the intended users. The criteria for selecting communities for water point construction will be safe water coverage, considering availability of functional protected water points, as well as the distance to the water point. In addition, reflecting GBV action for WASH 3, the location of the water points will be in areas that are accessible and safe for all, to that end the decision regarding the location of the new water point will actively involve discussion with all members of the community, and in general no more than 500m from HH. ACF will consider the safety and protection of users (e.g. ideally located near mosques or in the centre of villages to ensure safety of those responsible for water collection – essentially women and children). Rehabilitation activities will entail improving the water points to reduce the possibility/risk of contamination (reinforcement and plastering of well, construction of apron, drainage channel and soak pits, disinfection of the well and installation of hand pump). A water quality analysis before and after rehabilitation of water points will be conducted for all them before handover. ACF will construct/rehabilitate water points with the involvement of the communities, as opposed to sub-contracting the work to private contractors. During implementation, all the unskilled workers will be recruited from the community and for the skilled workers, priority will be given to those based in the communities where the water points are to be rehabilitated/constructed. ACF acknowledges that relying on community mobilization offers multiple advantages: full control on the supply chain and close monitoring of equipment/material use, increased sense of ownership by beneficiaries, acquisition of knowledge by community members on water point infrastructures and subsequent improvement in maintenance. ACF will facilitate community members to have their inputs in the issues concerning the works on the water points. ACF will use its female staff to go to selected HH to collect view of women, who are restricted from attending community meetings. Hiring local people as daily workers will also contribute to supporting community members' income and purchasing power. All the construction/rehabilitation of water points will be monitored by ACF, Shuras and CDCs; as well as provincial technical bodies in addition to the Head of the Department of Women's Affairs (DOWA) in order to ensure the quality of the works and respect of MRRD standards and maintained equity of access for women and girls. At the end of the project, all the structures will be formally handed over to the communities, in the presence of relevant local authorities, again supported by the DOWA to mainstream violence prevention messages on water sources in schools, health facilities and communities, and develop dignity and safety standards specific to each space e.g. different standards for young girls in schools compared to PLWs in HF.

Activity 1.1.3

Standard Activity : SA2- Household water treatment, water trucking, safe storage solutions, rehabilitation of emergency boreholes and hygiene promotion to ensure sufficient quantity of safe drinking water and appropriate means of hygiene practices.

Distribution of 570 Bio Sand Filters (BSF) to selected households and training on operation and maintenance, with a particular focus on female-headed households.

According to ACF experience, the Bio Sand Filter is the most suitable Household Water treatment (HWT) in this context. Since 2015, ACF has distributed 3,710 BSFs in Helmand. The Bio-Sand-Filters will be locally produced, and assembled by ACF technical team following established technical design standards. After having thoroughly checked their quality the BSFs, ACF technical team will then install the BSFs in targeted families' houses, and train recipients on how to operate and maintain them. Experience gained by ACF in promoting this technique in Afghanistan shows BSFs are one of the most cost-efficient options to improve access to safe water, with the following advantages: (i) easy operation and maintenance not associated with any cost, (ii) long life-span (ACF distributes metallic galvanized BSFs) and capacity to provide clean water for many years (40-80 liters daily and 10 years life expectancy).The provision of BSF will guarantee a better quality of the water especially for women as they use also for personal hygiene, decreasing their exposure to water related diseases. This approach is a further dimension of WASH and psychosocial integration, and will proactively respond to the physical risks and threats accessing water and other sanitation facilities can present for women (ACF Gender Analysis 2017). Households will be prioritized according to their vulnerabilities, with a specific focus on cumulative and compound vulnerabilities such as female-headed households with limited or no income. The rationale for distributing BSF is as follow: (i) poor quality of the water collected from the wells (very often salty or contaminated by E.Coli), forcing individuals to fetch water from unsafe sources (river, channel ,unprotected kanda/karez ,water pond, etc.), (ii) difficulty of providing safe and clean water from boreholes and hand dug wells in areas where water is scarce and digging/drilling is associated with high costs (need to go very deep), and (iii) population pressure on water sources linked to population migration and displacement, where numbers of users and frequency of use exceeds the operational capacity of the water point (like in Lashkargah), creating queues and breakdowns of the pump, forcing again families to fetch from unprotected sources of water. Considering (i) the high density of population in Helmand linked to economic migration and conflict induced displacement, (ii) the high rate of non-functional water points, reflecting poor capacity for maintenance, and (iii) the local geology (few springs and deep water table), Therefore, in a bid to durably improve access to safe water and reduce incidence of water borne diseases, ACF will continue the distribution of BSFs to households.

Activity 1.1.4

Standard Activity : Not Selected

Establishment/reinforcement of WSUCs, mechanics and caretakers

ACF will facilitate the establishment and/or support of water committees (one per targeted village or per school supported by the psychosocial officer to ensure different needs are properly voiced with sensitized monitoring and capacity building), who will be responsible for the overall organization, planning, and supervision of the operation and maintenance of the public water points, to promote the sustainability of the intervention. Low maintenance was identified during several ACF WASH surveys as one of the main barriers to accessing safe water for targeted communities. To strengthen the capacity of communities on operation and maintenance of water point, ACF will establish/reinforce the Water and Sanitation Users Committees (WSUCs), ensuring the presence of female members as foreseen by MRRD policies. ACF will coordinate with PRRD and CDC members to ensure that WSUC members are selected from the respective villages the water points are situated. The water committees will be trained on water point management and involved during activities implementation in order to ensure sustainability. The WSUCs will also be supplied with spare parts and tools to guarantee the repair of the hand-pumps. The training will include operation and maintenance of the hand pump, environmental hygiene of the water point, coordination with community members to contribute to the maintenance of the community water point. In schools, guards, cleaners, selected members from the community, the responsible teachers or health facility staff will be trained on the operation and maintenance of the pump. Mechanic and caretakers will be trained according to their competences and technical skills, and equipped with tools for maintenance (broom, bucket, shovel, and trowel - for caretakers) and repair (spanners, hacksaw, glue, sand paper, finishing tools, etc. - for mechanics). Responsible for planning and overseeing maintenance and repair operations, the WSUC will also be equipped with spare parts (PVC pipes and sockets, rods, centralizers, valves and rubbers, etc.) - which donation will be formalized into a Memorandum of Understanding with the Community development Committee (CDC). Under protection, utilising CDC as a means of distribution on GBV with info sharing on available resources within the local community related to GBV proactive (e.g. anti-violence messages available at water points) and reactive support (ACF psychosocial counselling service for GBV cases), sensitizations for disaggregated gender groups on GBV issues related to water access including general workshops on lack of safe WASH causes up to 50% of malnutrition creating burdens for families and communities and specialized sessions for key groups on lack of clean water for PLWs where there is no equal access or balanced distribution of water increases risk for hookworm infestation leading to reduced health and survival rates of both mother and child, and engaging communities on the topic under overall WASH work.

Activity 1.1.5

Standard Activity : Not Selected

Chlorination and water analysis of water points and Bio Sand Filters

The quality of water will be tested at each water point constructed or rehabilitated in the schools and communities, as per MRRD standards and protocols upon completion of the work and before installation of the hand pump. Analysis consists in pH, turbidity (NTU), electro-conductivity (µS) and bacteriological tests (E.Coli), sampling three times for each test. The water points will be chlorinated as required and tested one month after the intervention. At household level, ACF team will analyse the quality of water on a sample of BSFs beneficiaries (10%), one month after the installation, using three samples in the inlet (fetched water) and three after the treatment (drinking water), in order to verify the functionality of the BSF and its efficiency as household water treatment device. A total of 99 water samples will be analysed (57 for BSF and 42 samples for water points constructed or rehabilitated).

Outcome 2

Enhanced awareness on hygiene practices in selected vulnerable IDPs and host communities and improvement of sanitation infrastructure in most vulnerable schools of Lashkargah district, Helmand

Output 2.1

Description

Gender sensitized hygiene care practices and hygiene items are delivered in communities, and school levels

Assumptions & Risks

Political stability in the country and in the province
Security remains stable enough for project implementation
No force major natural disasters and disease outbreaks during the project implementation
No major economic crises
No major fluctuation in the exchange rate
Resources are available in the country or can be relatively easily imported
Community members are willing to participate, accept the involvement of women and children, and remain involved at each stage of the project
Relevant national and local authorities approve and support the project implementation

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 2.1.1	WATER, SANITATION AND HYGIENE	% of completed KAP surveys including gender and age disaggregation					100
Means of Verification : Questionnaire, trainings database and final reports							
Indicator 2.1.2	WATER, SANITATION AND HYGIENE	Number of gender sensitized hygiene promotion sessions conducted					560
Means of Verification : ACF activity reports							
Indicator 2.1.3	PROTECTION	Number of women safely and correctly using the menstrual hygiene kits distributed					2,647
Means of Verification : ACF distribution Reports KAP survey Reports, sensitization reports							
Indicator 2.1.4	WATER, SANITATION AND HYGIENE	Number of school children in IDPs and host communities (boys and girls) reached through Hygiene promotion sessions					25,061

Means of Verification : ACF activity Reports, sensitization reports 25,061 children will benefit from this activity : 14,200 girls and 10,861 boys.							
Indicator 2.1.5	WATER, SANITATION AND HYGIENE	SA2- Number of institutions in need with access to appropriate WASH facilities	14	0	0	0	14
Means of Verification : ACF activity Reports Please refer to the total number only. Number of men/women/girls/boys is not relevant here.							
Indicator 2.1.6	PROTECTION	Percentage of GBV survivors receiving protection services					20
Means of Verification : ACF activity Reports, referrals to ACF psychosocial counselling team, psychosocial BNF database and reports It is currently estimated based on current interventions that 1 in 5 women are now beginning to raise issues related to GBV under one or more of the following categories through the integrated psychosocial officer in the Nutrition team: denial of resources based on gender, forced marriage, battery against women, and sexual and emotional assault. Based on the socio-cultural responses to GBV and its related language is to be very sensitively introduced into more familiar humanitarian activities. 20% is the minimum percentage that can be sensitively reached while laying the groundwork to reach 100% under targeted activities at a later stage.							
Indicator 2.1.7	PROTECTION	Percentage of integrated activities effectively conducted					100
Means of Verification : Planning sessions, ACF activity Reports, sensitization reports, meeting reports, tracked adaptions made to programming where integrated feedback is reflected in programming All activities (100%) under Nutrition, FSL and WASH are integrated with MHCP through different strategies; either with integrated flying officer from the MHCP department in each sector to ensure that WASH, FSL and Nutrition objectives are fulfilled because there is qualitative attention to a minimum mitigate access risks for women and girls with regards these services.							

Activities

Activity 2.1.1

Standard Activity : Not Selected

Baseline and endline KAP survey to assess the knowledge of sanitation and hygiene practices

During project inception, a KAP survey will be conducted by ACF on a sample of targeted population and in schools to better understand the level of knowledge, attitudes and practices specific to WASH including individual motivations for care practices targeted for increase and those targeted for decrease. This survey will be technically informed by WASH integrated psychosocial officer and will be sensitively carried out on pupils in the schools, and households in targeted villages. Interviews to be held with key informants, and with special attention to issues related to menstrual hygiene (engaging with all gender groups and community leaders). The survey and FGDs will explore water provision and storage, use of latrine and open defecation practice, waste management habits, knowledge of their water borne diseases and vector transmission, handwashing, menstrual hygiene, food and cooking hygiene. At school levels and community level, data will be also collected on the incidence of students missing classes due to diarrhea and at community level, the incidences of diarrhea cases among the under 5. At the end of the project, a final KAP survey will be conducted by ACF on a sample of same targeted population to track changes in their knowledge, attitudes and practices, and the starting of the behavioural change process. There is a notable lack of research on the links between WASH and GBV, therefore, KAP will explore lack of access to WASH and increased vulnerability to physical violence, early marriages, access to education. Due to the characteristics of the assessment, the KAP survey will be focused on women, children and men as they are the main actors on above-mentioned topics and the specific issues on menstrual hygiene. To facilitate the interviewees and due to cultural barriers, the surveyors will mostly be women as in conducting data collection during baselines and endlines, facilitating women and children's participation will promote claimed rights on WASH access and mitigated GBV. Women's involvement and children's involvement in data provision and subsequent decision-making based on this data is critical to their empowerment.

Activity 2.1.2

Standard Activity : Not Selected

Provision of gender sensitized hygiene promotion sessions and distribution of menstrual hygiene kits to women

To ensure that the training provided to school teachers, community leaders, Community Development Councils (CDCs) Community health Workers (CHWs) effectively translate into increased outreach of health and hygiene promotion, ACF will work with Lashkargah authorities to supervise, monitor and support aforementioned actors for sensitizing pupils/students and the community members on personal and environmental hygiene in both communities and schools. This will be achieved by active supervision, provision of IEC material, and refresher/on-the-job training. ACF will seek to increase the frequency of outreach of hygiene promotion sessions in schools and at community levels. ACF will also support their effort by delivering radio spot messages. To account for the specific needs of women, ACF will also distribute hygiene kits, which may include menstrual materials (finalised following comprehensive baseline assessment on identified need and cultural acceptance - as a mitigation strategy for violence against women where specific hygiene items not culturally accepted yet distributed can create risk for women at their household level), soap, underwear, and soft cotton box. ACF has been distributing similar kits in many provinces of Afghanistan, along with sensitization around menstruation. While having received positive feedback from women targeted under precedent projects, ACF would like to collect stronger evidence on the impact of providing sensitization around menstruation hygiene, as well as menstrual hygiene kits. The WASH integrated psychosocial officer collaborating strongly with the WASH female Hygiene Expert to carry an in depth evaluation with female beneficiaries of this specific activity; disseminating findings and subsequent best practice to the WASH Cluster and other ACF partners. Reflecting on current gender analysis and past findings, will link directly with key decision makers at the household level (identified during KAP) who can facilitate behaviour changes on sensitive topics like menstruation management. In complement, hygiene promotion for men and children will be carried out through community sessions in mosques and public places on personal hygiene care practices (hand, body and clothes washing), water hygiene (water chain: transport, storage, container washing), environmental hygiene (house and compound cleaning, waste disposal, defecation free). The sessions in the mosques will be conducted by the Mullahs with the support of ACF staff and material (posters and leaflets), during pray sessions according to Muslim religion, and simply monitored in the following months. Leaders and CHPs will carry out community dialogues on topics including the promotion in public places i.e. close to water points, as these one are socialization points, jointly with ACF staff: the involvement of such as persons will promote acceptance by the beneficiaries, and sustainability of any development. ACF will deliver on site formal training to targeted leaders on selected hygiene messages identified in the KAP survey on water chain, excreta and waste management, personal hygiene, and vector transmission. As with other points of community engagement under this project, this point of community contact will also be used to disseminate information and sensitisation on GBV, thus further ensuring the sustainability of key messaging on the issue, and contributing to lifting the 'veil' on GBV.

Activity 2.1.3

Standard Activity : Not Selected

Conduct Hygiene promotion sessions (for boys and girls) in schools

ACF recognizes that to ensure sustainability of the WASH programs in schools, the involvement of national authorities, community leaders, communities and parents is crucial. ACF will not only construct/rehabilitate WASH facilities in the most vulnerable schools but will also work the provincial department of education to ensure impactful hygiene promotion sessions in the schools. ACF will conduct special sessions and with different styles for each the different age groups. The topics during the various sessions for students will include care practices on safe handling of drinking water, safe disposal of waste water, safe disposal of human excreta, disposal of solid waste, household sanitation and food hygiene and personal hygiene, and be taught using participatory methods where students actively identify the reasons for these care practices and what supports they need at home and community level to have sustainable practice. Integrated WASH and psychosocial programming will also facilitate children's involvement in youth hygiene clubs within and outside the school; in turn supported by community leaders and committees. To support hygiene promotion in the schools, IEC (materials posters and leaflets) will be distributed and followed up, in order to see how they implement hygiene sessions and provide advise where needed. Linking with above activities, special sessions will also be delivered to teachers to deliver Menstrual Hygiene management clues and advices in a sensitive and objective manner as per context of the project area, with follow up OTJ and supervision – addressing the international MHGap on limited follow up to sensitive topics of training leading to limited impact.

Activity 2.1.4

Standard Activity : Not Selected

Construction or rehabilitation of WASH infrastructure in selected crowded schools hosting both IDPs and pupils from host communities and in Nutrition Mobile clinics

Due to the ongoing conflict in Helmand province, most schools have been forced to close and especially the ones in Lashkargah town where the security situation relatively stable, many are crowded because of the influx of IDPs from the conflict area. In May 2017, ACF WASH team conducted a technical assessment in 31 schools and of these 12 schools were identified as most vulnerable this a total population of 40,000 students. The WASH facilities in the 12 schools have dilapidated with non-functional water points, insufficient and dirty toilets, no waste disposal pits and the promotion of hygiene related care practices are needed to avoid an outbreak of diarrhea diseases, worm and respiratory infections. ACF recognizes that poor sanitation and hygiene in schools also affects the wider community. Children who pick infectious agents from schools can bring home pathogens that may lead to household members becoming infected. During the assessment most toilets where full and need emptying, doors were broken and the cubicles where not enough for the student populations. On top of rehabilitating or constructing new water points in the selected schools, ACF intends to rehabilitate or construct new safe excreta disposal facilities to serve the specific needs of all users including young boys and girls, and those with disabilities. ACF will rehabilitate/construct latrines in schools to provide proper sanitation facilities for students and teachers. ACF will ensure that the facilities for girls are safe and comfortable most especially for menstrual hygiene management, which can be are a crucial factor in determining older girls' school attendance and will have enough space for associated changing, cleaning and waste disposal. ACF will run mobile nutrition clinics for treatment of malnutrition in selected villages where the cases are high and the beneficiaries cannot easily access health services. The clinics are housed in households or community centres where there are no WASH facilities and ACF will construct one-cubicle toilets for mothers who attend the clinics. During design of new sanitation facilities or their rehabilitation, integrated WASH and psychosocial teams will facilitate feedback from students and teachers throughout the process. For all newly constructed sanitation facilities for girls and most especially those who have reached the puberty stage plus the female school staff, ACF will ensure that the facilities provide privacy and as per MRRD standards. ACF will also ensure that facilities are all inclusive and accessible to pupils/students with limited mobility. Reliable water points and hand-washing facilities will be fixed near latrines or toilets and areas where food is prepared or eaten, with sensitization sessions delivered by integrated psychosocial officer and soft WASH software expert with beneficiaries linking interconnected care practices (e.g. personal hygiene and food preparation). During the Hygiene promotion sessions in, ACF will encourage students to have soap for hand washing instead of distribution, as this will be more sustainable. During project implementation, ACF will coordinate with the community leaders, teachers and the community to set up committees for maintenance of the sanitation facilities, many of which get full after few months of use. The primary beneficiaries of the proposed intervention are boys and girls not exclusive to those attending schools, and men and women in specific community roles including teachers, parents, and community leaders. The students will benefit from life-saving interventions aimed at reducing the incidence of diarrheal diseases and warm infection, implemented concurrently at community and school levels.

Additional Targets :

COORDINATION AND COMMON SERVICES

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Objective 1: Enabling Action (Assessments)- Strengthen humanitarian actor's response through the coordinated multi-sector assessments to inform humanitarian programing, strategic decision-making and improve understanding of critical humanitarian needs	SO4: Humanitarian conditions in hard-to-access areas of Afghanistan are improved	100

Contribution to Cluster/Sector Objectives : Nutrition surveys and assessments including sex-age disaggregation, gender analysis and individual security risks for gender groups will be implemented in hard to access areas of Afghanistan such as Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul provinces. As per the MoPH's Public Nutrition Department (PND) request, the assessments will cover the entire provinces, which is in line with the sectoral standards. However, SQUEAC surveys will not cover the whole province but only some districts. The districts will be selected by partners and ACF. As for the Rapid SMART, the areas will be selected according to the needs.
Outcomes of surveys will be disseminated to different clusters and different members on prevalence and coverage for nutrition program implementing partners, PND and other government line departments as well as donors to make informed decisions allocating resources and planning for nutrition interventions. The information will support the Nutrition Clusters to highlight the needs and plan response to ensure availability of updated and accurate nutrition and multi-sectoral data through integrated SMART surveys and coverage assessments, ACF will support governmental and non-governmental nutrition partners in the strengthening of data collection and implementation of nutrition surveys, which include multi-sectoral indicators, and in enhancing evaluation in the Cluster priority areas.
Assessments being one of the enabling action in the 2nd CHF call for government and partner agencies to get quality data from hard to access areas. The multi-sectoral assessments (Nutrition, Health, FSL and WASH) not only provide nutrition data but also help other cluster to provide information base for planning and resource allocation.

Outcome 1

Reduced Multi-sectoral assessment data gaps in hard to access areas in Afghanistan

Output 1.1

Description

Strengthening coordinated humanitarian multi-sectoral assessments, data quality, sharing and utilization for humanitarian response planning conducting 8 SMART, 2 Rapid SMARTs and 2 SQUEAC assessments in provinces with hard to reach districts

Assumptions & Risks

Security situation in many of the provinces is volatile at the movement creating access issues. ACF assumes the security situation will improve and allows conducting assessments. ACF will only be able to conduct surveys in provinces where security situation allows and partner BPHS implementers are able to reach majority of population developing access strategies. Based on our existing experiences at least in one province so far, conducting SMART surveys is subject to cooperation of government line ministries/departments at national and provincial levels, ACF assumes line ministries support remains available at all levels. The Nutrition, WASH, Health and FSL Clusters and PND support and facilitate the implementation of the project and partners remain committed throughout the project and actively participate at all stages of implementation.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	COORDINATION AND COMMON SERVICES	SA2 -Enabling Action (Assessments) - Number of cluster led sector specific needs assessments designed and implemented to enhance humanitarian needs analysis and inform strategic targeting and prioritisation					10
Means of Verification : Partnership MoU with BPHS IP and assessment data base							
Indicator 1.1.2	NUTRITION	Number of multi-sectoral assessments (SMART) conducted in provinces					8
Means of Verification : Partnership MOU, SMART data base							
Indicator 1.1.3	NUTRITION	Number of multi-sectoral assessment (SMART) reports shared with partners					8
Means of Verification : SMART Survey Reports AIMWG Minutes// Nutrition Cluster meeting minutes Datasets and database of assessments shared with the AIM-WG with clear disaggregation of Residency status of the assessed population (Host Communities, IDPs, Refugees). Sharing the report with FSL, WASH and Health Cluster. Usage of Report for IPC.							
Indicator 1.1.4	NUTRITION	Number of staff trained on multi-sectoral (SMART) assessment					200
Means of Verification : Training attendance lists and certificates; Updated database shared through AIM-WG and Cluster							
Indicator 1.1.5	NUTRITION	Number of Rapid SMART assessments conducted					2
Means of Verification : Partnership MoU with BPHS IP and assessment data base							
Indicator 1.1.6	NUTRITION	Number of Rapid SMART assessments report shared					2
Means of Verification : Rapid SMART Assessment report							
Indicator 1.1.7	NUTRITION	Number of staff trained on Rapid SMART assessment					48

Means of Verification : Training attendance sheet, training reports, photos pre-post test results

Activities

Activity 1.1.1

Standard Activity : Not Selected

Identification of 8 provinces for 8 integrated multi-sectoral assessments (SMART) and 2 rapid SMART surveys.

In 8 provinces, Nutrition Cluster partners and selected staff of government authorities, BPHS IPs and NGOs will benefit from capacity building and on-the-job support on integrated and rapid SMART surveys. Integrated SMART surveys include the following components: Anthropocentric data, Emergency Mortality, Morbidity, basic Health indicators, key WASH and FSL indicators.
Under the supervisions of Assessment and Information Management Working Group of Nutrition Cluster, these SMART assessments will be conducted in provinces with hard to access districts and areas in close partnerships of BPHS implementing partners that implementing nutrition programs in their respective districts. A partnership MoU will be developed with each provincial level partner, BPHS implementing agencies with specific roles and responsibilities to conduct these assessments in the provinces. A part of the budget will be transferred to these partners to hire data enumerators and facilitate conducting the assessment like training of data enumerators, providing logistic support, and jointing monitoring the data collection process in field with ACF technical team. They will also help in data feeding and then ACF technical team will develop and share reports to AIM-WG and nutrition cluster for partners to use the data in future planning.

Activity 1.1.2

Standard Activity : Not Selected

Identification and capacity building of BPHS partners on SMART assessments.

These assessments in close coordination with BPHS IPs will help building their capacity to conduct SMART assessment for their respective provinces in future. On-the-job trainings for BPHS staff, NGOs and local Government will develop a pool of experts in these hard to access areas in country to conduct assessments for their respective program when required after this project. ACF targets 200 people, of which 48 women and 152 men, which includes survey supervisors, team leaders and data enumerators. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SMART Surveys.

Activity 1.1.3

Standard Activity : SA2- Enabling Action (Assessments) - Sector specific needs assessments that address current humanitarian data gaps and inform strategic cluster programming approaches. Priority will be given to proposals for humanitarian assessments covering a wide range of actors and their information needs across sectors as well as within the 45 hard to reach districts identified by the ICCT;

Conduct 8 multi-sectoral assessments (SMART) and 2 Rapid SMART assessments in 8 targeted provinces of Afghanistan.

Implementation of 8 multi-sectoral assessments (Nutrition, WASH, Health and FSL) and 2 Rapid SMART by partner with technical support from ACF as part of its new capacity building strategy, ACF will seek to empower and support partners to take the lead on the process of SMART implementation, from the methodology, questionnaire, sampling to data collection, entry, analysis and preliminary report writing. The 8 multi-sectoral assessments will be implemented in hard to reach provinces and as per the Public Nutrition Department request, they will cover the entire provinces of Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul. As for the Rapid SMART, they will be implemented in hard to reach provinces according to needs identified.

During the previous project, ACF staff was acting as SMART Manager, directly providing training to supervisors and enumerators in the field, although with compulsory participation of senior level partners, field staff in a bid to enhance their capacity. Under the proposed project, ACF will engage the SMART Managers and members of the AIM-WG trained during the previous project to strongly participate to and implement the surveys, with ACF acting as technical backstop. Following the formal training provided to partner's nutrition field staff at central level, ACF will provide field-level practical training to Survey Managers for the implementation of one SMART survey in their province. Capacitated during the formal training, Survey Managers will be supported to take the lead and conduct the 7 days theoretical training for enumerators and supervisors led by the partner Survey Manager, with job shadowing by ACF SMART experts. Partner Survey Manager will also be responsible for planning field work and supervising data collection, including quality checks, and data entry on ENA software. ACF considered that a SMART survey requires the mobilization of 6 supervisors, 6 team leaders, and 12 enumerators (2 enumerators per team, 1 male and 1 female when possible) plus one Public Nutrition Officer/MoPH from each province. The number of staff actually targeted will be verified against attendance lists to the SMART training, and daily worker payment sheets that the partner will provide to ACF at the end of the survey to justify expenses.

Activity 1.1.4

Standard Activity : Not Selected

Production and dissemination of 8 integrated and 2 rapid SMART Survey reports

Production and dissemination of reports through National and Sub-national Clusters. Processing of shadowing partner's Survey Manager will extend to preliminary report writing for ACF SMART experts will provide continuous hands-on support. Considering the advanced technical knowledge required for writing the full report. ACF will keep the lead on writing the full report, while working in close collaboration and inputs/review/validation with partners. This will ensure timely production and dissemination of the report to the Nutrition Cluster.
As co-chair of the AIM-WG, ACF has worked in 2014-17 on establishing quality assurance mechanisms for SMART and Rapid SMART data, the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of nutrition data produced under SMART and Rapid SMARTs by a restricted pool of experts. In line with this approach, and following the current process of validation, results of the SMART and Rapid SMARTs, after validation by ACF and partners, will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Clusters. For integrated SMART surveys, a preliminary report will be released one week after the completion of the data collection, while the final report will be shared within one month through the AIM-WG. For Rapid SMARTs, the report will be produced and shared within a week. As partners will be more involved than before in report writing (until the preliminary report stage), and will have more ownership of the overall survey, results will be jointly presented to the AIMWG, and to the Cluster by ACF and the partner. Acknowledging the need to channel the results down to the provincial level, ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.

Output 1.2

Description

Coverage of SAM and MAM services and barriers and boosters for access are evaluated in 2 IMAM programs with very high and low coverage using SQUEAC methodology

Assumptions & Risks

Security does not deteriorate in target areas and allow access to field teams
Partners remain committed throughout the project and actively participate to training.
AIM-Working Group and nutrition cluster support ACF signing MoUs with BPHS IP
MoPH and PND support will be available resolving provincial level departmental facilitation required

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.2.1	COORDINATION AND COMMON SERVICES	SA2 -Enabling Action (Assessments) - Number of cluster led sector specific needs assessments designed and implemented to enhance humanitarian needs analysis and inform strategic targeting and prioritisation					2
Means of Verification : Partnership MoU. SQUEAC data base							
Indicator 1.2.2	NUTRITION	Number of SQUEAC assessments conducted in provinces					2
Means of Verification : Partnership MoU. SQUEAC data base							
Indicator 1.2.3	NUTRITION	Number of SQUEAC reports shared with partners					2
Means of Verification : SQUEAC report, minutes of AIM-WG meeting minutes of report presentation and endorsement							
Indicator 1.2.4	NUTRITION	Number of staff trained on SQUEAC assessment					50
Means of Verification : SQUEAC training report participants lists, training evaluation reports, training report							

Activities

Activity 1.2.1

Standard Activity : Not Selected

Identification of priority areas for conducting 2 SQUEAC assessments

2 SQUEAC will be implemented in 2 of the targeted provinces, to allow for compressive analysis of barriers and boosters of IMAM program in targeted provinces and to support informed decision making of the BPHS partner on the ground as to where and how to improve IMAM services within the province. The coverage of SQUEAC (e.g. number of districts) will be discussed bilaterally with partners during project inception, considering access and review of secondary data. The main criteria for selection of a province for SQUEAC assessment will be the existence of both SAM and MAM services in the province. It will be discussed with partners in AIM-WG of nutrition cluster before planning and signing MoU with BPHS IP or any other IMAM program implementing partner. A MOU will be signed with the partner for its respective province SQUEAC arrangement to facilitate the ACF technical team to work with partner organization to conduct the assessment. The MoU will clarify the role and responsibilities of IP and ACF including the financial management of the activity.

Activity 1.2.2

Standard Activity : Not Selected

Identification and capacity building of BPHS partners on SQUEAC assessments

Conduction of capacity building and on-the-job trainings for BPHS staff, NGOs and Government line departments like provincial level staff of PND. ACF targets 50 people, of which 12 women and 38 men. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SQUEAC Surveys. The capacity building of partner organizations will involve the partner staff who have attended previous managerial level SQUEAC training organized by ACF with CHF funding. These training of partner staff and data enumerators at provincial level build capacities of local experts to be present in their respective provinces to support nutrition program conducting SQUEAC in future.

Activity 1.2.3

Standard Activity : SA2- Enabling Action (Assessments) - Sector specific needs assessments that address current humanitarian data gaps and inform strategic cluster programming approaches. Priority will be given to proposals for humanitarian assessments covering a wide range of actors and their information needs across sectors as well as within the 45 hard to reach districts identified by the ICCT;

Conduct SQUEAC in the two targeted provinces of Zabul and Uruzgan in support of partners.

Once area of SQUEAC identified in the provinces of Zabul and Uruzgan, MoU signed and partner staff and data enumerators are trained, they will formally start with support of partner organizations and locally hired data enumerators. ACF technical staff will be present in province to train the partner organization's staff and data enumerators and technically support data collection for quality data, monitor the data collection and feeding process as well as work with partner organization to clean and analyze data for first draft report of the each of 2 SQUEACs. Partners will provide logistic support and ACF technical team will be there for technical support of the process as well as building capacities of partner organization to conduct SQUEAC in their respective provinces to monitor barriers and boosters of IMAM program being implemented there.

Activity 1.2.4

Standard Activity : Not Selected

Production and dissemination of reports through National and Sub-national Clusters

ACF will be responsible in guiding the trained partner staff in producing the SQUEAC report, with active involvement of the partner for review/validation prior external dissemination. For SQUEAC evaluations, draft report will be released with a month after the completion of the survey, while the full report should be completed within the following month. In an attempt to capacitate partner staff on SQUEAC, and encourage ownership of the findings, results will be presented jointly by ACF and the partner to the AIM-WG, and to the Cluster. As co-chair of the AIM-WG, ACF has supported the establishment of quality assurance mechanisms for SQUEAC; the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of SQUEAC evaluation - by a restricted pool of experts. In line with this approach, and following the current process of validation results of the SQUEAC will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Cluster. Acknowledging the need to channel down the results to provincial level, ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.

Additional Targets :

M & R

Monitoring & Reporting plan

As indicated in the five LFAs, specific standard indicators per cluster directly correlate to CHF cluster specific strategy objectives as well as individual technical indicators. The activities outlined have a corresponding indicator that tracks the quantitative and qualitative contribution to cluster strategies. ACF will develop integrated monitoring tools as needed to collect data as programs are implemented without creating burden on communities. i.e. Mainstreamed protection in WASH and integrated protection within WASH and Nutrition are monitored using specifically designed tools that collect data on the impact of each activity through the targets set within the LFAs. To sort integrated data MEAL and technical teams will use analysis matrix to track 3 outputs: 1) contribution to cluster indicators and strategies comparing set targets to yet to be reached, 2) contribution to technically specific indicators, and 3) the depth and quality of integration and mainstreaming within each activity (Denzin 2000). The collection of data will contribute to communication and reporting to each cluster on each output, adapting output 2 to be more on relevant cluster specific technical details when reporting. As well as uploading to the relevant Reporthubs on the standard indicators per clusters each month, quarterly reporting using the WWW per clusters and the ACF monthly APRs, mapping matrix on locations of activities – following shared drafts of the tools, lessons learned and best practices template, cluster specific field assessment, ACF specific dissemination products, and research learning based papers will all be used to filter and funnel output and outcome reporting to relevant bodies. Nutrition is ACF primary mandate. There has always been a focus on how malnutrition is mitigated using Nutrition and complimentary WASH, FSL and MHCP. This has also been reliant on ACF's nutritional surveillance, which is central to the scope and need of nutritional support and its contributing factors. . Integrated and mainstreamed activities here will be supported under ACF monitoring system, which uses Nutritional surveillance, and Nutrition, WASH, FSL and protection referents. Standard tools are outcome oriented, and include (i) weekly progress reports, indicating achievements vs planned objectives, and (ii) APRs providing programming information including beneficiaries reached - using indicators of the LFA. Baseline on integrated behaviors in multi-sectors will be conducted to design BCC strategies that would contribute in improving the hygiene and nutrition practices. Baseline will provide a measure of the improvements by contrasting its findings with endline. ACF also will collect/analyze nutrition data on daily basis from the targeted villages, baseline information on FS indicators from the proposed targeted prolonged IDP HH and conduct a door-to-door beneficiary selection survey among prolonged IDPs, using HEAT assessment form with further FS indicators. PDM data will be collected to observe changes in FS indicators and the satisfaction and utilization of hygiene kit and BSF distribution. ACF will regularly report to the AIM-WG, ACF will report all cluster specific progresses, achievements, and challenges, identifying further opportunities to contribute to cluster strategies as programs progress and overall maximize humanitarian impact. All reports produced under this project will be shared through the National and Sub-national Clusters, as well as relevant health authorities at Provincial, and District levels.
Under the technical guidance of the MEAL and technical departments at the country level, field teams collect data from beneficiaries using HH interview, FGD, transect walk, community based feedback mechanisms and direct observations. To ensure the quality of services delivered, any gaps, needs, or delays observed will be used to improve the programs and inform future programs planning.

Workplan

Activitydescription	Year	1	2	3	4	5	6	7	8	9	10	11	12
Activity 1.1.1: Identification of 8 provinces for 8 integrated multi-sectoral assessments (SMART) and 2 rapid SMART surveys. In 8 provinces, Nutrition Cluster partners and selected staff of government authorities, BPHS IPs and NGOs will benefit from capacity building and on-the-job support on integrated and rapid SMART surveys. Integrated SMART surveys include the following components: Anthropocentric data, Emergency Mortality, Morbidity, basic Health indicators, key WASH and FSL indicators. Under the supervisions of Assessment and Information Management Working Group of Nutrition Cluster, these SMART assessments will be conducted in provinces with hard to access districts and areas in close partnerships of BPHS implementing partners that implementing nutrition programs in their respective districts. A partnership MoU will be developed with each provincial level partner, BPHS implementing agencies with specific roles and responsibilities to conduct these assessments in the provinces. A part of the budget will be transferred to these partners to hire data enumerators and facilitate conducting the assessment like training of data enumerators, providing logistic support, and jointing monitoring the data collection process in field with ACF technical team. They will also help in data feeding and then ACF technical team will develop and share reports to AIM-WG and nutrition cluster for partners to use the data in future planning.	2017											X	
	2018												

Activity 1.1.1: Mobilization of the communities, selection of sites in schools and villages, and signing of MoU with the respective ministry and with each selected villages of Lashkargah district During project inception, a technical assessment of all existing water sources of the selected area will be carried out, in order to acquire deep knowledge about quantity and quality of water available to population, functionality and condition of water points (hand pump, apron, and surrounding area), habits of people with regards to fetching water, water chain and conservation (containers cleanness, transport, water use). In assessing these, due attention will be reflected on women and children's roles as primary collectors of water, the safety of water collection points including shade where there are queues. Facilitated by an integrated psychosocial officer in the WASH sector per base to reflect GBV action for WASH 2 - the informed mobilisation of communities and the selection of sites linked to women and girls protection and dignity, ACF will ensure equal participation from different gender groups in the location, design and maintenance of WASH facilities to ensure women are not overburdened with these roles in addition to the typical gender daily calendar, facilitate different gender groups to identify the full scope of risky hygiene practices and their subsequent community appropriate mitigation, and advocate to ensure a gender balance in committees – to be comprised of 50% women. Results of all committee findings, lessons learned from earlier water point constructions, and best practices will be member checked with Health Facility (HF) management staff, schools directors, and community members, and a final dissemination to all groups for last inputs before construction begins. In communities identified as water-stressed, site selection will be done jointly with CDC and PRRD to guarantee full involvement of communities and key focal community engaged authorities including the Department of Women's Affairs, which currently leads in different provinces on interventions for the reduction of GBV, as well as transparency and respect of local culture and norms. Upon selection of sites, a MoU will be signed with each community in order to clarify and acknowledge roles and responsibility of each party to the project with particular focus on clear definitions of integrated roles. Local authorities and technical bodies of Helmand Province (PRRD) will be invited during discussions with the communities regarding the MoU and the project action plan.	2017											X	
	2018												
Activity 1.1.1: MoUs with local authorities (DoRR) on project ACF will develop and sign a mutual MoU with assigned rules and responsibilities of DoRR and ACF for the selection of beneficiaries and cash distribution.	2017											X	
	2018												
Activity 1.1.1: Provision of mainstreamed mobile outreach protection services There is a notable lack of research on the links between WASH and GBV, therefore, an ACF WASH KAP will also explore lack of access to WASH and increased vulnerability to physical violence, early marriages, access to education. The surveyors will mostly be women, facilitating women and children's participation will promote claimed rights on WASH access and mitigated GBV. Women's involvement and children's involvement in data provision and subsequent decision making based on this data is critical to their empowerment. Informed mobilisation of communities and the selection of sites linked to women and girls protection and dignity, ACF will ensure equal participation from different gender groups in the location, design and maintenance of WASH facilities to ensure women are not overburdened with these roles, facilitate different gender groups to identify the full scope of risky hygiene practices and their subsequent community appropriate mitigation, and advocate to ensure a gender balance in committees. Results of all committee findings including lessons learned and best practices will be member checked with Health Facility management staff, Schools directors, and community members. Water stressed site selections will be coordinated with Department of Women's Affairs which currently leads in different provinces on interventions for the reduction of GBV, we well as transparency and respect of local culture and norms. Training for schoolteachers, community leaders, Community Development Councils and health Workers will lead to increased outreach of health and hygiene promotion, as ACF will work with authorities to supervise, monitor and support aforementioned actors for sensitizing pupils/students and the community members on personal and environmental hygiene in both communities and schools. Supported by active supervision, provision of IEC material, and refresher/on-the-job training. Increasing the frequency of outreach of hygiene promotion sessions in schools and at community levels.	2017											X	
	2018										X		

Activity 1.1.1: Screening, referral and treatment of SAM and MAM children and malnourished PLW through mobile clinics integrated with psychosocial support and care practices ACF will directly implement mobile nutrition services in IDP Mukhtar settlement and in other villages outside the camp, composed of one supervisor (medical doctor), two certified Nurses/midwifes, 2 measurers/screeners, 1 for health education and 1 psychosocial officer with the aim of (i) conducting passive case finding of SAM-MAM children (in support to CHWs that ACF will train and supervise), and (ii) delivering SAM, MAM and acute malnutrition PLW treatment at community level integrating psychosocial support and care practices to account for the many barriers including potential social norms acting as barriers (e.g. Mother's in law not supporting exclusive breastfeeding sessions) to accessing such services identified in Helmand. Mother's in law have been consistently identified during Helmand based GBV workshop and Ghor based Gender Analysis lead by ACF Gender/GBV expert to be consistent triggers in GBV at home level. Acute malnourished children with medical complications and/or poor appetite who require intensive care it will be referred to an inpatient facility and receive follow up treatment at mobile clinics. During the consultation child measurement, appetite test, medical consultation, postnatal depression assessment (where needed), assessment of understanding of care practices (where needed), observation of mother-child relationship, distribution of medical and nutritional treatment in line with the national guideline, and referred to any psychoeducation or counselling groups where needed. ACF will be entirely accountable for the performance of this team, and report on the number of children screened, admitted, and OTP and basic general and psychosocial health performance indicators (i.e. number of medical consultations, psychosocial assessments, GBV referrals, cured rate, defaulter rate, progression in care practices, and death rate).	2017											X	X
	2018	X	X	X	X	X	X	X	X	X	X		

Activity 1.1.2: Construction/Rehabilitation of water sources in schools, health facilities and communities The construction/rehabilitation of 21 water sources will take in consideration the characteristics of underground water, and will cover schools, HF and most vulnerable IDPs and host communities with lack or poor access to safe and clean water. The intervention will focus on the rehabilitation of existing water points, according to needs (e.g. physical condition of the water point), suitability of access for different gender groups, and priority ranking of the institutions depending on the number of students. Where no water point exists in the school compound, a new bore well will be constructed. In HF, ACF will rehabilitate the existing water sources, install a solar powered submersible pump for water pumping and ensure that water is available in the key areas including the delivery rooms, toilets, hand washing stations and the clinical laboratory. The design and construction of the water points will be done in consultation with the intended users. The criteria for selecting communities for water point construction will be safe water coverage, considering availability of functional protected water points, as well as the distance to the water point. In addition, reflecting GBV action for WASH 3, the location of the water points will be in areas that are accessible and safe for all, to that end the decision regarding the location of the new water point will actively involve discussion with all members of the community, and in general no more than 500m from HH. ACF will consider the safety and protection of users (e.g. ideally located near mosques or in the centre of villages to ensure safety of those responsible for water collection – essentially women and children). Rehabilitation activities will entail improving the water points to reduce the possibility/risk of contamination (reinforcement and plastering of well, construction of apron, drainage channel and soak pits, disinfection of the well and installation of hand pump). A water quality analysis before and after rehabilitation of water points will be conducted for all them before handover. ACF will construct/rehabilitate water points with the involvement of the communities, as opposed to sub-contracting the work to private contractors. During implementation, all the unskilled workers will be recruited from the community and for the skilled workers, priority will be given to those based in the communities where the water points are to be rehabilitated/constructed. ACF acknowledges that relying on community mobilization offers multiple advantages: full control on the supply chain and close monitoring of equipment/material use, increased sense of ownership by beneficiaries, acquisition of knowledge by community members on water point infrastructures and subsequent improvement in maintenance. ACF will facilitate community members to have their inputs in the issues concerning the works on the water points. ACF will use its female staff to go to selected HH to collect view of women, who are restricted from attending community meetings. Hiring local people as daily workers will also contribute to supporting community members' income and purchasing power. All the construction/rehabilitation of water points will be monitored by ACF, Shuras and CDCs; as well as provincial technical bodies in addition to the Head of the Department of Women's Affairs (DOWA) in order to ensure the quality of the works and respect of MRRD standards and maintained equity of access for women and girls. At the end of the project, all the structures will be formally handed over to the communities, in the presence of relevant local authorities, again supported by the DOWA to mainstream violence prevention messages on water sources in schools, health facilities and communities, and develop dignity and safety standards specific to each space e.g. different standards for young girls in schools compared to PLWs in HF.	2017												X
	2018	X				X	X	X						
Activity 1.1.2: Identification and capacity building of BPHS partners on SMART assessments. These assessments in close coordination with BPHS IPs will help building their capacity to conduct SMART assessment for their respective provinces in future. On-the-job trainings for BPHS staff, NGOs and local Government will develop a pool of experts in these hard to access areas in country to conduct assessments for their respective program when required after this project. ACF targets 200 people, of which 48 women and 152 men, which includes survey supervisors, team leaders and data enumerators. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SMART Surveys.	2017												X
	2018	X												
Activity 1.1.2: Integrated IMNCI services for children through mobile clinics The mobile teams will also provide medical treatment for children affected by common and basic illnesses who do not need to be referred to an inpatient facility, and engage the local partner in order to facilitate the referral of children needing admission in therapeutic feeding units or pediatric wards. From the actual project in Helmand, an average of 2 consultations per child per year will be done.	2017											X	X
	2018	X	X	X	X	X	X	X	X	X	X			

Activity 1.1.2: Provision of mainstreamed static protection services	2017											X	
During Construction/Rehabilitation of water sources in schools, health facilities and communities, reflecting GBV action for WASH 3, the location of the water points will be in areas that are accessible and safe for all, to that end the decision regarding the location of the new water points will actively involve discussion with all members of the community, and in general no more than 500 meters from households. Due consideration to safety and protection of users (e.g. ideally located in close to mosques or in the centre of villages to ensure safety of those responsible for water collection – essentially women and children). Before rehabilitation or construction of the water points, ACF will facilitate a community with members to have their inputs in the issues concerning the rehabilitation or construction of the water point. ACF will use its WASH team of female staff to go to selected households to collect view of women, who are restricted from attending community meetings. Hiring local people as daily workers will also contribute to supporting community members' income and purchasing power. All the construction/rehabilitation of water points will be monitored by ACF, Shuras and CDCs; as well as provincial technical bodies PRRD (Provincial Rural Rehabilitation and Development) in addition to the Head of the Department of Woman's affairs in order to ensure the quality of the works and respect of MRRD standards and maintained equity of access for women and girls. At the end of the project, all the structures will be formally handed over to the communities, in the presence of relevant local authorities, again supported by the Department of Woman's Affairs. With this support, mainstreamed violence prevention messages on water sources in schools, health facilities and communities, will develop dignity and safety standards specific to each space e.g. different standards for young girls in schools compared to PLWs in health facilities. Conducting Hygiene promotion sessions (for boys and girls) in Schools, ACF reorganizes that to ensure sustainability of the WASH programs in schools, the involvement of national authorities, community leaders, communities and parents is crucial. ACF will not only construct/rehabilitate WASH facilities in the most vulnerable schools but will also work the provincial department of education to ensure impactful hygiene promotion sessions in the schools. ACF will conduct special sessions and with different styles for each the different age groups. The mainstreamed topics during the various sessions for students will include care practices on safe handling of drinking water, safe disposal of wastewater, safe disposal of human excreta, disposal of solid waste, household sanitation and food hygiene and personal hygiene. These topics will be taught using participatory methods where students actively identify the reasons for these care practices and what supports they need at home and community level to have sustainable practice. Integrated WASH and psychosocial programming will also facilitate children's involvement in youth hygiene clubs within and outside the school; in turn supported by community leaders and committees. To support hygiene promotion in the schools, IEC (materials posters and leaflets) will be distributed and followed up, in order to see how they implement hygiene sessions and provide advise where needed. Linking with above activities, special sessions will also be delivered to teachers to deliver Menstrual Hygiene management clues and advises in a sensitive and objective manner as per context of the project area, with follow up OTJ and supervision – addressing the international MHGap on limited follow up to sensitive topics of training leading to limited impact.	2018												

Activity 1.1.2: Selection and registration of food insecure beneficiaries based on assigned criteria	2017											X
Having identified the need for cash assistance, in response ACF will start the process of screening the prolonged IDPs households and selecting the most vulnerable and eligible prolonged IDPs households for this assistance. The process will be started with screening internal lists (as part of the ERM project). ACF team will do cross check individually, through household visit and administration of HEAT questionnaire based on which ACF will extract the final list of beneficiary households. The cash assistance will be delivered for food insecure prolonged IDPs households' targeted based on vulnerability criteria. To target the prolonged food insecure conflict induced IDPs households who have been staying in Helmand, ACF will apply vulnerably scoring technical using weigh for each vulnerability criteria identified. Then the data collection will be carried out on paper and enter into excel data base, analysis and scoring will be conducted to identify the eligible beneficiaries. The pre identified criteria for selecting prolonged vulnerable households is as followings: 1. Status (displaced for more than 6 months up to 2 years), 2. Size and composition of the family (large households with more than 8 members) 3. Female/disabled/headed households 4. Households with no working age adults 5. Sources of income (no income or earning main income from either borrowing, casual unskilled non-construction labor, begging, casual construction labor, small business, or others non-specified jobs used as proxy indicator for poverty) 6. Households with more than 2 children under 5 years old 7. Household with more than 1 pregnant woman 8. High rCSI of 18 or above scores/ or using more than one food base coping strategy 9. Household with poor food consumption score 10. Households living in shelter with mud walls and tarpaulin roof, or households living in tents 11. Household with less than 3 weeks food stock 12. Households with more than 1 elderly person 13. Households with more than 1 disabled person 14. Households with more than 1 chronically ill person	2018	X	X									

Activity 1.1.3: Cash assistance to food insecure prolonged IDP HH in Lashkargah district, Helmand province Once the eligible beneficiaries based on vulnerability scoring techniques are identified for this intervention, ACF will disburse the cash in two months. The market systems continue to function in targeted area of Helmand. Cash has been proven an effective tool to deliver aid in a way that empowers vulnerable people to meet their needs with mainstreamed protection supported by an integrated psychosocial officer to ensure more flexibility, dignity and choice. In addition, cash transfer programming supports local markets and stimulate trade. ACF has advocated for the use of cash transfers as an emergency response and have been appropriate and successful due to its suitability in terms of community acceptance, market access and capacities, and availability of various transfer mechanisms. However, ACF is aware and commits to mitigate risks women and girls where cash is distributed. ACF has a long experience and experienced staff in CBI sector. Moreover, ACF implemented numerous projects in different provinces of Afghanistan. In order to avoid duplication, ACF will consult and coordinate with DoRR and active NGOs in Helmand. Furthermore, ACF has maintained and strengthened regular coordination and communication with OCHA regional offices, regional/national clusters and other partners working in Helmand. The new field staff to be recruited will undergo series of training and orientations on the project objectives and technical inputs, including protection in emergency and mainstreamed protection in FSL. ACF will hire female staff to be engaged in the fieldwork and conduct the beneficiary verification and post distribution monitoring surveys (PDM will be led by an independent MEAL unit, with the assistance of female project staff) to mitigate exposure to risks for women and girls during data collection thus ensuring the female voice is represented and integrated to program activities. Traditional beliefs are very strong in the rural population in Helmand, male staff cannot survey and contact female member of households. ACF has been conducting market surveillance under ERM and CHF project in Helmand province concerning supply and price conditions that has confirmed the availability of food and NFIs. As items were found to be available in sufficient quantity and at affordable prices. Lashkargah, being the province capitals, host a major market that continues to function even during massive conflict around Lashkargah city. This led to the adoption of a CBI approach for the IDPs against in-kind assistance. The CBI modality chosen for this intervention is DIRECT CASH to be provided to the beneficiaries using the existing Hawala system. There will be two tranches for cash distribution for each beneficiary household selected: The cash distribution will take place after beneficiaries are identified based on assigned vulnerability criteria and vulnerability scoring techniques. ACF has aligned the amount to the FSAC standard package of 2,100 Kcal/person/day (i.e.180 USD per HH for a total of 2 months covered). The cash will be distributed in two installments covering their 2 months food needs. 1,000 food insecure prolonged conflict IDPs households of Helmand will benefit from this UCT activity. Delivery of cash to the beneficiaries will be through the existing Hawala system (with presence of ACF staffs), an informal remittance system, prevalent and effective in the country and in Helmand province. ACF has been using the Hawala system since 2008. A distribution plan will be developed to include the scheduling, cash distribution points taking careful consideration on security, mitigate risks, and not to disrupt market prices. ACF will be conducting monthly price monitoring on the markets to monitor the impact of the intervention and potential inflation of prices.	2017											
	2018		X	X								

Activity 1.1.3: Conduct 8 multi-sectoral assessments (SMART) and 2 Rapid SMART assessments in 8 targeted provinces of Afghanistan. Implementation of 8 multi-sectoral assessments (Nutrition, WASH, Health and FSL) and 2 Rapid SMART by partner with technical support from ACF as part of its new capacity building strategy, ACF will seek to empower and support partners to take the lead on the process of SMART implementation, from the methodology, questionnaire, sampling to data collection, entry, analysis and preliminary report writing. The 8 multi-sectoral assessments will be implemented in hard to reach provinces and as per the Public Nutrition Department request, they will cover the entire provinces of Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul. As for the Rapid SMART, they will be implemented in hard to reach provinces according to needs identified. During the previous project, ACF staff was acting as SMART Manager, directly providing training to supervisors and enumerators in the field, although with compulsory participation of senior level partners, field staff in a bid to enhance their capacity. Under the proposed project, ACF will engage the SMART Managers and members of the AIM-WG trained during the previous project to strongly participate to and implement the surveys, with ACF acting as technical backstop. Following the formal training provided to partner's nutrition field staff at central level, ACF will provide field-level practical training to Survey Managers for the implementation of one SMART survey in their province. Capacitated during the formal training, Survey Managers will be supported to take the lead and conduct the 7 days theoretical training for enumerators and supervisors led by the partner Survey Manager, with job shadowing by ACF SMART experts. Partner Survey Manager will also be responsible for planning field work and supervising data collection, including quality checks, and data entry on ENA software. ACF considered that a SMART survey requires the mobilization of 6 supervisors, 6 team leaders, and 12 enumerators (2 enumerators per team, 1 male and 1 female when possible) plus one Public Nutrition Officer/MoPH from each province. The number of staff actually targeted will be verified against attendance lists to the SMART training, and daily worker payment sheets that the partner will provide to ACF at the end of the survey to justify expenses.	2017												
	2018		X	X	X	X	X	X					
Activity 1.1.3: Distribution of 570 Bio Sand Filters (BSF) to selected households and training on operation and maintenance, with a particular focus on female-headed households. According to ACF experience, the Bio Sand Filter is the most suitable Household Water treatment (HWT) in this context. Since 2015, ACF has distributed 3,710 BSFs in Helmand. The Bio-Sand-Filters will be locally produced, and assembled by ACF technical team following established technical design standards. After having thoroughly checked their quality the BSFs, ACF technical team will then install the BSFs in targeted families' houses, and train recipients on how to operate and maintain them. Experience gained by ACF in promoting this technique in Afghanistan shows BSFs are one of the most cost-efficient options to improve access to safe water, with the following advantages: (i) easy operation and maintenance not associated with any cost, (ii) long life-span (ACF distributes metallic galvanized BSFs) and capacity to provide clean water for many years (40-80 liters daily and 10 years life expectancy).The provision of BSF will guarantee a better quality of the water especially for women as they use also for personal hygiene, decreasing their exposure to water related diseases. This approach is a further dimension of WASH and psychosocial integration, and will proactively respond to the physical risks and threats accessing water and other sanitation facilities can present for women (ACF Gender Analysis 2017). Households will be prioritized according to their vulnerabilities, with a specific focus on cumulative and compound vulnerabilities such as female-headed households with limited or no income. The rationale for distributing BSF is as follow: (i) poor quality of the water collected from the wells (very often salty or contaminated by E.Coli), forcing individuals to fetch water from unsafe sources (river, channel ,unprotected kanda/karez ,water pond, etc.), (ii) difficulty of providing safe and clean water from boreholes and hand dug wells in areas where water is scarce and digging/drilling is associated with high costs (need to go very deep), and (iii) population pressure on water sources linked to population migration and displacement, where numbers of users and frequency of use exceeds the operational capacity of the water point (like in Lashkargah), creating queues and breakdowns of the pump, forcing again families to fetch from unprotected sources of water. Considering (i) the high density of population in Helmand linked to economic migration and conflict induced displacement, (ii) the high rate of non-functional water points, reflecting poor capacity for maintenance, and (iii) the local geology (few springs and deep water table), Therefore, in a bid to durably improve access to safe water and reduce incidence of water borne diseases, ACF will continue the distribution of BSFs to households.	2017												
	2018	X	X	X	X								

Activity 1.1.3: IYCF message given through mobile clinics	2017											X	X
The current majority of admissions into nutrition programs are children aged 2 years or less. There is a gap on the successful dissemination of key messages on the 1,000 days (7 ENA, including IYCF). ACF integrated programming will strengthen the methodology for dissemination through more participatory and psychosocial methods and the purposive targeting of key groups including husbands, fathers and mothers-in-law as a mitigation strategy against GBV at household level where otherwise the mother trained would be entirely responsible for transferring knowledge to the household and sustaining IYCF related household behavior change. These messages will be delivered during specialized psychoeducation sessions on care practices during mobile clinic activity. The messages will include topics on maternal and personal health care, infant and young child feeding including exclusive breastfeeding, and health care complemented with corresponding topics on mother self-care (using this specific module as a means of distribution on GBV awareness), mother-child attachment, balance food preparation and person and home hygiene. A system of messages, building on previous sessions, will be organized every week targeting all caretakers accessible including those with the child independent form IMCI consultation or nutrition program. Addressing the Mental Health Gap in education and training from a global mental health and psychosocial services (MHPSS) perspective, during follow up, if the mother requests or indicates further supports/training is needed. Or if integrated Health, Nutrition and Psychosocial team identify additional or ongoing need, further appropriate support by specialized education will be provided. Where the ongoing need or additional need is rapidly contributing to infant's reduced or stagnant weight, the infant will be referred to the therapeutic feeding unit at the hospital immediately, while the mother is supported.	2018	X	X	X	X	X	X	X	X	X	X		
Activity 1.1.4: Establishment/reinforcement of WSUCs, mechanics and caretakers	2017												
ACF will facilitate the establishment and/or support of water committees (one per targeted village or per school supported by the psychosocial officer to ensure different needs are properly voiced with sensitized monitoring and capacity building), who will be responsible for the overall organization, planning, and supervision of the operation and maintenance of the public water points, to promote the sustainability of the intervention. Low maintenance was identified during several ACF WASH surveys as one of the main barriers to accessing safe water for targeted communities. To strengthen the capacity of communities on operation and maintenance of water point, ACF will establish/reinforce the Water and Sanitation Users Committees (WSUCs), ensuring the presence of female members as foreseen by MRRD policies. ACF will coordinate with PRRD and CDC members to ensure that WSUC members are selected from the respective villages the water points are situated. The water committees will be trained on water point management and involved during activities implementation in order to ensure sustainability. The WSUCs will also be supplied with spare parts and tools to guarantee the repair of the hand-pumps. The training will include operation and maintenance of the hand pump, environmental hygiene of the water point, coordination with community members to contribute to the maintenance of the community water point. In schools, guards, cleaners, selected members from the community, the responsible teachers or health facility staff will be trained on the operation and maintenance of the pump. Mechanic and caretakers will be trained according to their competences and technical skills, and equipped with tools for maintenance (broom, bucket, shovel, and trowel - for caretakers) and repair (spanners, hacksaw, glue, sand paper, finishing tools, etc. - for mechanics). Responsible for planning and overseeing maintenance and repair operations, the WSUC will also be equipped with spare parts (PVC pipes and sockets, rods, centralizers, valves and rubbers, etc.) - which donation will be formalized into a Memorandum of Understanding with the Community development Committee (CDC). Under protection, utilising CDC as a means of distribution on GBV with info sharing on available resources within the local community related to GBV proactive (e.g. anti-violence messages available at water points) and reactive support (ACF psychosocial counselling service for GBV cases), sensitizations for disaggregated gender groups on GBV issues related to water access including general workshops on lack of safe WASH causes up to 50% of malnutrition creating burdens for families and communities and specialized sessions for key groups on lack of clean water for PLWs where there is no equal access or balanced distribution of water increases risk for hookworm infestation leading to reduced health and survival rates of both mother and child, and engaging communities on the topic under overall WASH work.	2018				X	X	X						
Activity 1.1.4: Implementation of integrated programming	2017												X
Mental Health and Care Practices (MHCP) department will conduct coordinated implementation of integrated programming with psychosocial and care practices components and conduct trainings and program design support for any implementing actor on psychosocial counselling services including the support for integrated psychosocial officer in Water, Sanitation and Hygiene (WASH), Emergency, Monitoring, Evaluation, Accountability and Learning (MEAL) and Food Security and Livelihood (FSL) departments.	2018	X	X	X	X	X	X	X	X	X	X		

Activity 1.1.4: Post cash distribution monitoring survey One month after the distribution of cash, ACF MEAL team will carry a Post Cash Distribution Monitoring on a representative, randomly selected sample of beneficiaries in the area of the project. An independent MEAL unit will lead post-distribution monitoring, with the assistance of female project staff. The PDM will assess beneficiary satisfaction towards (i) the quantity of cash received, (ii) the timeliness of the distribution, (iii) the organization of the distribution, (iii) the cash usage, (iv) complaints and concern of beneficiaries. Results will be used to evaluate the quality of targeting (the level of use of the cash can be used as proxy indicator to understand whether the project effectively targeted the most vulnerable prolonged IDPs households), effectiveness of the intervention in responding to priority needs of targeted families (same comment), and support a short lesson learnt document to serve for future implementation of similar project. For PDM, 106 beneficiaries, representing 10% of the targeted beneficiaries as representative sample, will be selected for the interview. The sample size was drawn using a confidence level of 95% and a confidence interval of 9. This is the minimum percentage that ACF will include in the sampling for the PDMs to be conducted. A baseline survey will be conducted during the beneficiary selection in order to determine the current food security situation and conditions of the population. A Final survey together with PDM will be undertaken to compare with the baseline data, and to measure the impact of the project on beneficiaries. The baseline and final survey will contains food security indicators (i.e. FCS, rCSI and food stock). ACF has already started utilizing the PDM tool recently created by the Afghanistan Cash Voucher Working Group, endorsed by the ICC, and will submit a PDM report to the CHF and further sharing with the Afghanistan Cash Voucher Working Group and the Clusters.	2017											
	2018			X	X							
Activity 1.1.4: Production and dissemination of 8 integrated and 2 rapid SMART Survey reports Production and dissemination of reports through National and Sub-national Clusters. Processing of shadowing partner's Survey Manager will extend to preliminary report writing for ACF SMART experts will provide continuous hands-on support. Considering the advanced technical knowledge required for writing the full report. ACF will keep the lead on writing the full report, while working in close collaboration and inputs/review/validation with partners. This will ensure timely production and dissemination of the report to the Nutrition Cluster. As co-chair of the AIM-WG, ACF has worked in 2014-17 on establishing quality assurance mechanisms for SMART and Rapid SMART data, the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of nutrition data produced under SMART and Rapid SMARTs by a restricted pool of experts. In line with this approach, and following the current process of validation, results of the SMART and Rapid SMARTs, after validation by ACF and partners, will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Clusters. For integrated SMART surveys, a preliminary report will be released one week after the completion of the data collection, while the final report will be shared within one month through the AIM-WG. For Rapid SMARTs, the report will be produced and shared within a week. As partners will be more involved than before in report writing (until the preliminary report stage), and will have more ownership of the overall survey, results will be jointly presented to the AIMWG, and to the Cluster by ACF and the partner. Acknowledging the need to channel the results down to the provincial level, ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.	2017											
	2018			X	X	X	X	X	X			
Activity 1.1.5: Chlorination and water analysis of water points and Bio Sand Filters The quality of water will be tested at each water point constructed or rehabilitated in the schools and communities, as per MRRD standards and protocols upon completion of the work and before installation of the hand pump. Analysis consists in pH, turbidity (NTU), electro-conductivity (µS) and bacteriological tests (E.Coli), sampling three times for each test. The water points will be chlorinated as required and tested one month after the intervention. At household level, ACF team will analyse the quality of water on a sample of BSFs beneficiaries (10%), one month after the installation, using three samples in the inlet (fetched water) and three after the treatment (drinking water), in order to verify the functionality of the BSF and its efficiency as household water treatment device. A total of 99 water samples will be analysed (57 for BSF and 42 samples for water points constructed or rehabilitated).	2017											
	2018				X	X		X	X			

Activity 1.1.5: Conducting psychosocial education and/or counselling sessions	2017												X
Workshops employing adult education models will roll out staged modules on psychosocial and care practices, and protection to local partners and/or coordinated agencies operating in the area. To maximize learning and development for participants, numbers of participants per workshop will be capped at 20 participants per group, with a ratio of 2 trainers to 20 participants. To support the move of the theoretical training content to practical application at field level, ACF master trainers will also train all APA managers in a two-day orientation training on the core components partner, coordinated and ACF staff are inducted on. On-the-job mentoring and support for facilities and healthcare providers who have received training will then be implemented. Each facility where the partner is providing psychosocial counselling that has been trained will be visited at least twice for comprehensive post-training follow-up, mentoring and on-the-job training during the project. Following post training visits and midline project evaluation (as part of a broader monitoring, evaluation, learning and accountability plan), ACF master trainers will also organize refresher trainings for a percentage of trained staff targeting those who receive the lowest marks during post-training visits across the two provinces. In addition, where cases of GBV are identified, a response team integrated within the Health team made up of psychosocial counselling staff managed by the psychosocial coordinating officer will provide group and individual counselling at field level securely with best practice responses including 1) warmth and acceptance, 2) emotional and practical support within a safe environment, 3) technical understanding of psychological impact of GBV, 4) validation on all reactions – no reaction is wrong or maladaptive, 5) believing the story, 6) confidentiality, 7) technical support on medical and legal supports, and 5) control over their process and choice. This team will also link with advocacy and accompaniment to clinics, police, court, referral to other agencies and finally coordination with those agencies and partners completing workshops with ACF (this coordination list is not limited to these actors and may include any actors under the World Health Organization/ Ministry of Public Health (WHO/MoPH) upcoming capacity building of Health Facility staff on GBV). GBV is defined here as violence that involves men, women, boys and girls where the violence is perpetrated because the target belongs to the gender group e.g. she is beaten because she is a woman, or the violence affects a particular gender groups disproportionately e.g. during a conflict, victim ratio is 20:80 men to women. WHO Classifications of GBV include Rape, Sexual assault, Physical assault, Forced marriage, Denial of resources, and/or Psychological/emotional abuse.	2018	X	X	X	X	X	X	X	X	X	X		
Activity 1.1.5: Monthly market monitoring survey	2017											X	X
ACF will be conducting monthly price monitoring on the markets to monitor the impact of the intervention and potential inflation of prices. ACF has been conducting market surveillance under ERM and CHF project in Helmand province with regards to supply and price conditions which has confirmed the availability of food and NFIs. As items were found to be available in sufficient quantity and at affordable prices. Lashkargah, being the province capitals, host a major market that continues to function even during massive conflict around Lashkargah city. This led to the adoption of a Cash Based Intervention approach for the IDPs against in-kind assistance.	2018	X	X	X	X								

Activity 1.1.6: 7 Essential Nutrition Actions (ENA) are given by promoters through the community HH by HH (house to house approach) 1000 days (including IYCF messages), Nutrition cluster and PND are working towards harmonization of approaches to IYCF promotion. While ENA is one of the recommended approaches, it would be worthwhile to highlight that ENA will be implemented in harmony with national IYCF strategy (work in progress) and counseling package and not in parallel. ACF recognizes a cultural barrier significant in limiting humanitarian access to the majority of primary care givers; female members of the household whole household role includes the responsibility for children (ACF Gender Analysis 2017) who often cannot leave their homes without permission from the head of the family – husband, father/father in law or at times mother in law. The transmission of the 1000 days message and how it can contribute to reducing emergency needs by the use of door-to-door promoters. The promoters will be females to transmit messages to the females at household (HH) level, further sensitizing information transmission, and will be technically trained on sensitivity and whole household engagement where possible by the integrated psychosocial officer within ACF Nutrition team. Community Health Workers and Family Health Action Groups are at the forefront of the MoPH community outreach strategy, and have a key role to play in the expansion of coverage of nutrition services. Acknowledging this, ACF will seek to enhance their capacity to conduct screening and referral (for Community Health Workers), and promotion of Essential Nutrition Actions (for Family Health Action Groups), as well as ensure active supervision/monitoring - seen as instrumental to boost their motivation and performance. While supporting Community Health Supervisors (CHS) to monitor CHWs and FHAGs, ACF will also get directly involved into supervising them. As part of its integrated approach, ACF will also be working with CHWs and FHAGs, HF staff and community leaders on GBV, core care practices, hygiene education and WASH-related topics. The aim is to foster broader understanding of targeted child illnesses, and the linkages between the two (i.e. the vicious diarrhea-malnutrition cycle) and between care practices that can either exacerbate or mitigate targeted child illnesses. Community base nutrition program (CBNP) recently reviewed by the PND will be used to train the CHW and FHAG. Working through these actors, as well as community leaders, possess the advantages of strengthening (i) recognition of community members who are perceived as legitimate sources of knowledge and skill in passing on such key nutrition messages, (ii) adaptability of the messages to local circumstances and norms; linked with other activities above, community actors are in best position to tailor the messages to their specific audience ensuring messages are processed, understood and applied correctly at a fundamental level, and (iii) outreach through these different actors to facilitate ACF's humanitarian access to reach a larger percentage of the community than direct ACF to Community sensitization allows.	2017											X	X
	2018	X	X	X	X	X	X	X	X	X	X		
Activity 1.1.6: Establish beneficiary and stakeholder feedback and complaint mechanism As a part of its general policy, ACF will establish a feedback mechanism to enable beneficiaries to make a suggestion or make complaints. ACF will introduce a range of ways that is contextually feasible including introduction of a telephone complaint line, feedback e-mail address for stakeholder and beneficiaries, and interviews with beneficiaries. MEAL Department will oversee and the establishment and/or management of the feedback mechanism to ensure that a more formalized system of asking, receiving, processing and responding to the feedback and complaints is, independently, in place. The feedback mechanism well be clearly communicated to staffs, communities and government institutions about why ACF has a feedback mechanism, what it is for and how it works. As such, information sharing about the feedback mechanism will be integrated into the community mobilization of the project. Similarly, MEAL Department will communicate with the target groups about their right to complain and raise their concern how we work. The department will also discuss what constitutes an ACF related and non-ACF related feedback/complaints and how ACF will deal with feedback and complaints. In addition, ACF MEAL department will conduct regular individual face-to-face meeting during monitoring visits at community levels. This will allow beneficiaries with no access to phone or being illiterate to provide their feedback. As with all feedback mechanisms established, every effort will be made to prevent harm and unintended negative consequences on those making complaints, protect confidentiality and encourage reporting of complaints and concerns in a safe environment.	2017												
	2018	X	X										

Activity 1.1.7: Screening through Mother led MUAC strategy	2017												X
Mothers with children under 5 years old will be trained on how to conduct the measurement of MUAC and edema as early detection signs of malnutrition. Training mothers on early warning signs of health issues has a strong evidence base, specifically for ACF and the successful sustainable treatment of malnutrition; the demand and coverage of the nutrition program increases. The rationale for ACF aiming to teach mothers how to perform MUAC is to achieve an early diagnosis of SAM, which if acted upon in a timely manner would decrease mortality and morbidity related to malnutrition, reduce program costs due to shorter treatment times, lower the proportion of children requiring expensive in-patient care for SAM with complications. The aim is to keep the structure at community level, going through CHW and FHAG. They will be trained on the mother strategy and it will be the first step. Instead of the CHW go house to house doing screening (which in reality is not done), the mother will come to see the CHW and FHAG to receive confirmation of the diagnostic and if it is not the case to receive a refreshment on the MUAC and edema technique. For the mothers, the training will focus on three key execution strategies (i) training of mothers through door to door visits by Family Hygiene Action Groups members and (ii) organized group training of mothers during mass community sensitization and demonstration exercises in the settlements for WASH and nutrition messages (e.g. cooking demonstrations) (iii) use of media to pass messages to maintain the regularity of the screening activities (radio spot messages and posters). In order to minimize false referrals by mothers ACF will establish a control mechanism where there will be a multi-step screening and identification of malnourished cases before admission to the nutrition program. The first step being the mother's screening of their own child, the second step if possible the mother will see the CHW or FHAG of the villages to confirm the detection and refer to the mobile clinic or HF and the third step is the verification of the child's MUAC and WHZ by a screener from the mobile team before admission to the program. The ability of mothers to assess the nutrition status of their children is also considered to have a positive deviance effect on the community's understanding and appreciation of the nutrition program. ACF expects that by mothers gaining knowledge on how to the nutrition status of their own children coupled with key sensitization on IYCF and proper hygiene they will understand better the importance of proper nutrition and diet as a measure of avoiding their children from being malnourished. This in effect will influence the mothers feeding practices and lead to adoption of better feeding practices and improved health seeing behavior. At the mobile clinics and at the community a regular evaluation on the quality of MUAC screening will be done. If the quality screening done by the mother is low, a refreshment training will be done.	2018	X	X	X	X	X	X	X	X	X	X		
Activity 1.1.8: Cooking demonstration for mothers/caregivers of children U2	2017												X
More than 80% of admissions to OPD are between 6 and 24 months (ACF program in Lashkagah). As a measure of sustainable intervention in this area and to be able to effectively support the primary caregiver whose role is solely linked to malnutrition management at the household/family level, ACF will actively implement cooking demonstrations in coordination with the cooking demonstrations implemented by the BPHS, as recommended by the Public Nutrition Department (PND). Where possible, ACF will partner with the BPHS on a series of the same demonstration to ensure coherency and consistency in messaging. Cooking demonstrations will emphasize on the complementary feeding from 6 to 24 months following exclusive breastfeeding, thus reinforcing this core message also. It will demonstrate how to prepare a complementary feeding with available seasonal food on the market-using balanced diet recipes suited to the developmental stage of the child. More specifically, a number of cooking demonstrations will be conducted for mothers of children under 2 years old under MAM treatment during to their IMCI consultation. During the demonstration, psychosocial health education session will also be integrated. At the mobile clinic level, at each site, cooking demonstrations will be conducted once a month and purposive targeting will ensure that each caretaker supported under different components of this program in the program will benefit from the demonstration. The demonstration will be adapted to the seasonal food, covering the 4 seasons and the needs on micronutrient. All feedback will be incorporated into adapting the suitability of the cooking demonstrations to each target audience to build a sustainable environment to facilitate the targeted sustainable behavior changes and mitigate any GBV triggers as previously discussed potentially found in focusing all knowledge transfer on one mother per household without support mother in law.	2018	X	X	X	X	X	X	X	X	X	X		
Activity 1.1.9: Radio messages	2017												X
In link with the different activities addressed above, the team will organize radio broadcast. The different topics will address messages on detection and prevention of malnutrition. They will include detection by MUAC, IYCF, maternal health, micronutrients, care practice messages.	2018	X	X	X	X	X	X	X	X	X	X		

Activity 1.2.1: Identification of priority areas for conducting 2 SQUEAC assessments 2 SQUEAC will be implemented in 2 of the targeted provinces, to allow for compressive analysis of barriers and boosters of IMAM program in targeted provinces and to support informed decision making of the BPHS partner on the ground as to where and how to improve IMAM services within the province. The coverage of SQUEAC (e.g. number of districts) will be discussed bilaterally with partners during project inception, considering access and review of secondary data. The main criteria for selection of a province for SQUEAC assessment will be the existence of both SAM and MAM services in the province. It will be discussed with partners in AIM-WG of nutrition cluster before planning and signing MoU with BPHS IP or any other IMAM program implementing partner. A MOU will be signed with the partner for its respective province SQUEAC arrangement to facilitate the ACF technical team to work with partner organization to conduct the assessment. The MoU will clarify the role and responsibilities of IP and ACF including the financial management of the activity.	2017											X	
	2018												
Activity 1.2.2: Identification and capacity building of BPHS partners on SQUEAC assessments Conduction of capacity building and on-the-job trainings for BPHS staff, NGOs and Government line departments like provincial level staff of PND. ACF targets 50 people, of which 12 women and 38 men. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SQUEAC Surveys. The capacity building of partner organizations will involve the partner staff who have attended previous managerial level SQUEAC training organized by ACF with CHF funding. These training of partner staff and data enumerators at provincial level build capacities of local experts to be present in their respective provinces to support nutrition program conducting SQUEAC in future.	2017												
	2018	X											
Activity 1.2.3: Conduct SQUEAC in the two targeted provinces of Zabul and Uruzgan in support of partners. Once area of SQUEAC identified in the provinces of Zabul and Uruzgan, MoU signed and partner staff and data enumerators are trained, they will formally start with support of partner organizations and locally hired data enumerators. ACF technical staff will be present in province to train the partner organization's staff and data enumerators and technically support data collection for quality data, monitor the data collection and feeding process as well as work with partner organization to clean and analyze data for first draft report of the each of 2 SQUEACs. Partners will provide logistic support and ACF technical team will be there for technical support of the process as well as building capacities of partner organization to conduct SQUEAC in their respective provinces to monitor barriers and boosters of IMAM program being implemented there.	2017												
	2018		X		X								
Activity 1.2.4: Production and dissemination of reports through National and Sub-national Clusters ACF will be responsible in guiding the trained partner staff in producing the SQUEAC report, with active involvement of the partner for review/validation prior external dissemination. For SQUEAC evaluations, draft report will be released with a month after the completion of the survey, while the full report should be completed within the following month. In an attempt to capacitate partner staff on SQUEAC, and encourage ownership of the findings, results will be presented jointly by ACF and the partner to the AIM-WG, and to the Cluster. As co-chair of the AIM-WG, ACF has supported the establishment of quality assurance mechanisms for SQUEAC; the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of SQUEAC evaluation - by a restricted pool of experts. In line with this approach, and following the current process of validation results of the SQUEAC will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Cluster. Acknowledging the need to channel down the results to provincial level, ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.	2017												
	2018			X		X							

Activity 2.1.1: Baseline and endline KAP survey to assess the knowledge of sanitation and hygiene practices During project inception, a KAP survey will be conducted by ACF on a sample of targeted population and in schools to better understand the level of knowledge, attitudes and practices specific to WASH including individual motivations for care practices targeted for increase and those targeted for decrease. This survey will be technically informed by WASH integrated psychosocial officer and will be sensitively carried out on pupils in the schools, and households in targeted villages. Interviews to be held with key informants, and with special attention to issues related to menstrual hygiene (engaging with all gender groups and community leaders). The survey and FGDs will explore water provision and storage, use of latrine and open defecation practice, waste management habits, knowledge of their water borne diseases and vector transmission, handwashing, menstrual hygiene, food and cooking hygiene. At school levels and community level, data will be also collected on the incidence of students missing classes due to diarrhea and at community level, the incidences of diarrhea cases among the under 5. At the end of the project, a final KAP survey will be conducted by ACF on a sample of same targeted population to track changes in their knowledge, attitudes and practices, and the starting of the behavioural change process. There is a notable lack of research on the links between WASH and GBV, therefore, KAP will explore lack of access to WASH and increased vulnerability to physical violence, early marriages, access to education. Due to the characteristics of the assessment, the KAP survey will be focused on women, children and men as they are the main actors on above-mentioned topics and the specific issues on menstrual hygiene. To facilitate the interviewees and due to cultural barriers, the surveyors will mostly be women as in conducting data collection during baselines and endlines, facilitating women and children's participation will promote claimed rights on WASH access and mitigated GBV. Women's involvement and children's involvement in data provision and subsequent decision-making based on this data is critical to their empowerment.	2017											X	
	2018										X		
Activity 2.1.1: Integrated protection services within mobile outreach services During screening and treatment of PLW affected by malnutrition through mobile clinic integrated with psychosocial support and care practices ACF will directly implement mobile nutrition services in IDP Mukhtar settlement and in other villages outside the camp. The intervention team will be composed of 1 supervisor (medical doctor), 2 certified Nurses/midwifes, 2 measurers/screeners, 1 for health education and 1 flying psychosocial officer with the aim of delivering SAM, MAM and acute malnutrition PLW treatment at community level. The flying officer will integrate psychosocial support and care practices to account for the many barriers including potential social norms acting as barriers e.g. Mother's in law not supporting exclusive breastfeeding sessions have been consistently identified during Helmand based GBV workshop and Ghor based Gender Analysis lead by ACF Gender/GBV expert to be consistent triggers in GBV at home level. During the consultation child measurement, appetite test, medical consultation, postnatal depression assessment (where needed), assessment of understanding of care practices (where needed), observation of mother-child relationship, distribution of medical and nutritional treatment in line with the national guideline, and referred to any psychoeducation or counselling groups including ACF's counselling team and he broader services available. Integrated services will also address gaps in current standalone nutrition interventions. There is a gap on the successful dissemination of key messages on the 1000 days. ACF using integrated programming will strengthen the methodology for dissemination through more participatory and psychosocial methods and the purposive targeting key groups including husbands, fathers and mothers-in-law as a mitigation strategy against GBV at household level where otherwise the mother trained would be entirely responsible for transferring knowledge to the HH and sustaining IYCF related household behavior change. These messages will be delivered during specialized psychoeducation sessions on care practices during mobile clinic activity. They will include the topics on maternal and personal health care, IYCF including exclusive breastfeeding, and health care complimented with corresponding topics on mother self-care (using this specific module as a means of distribution on GBV awareness), mother-child attachment, food preparation and person and home hygiene. A system of messages, building on previous sessions, will be organized every week targeting all caretakers accessible including those with the child independent form IMNCI consultation or nutrition program. Addressing the Mental Health Gap in education and training from a global mental health and psychosocial services (MHPSS) perspective, during follow up, if the mother requests or indicates further supports/training is needed, or if integrated, Nutrition and Psychosocial team identify additional or ongoing need, further appropriate support by specialized education will be provided. Where the ongoing or additional need is rapidly contributing to infant reduced or stagnant weight, the infant will be referred to the therapeutic feeding unit at the hospital immediately, while the mother is supported.	2017												
	2018		X	X	X	X	X	X	X	X	X		

Activity 2.1.2: Implementation of GBV action for WASH 2 through the use of formative research In addition to the PSS counsellors and mainstreamed actions, a flying team of psychosocial officers will promote qualitative interactions with beneficiaries including specific GBV actions. In the WASH sector, the flying officer will implement GBV action for WASH 2 - the informed mobilisation of communities and the selection of sites linked to women and girls' protection and dignity. This officer will respond to GBV related socio cultural issues related to blocked access to resources identified in ongoing Nutrition activities in the province. The flying PSS officer within the WASH team will reach out to female community members at house-to-house level with female WASH promotors to ensure equal participation from different gender groups in the location, design and maintenance of WASH facilities. To ensure women are not overburdened with additional roles gender daily calendars will be generated as part of a broader formative research to identify barriers to mobilisation, facilitate different gender groups to identify the full scope of risky hygiene practices and their subsequent community appropriate mitigation, and conduct sensitisations with community leaders and Mullahs to advocate for an authentic gender balance in committees participation. In communities identified as water-stressed, the flying officer will promote site selection in coordination with CDC and PRRD to guarantee full involvement of communities and key focal community engaged authorities including the Department of Women's Affairs, which currently leads in different provinces on interventions for the reduction of GBV, we well as transparency and respect of local culture and norms. In this way, GBV is proactively reduced by ensuring sites selected do not present GBV related risks for women, girls or boys.	2017												
	2018		X	X	X	X	X	X	X	X	X		
Activity 2.1.2: Provision of gender sensitized hygiene promotion sessions and distribution of menstrual hygiene kits to women To ensure that the training provided to school teachers, community leaders, Community Development Councils (CDCs) Community health Workers (CHWs) effectively translate into increased outreach of health and hygiene promotion, ACF will work with Lashkargah authorities to supervise, monitor and support aforementioned actors for sensitizing pupils/students and the community members on personal and environmental hygiene in both communities and schools. This will be achieved by active supervision, provision of IEC material, and refresher/on-the-job training. ACF will seek to increase the frequency of outreach of hygiene promotion sessions in schools and at community levels. ACF will also support their effort by delivering radio spot messages. To account for the specific needs of women, ACF will also distribute hygiene kits, which may include menstrual materials (finalised following comprehensive baseline assessment on identified need and cultural acceptance - as a mitigation strategy for violence against women where specific hygiene items not culturally accepted yet distributed can create risk for women at their household level), soap, underwear, and soft cotton box. ACF has been distributing similar kits in many provinces of Afghanistan, along with sensitization around menstruation. While having received positive feedback from women targeted under precedent projects, ACF would like to collect stronger evidence on the impact of providing sensitization around menstruation hygiene, as well as menstrual hygiene kits. The WASH integrated psychosocial officer collaborating strongly with the WASH female Hygiene Expert to carry an in depth evaluation with female beneficiaries of this specific activity; disseminating findings and subsequent best practice to the WASH Cluster and other ACF partners. Reflecting on current gender analysis and past findings, will link directly with key decision makers at the household level (identified during KAP) who can facilitate behaviour changes on sensitive topics like menstruation management. In complement, hygiene promotion for men and children will be carried out through community sessions in mosques and public places on personal hygiene care practices (hand, body and clothes washing), water hygiene (water chain: transport, storage, container washing), environmental hygiene (house and compound cleaning, waste disposal, defecation free). The sessions in the mosques will be conducted by the Mullahs with the support of ACF staff and material (posters and leaflets), during pray sessions according to Muslim religion, and simply monitored in the following months. Leaders and CHPs will carry out community dialogues on topics including the promotion in public places i.e. close to water points, as these one are socialization points, jointly with ACF staff: the involvement of such as persons will promote acceptance by the beneficiaries, and sustainability of any development. ACF will deliver on site formal training to targeted leaders on selected hygiene messages identified in the KAP survey on water chain, excreta and waste management, personal hygiene, and vector transmission. As with other points of community engagement under this project, this point of community contact will also be used to disseminate information and sensitisation on GBV, thus further ensuring the sustainability of key messaging on the issue, and contributing to lifting the 'veil' on GBV.	2017												
	2018	X	X	X	X	X	X	X	X				

Activity 2.1.3: Conduct GBV focused formative research using construction/rehabilitation of water sources in schools, health facilities and communities as a means of introduction In addition, reflecting GBV action for WASH 3, the location of the water points will be in areas that are accessible and safe for all, to that end the decision regarding the location of the new water points will actively involve discussion with all members of the community, and in general no more than 500 meters from households. In addition, reflecting GBV action for WASH 3, the location of the water points will be in areas that are accessible and safe for women and girls, to that end the decision regarding the location of water points will be identified through formative research where female participation is central. This formative research will focus on GBV and all related issues within the province. Female led analysis of barriers to safe access to water points as well as sanitation facilities will identify determinants to GBV risks, and identify solutions to minimise distress at community level in past WASH actions in other emergencies where women and girls have reported latrines as areas for GBV and conflicts at water sources. ACF's flying PSS officer within the WASH team of female staff to go to selected households to collect views of women, who are restricted from attending community meetings to enable women's participation in bodies that can oversee proper use and maintenance of WASH facilities. The flying Support PSS officer positioned within WASH will support qualitative interactions and facilitate sensitized responses through focus formative research including focus group discussions; key informant interviews and iterative analyses overall leading to informed behaviour change communications; women to women engagement and male to male engagement. .	2017												
	2018	X				X	X	X					
Activity 2.1.3: Conduct Hygiene promotion sessions (for boys and girls) in schools ACF recognizes that to ensure sustainability of the WASH programs in schools, the involvement of national authorities, community leaders, communities and parents is crucial. ACF will not only construct/rehabilitate WASH facilities in the most vulnerable schools but will also work the provincial department of education to ensure impactful hygiene promotion sessions in the schools. ACF will conduct special sessions and with different styles for each the different age groups. The topics during the various sessions for students will include care practices on safe handling of drinking water, safe disposal of waste water, safe disposal of human excreta, disposal of solid waste, household sanitation and food hygiene and personal hygiene, and be taught using participatory methods where students actively identify the reasons for these care practices and what supports they need at home and community level to have sustainable practice. Integrated WASH and psychosocial programming will also facilitate children's involvement in youth hygiene clubs within and outside the school; in turn supported by community leaders and committees. To support hygiene promotion in the schools, IEC (materials posters and leaflets) will be distributed and followed up, in order to see how they implement hygiene sessions and provide advise where needed. Linking with above activities, special sessions will also be delivered to teachers to deliver Menstrual Hygiene management clues and advices in a sensitive and objective manner as per context of the project area, with follow up OTJ and supervision – addressing the international MHGap on limited follow up to sensitive topics of training leading to limited impact.	2017												
	2018		X	X		X	X	X	X	X			

Activity 2.1.4: Construction or rehabilitation of WASH infrastructure in selected crowded schools hosting both IDPs and pupils from host communities and in Nutrition Mobile clinics Due to the ongoing conflict in Helmand province, most schools have been forced to close and especially the ones in Lashkargah town where the security situation relatively stable, many are crowded because of the influx of IDPs from the conflict area. In May 2017, ACF WASH team conducted a technical assessment in 31 schools and of these 12 schools were identified as most vulnerable this a total population of 40,000 students. The WASH facilities in the 12 schools have dilapidated with non-functional water points, insufficient and dirty toilets, no waste disposal pits and the promotion of hygiene related care practices are needed to avoid an outbreak of diarrhea diseases, worm and respiratory infections. ACF recognizes that poor sanitation and hygiene in schools also affects the wider community. Children who pick infectious agents from schools can bring home pathogens that may lead to household members becoming infected. During the assessment most toilets where full and need emptying, doors were broken and the cubicles where not enough for the student populations. On top of rehabilitating or constructing new water points in the selected schools, ACF intends to rehabilitate or construct new safe excreta disposal facilities to serve the specific needs of all users including young boys and girls, and those with disabilities. ACF will rehabilitate/construct latrines in schools to provide proper sanitation facilities for students and teachers. ACF will ensure that the facilities for girls are safe and comfortable most especially for menstrual hygiene management, which can be are a crucial factor in determining older girls' school attendance and will have enough space for associated changing, cleaning and waste disposal. ACF will run mobile nutrition clinics for treatment of malnutrition in selected villages where the cases are high and the beneficiaries cannot easily access health services. The clinics are housed in households or community centres where there are no WASH facilities and ACF will construct one-cubicle toilets for mothers who attend the clinics. During design of new sanitation facilities or their rehabilitation, integrated WASH and psychosocial teams will facilitate feedback from students and teachers throughout the process. For all newly constructed sanitation facilities for girls and most especially those who have reached the puberty stage plus the female school staff, ACF will ensure that the facilities provide privacy and as per MRRD standards. ACF will also ensure that facilities are all inclusive and accessible to pupils/students with limited mobility. Reliable water points and hand-washing facilities will be fixed near latrines or toilets and areas where food is prepared or eaten, with sensitization sessions delivered by integrated psychosocial officer and soft WASH software expert with beneficiaries linking interconnected care practices (e.g. personal hygiene and food preparation). During the Hygiene promotion sessions in, ACF will encourage students to have soap for hand washing instead of distribution, as this will be more sustainable. During project implementation, ACF will coordinate with the community leaders, teachers and the community to set up committees for maintenance of the sanitation facilities, many of which get full after few months of use. The primary beneficiaries of the proposed intervention are boys and girls not exclusive to those attending schools, and men and women in specific community roles including teachers, parents, and community leaders. The students will benefit from life-saving interventions aimed at reducing the incidence of diarrheal diseases and warm infection, implemented concurrently at community and school levels.	2017												X
	2018	X	X	X	X	X								
Activity 2.1.4: Implementation of proactive and reactive strategies using establishment/reinforcement of WSUCs, mechanics and caretakers as means of distribution ACF flying officer within the WASH team in collaboration with the psychosocial counselling team will utilise WSUCs (and CDCs) as a means of distribution on GBV. This integrated team will disseminate information on all agencies available resources within the local community related to GBV. This team will also facilitate proactive design and/or jointly selecting with members of the affected population regarding GBV anti violence messages from the cloud repository on IEC materials available for Asia Foundation and Women for women international. These messages will be made available at water points, focus groups, health facilities, the Department of Women's Affairs and other locations where groups gather, with messages aligned to different gender communication levels e.g. more visually orientated and simplified communication strategies for children. Similarly, the establishment of WSUCs can provide a community supported and sensitized distribution mechanism for reactive support to GBV cases. WSUCs will introduce psychosocial counselling services for GBV cases, sensitization sessions for disaggregated gender groups on GBV issues related to water access including general workshops on social and cultural issues in personal and community hygiene that can lead to GBV and related protection concerns for different community members.	2017												
	2018				X	X	X							

Activity 2.1.5: Provision of gender sensitized hygiene promotion sessions and distribution of menstrual hygiene kits to women and girls Distribution of menstrual hygiene kits with beneficiaries will also be facilitated by the flying psychosocial officer in WASH and Nutrition teams to address issues of stigma hosting of women's support groups conducted prior to distribution of menstrual hygiene kits; and assessment and analysis' contribution to local social, cultural and institutional context. This distribution directly accesses the female population, which are directly affected by stigma triggered GBV in relation to menstruation. This activity will therefore reflect outcomes and findings of the formative research in relation to choice of sanitary protection as a personal decision, influence of cultural acceptability and user preferences. It is critical that this programme will support women and girls by involving them in the planning discussions and decisions about the materials and/or products to be supported, facilitated by the integrated PSS officer within WASH. At the same time, the GBV counselling group who will respond to any psychological barriers identified to using sanitary products will also support this activity. ACF has been distributing similar kits in many province of Afghanistan, along with sensitization around menstruation. While having received positive feedback from women targeted under precedent projects, ACF would like to collect stronger evidence on the impact of providing sensitization around menstruation hygiene, as well as hygiene kits. The WASH integrated psychosocial officer collaborating strongly with the WASH female Hygiene Expert to carry an in depth evaluation with female beneficiaries of this specific activity; disseminating findings and subsequent best practice to the WASH Cluster and other ACF partners. Reflecting on current gender analysis and past findings, will link directly with key decision makers at the household level (identified during KAP) who can facilitate behaviour changes on sensitive topics like menstruation management. As with other points of community engagement under this project, this point of community contact will also be used to disseminate information and sensitisation on GBV, thus further ensuring the sustainability of key messaging on the issue, and contributing to lifting the 'veil' on GBV. To account for the hygiene needs of men and women, ACF will also distribute standard hygiene kits following comprehensive baseline assessment on cultural acceptance and hygiene need of kit items. While this is not a GBV dignity kit distribution, as a mitigation strategy for violence against women, hygiene kits following the WASH cluster approved content, will be distributed following sensitization and promotion with community leaders, WSUCs and household members. WASH integrated psychosocial officer collaborating strongly with WASH female Hygiene Expert will do in depth evaluation with female beneficiaries of this specific activity; disseminating findings and subsequent best practice with relevant stakeholders. Reflecting on current gender analysis and past findings, will link directly with key decision makers at the household level (identified during KAP) who can facilitate behaviour changes on sensitive topics like menstruation. This point of community contact will also be used to disseminate information and sensitisation on GBV including psychosocial counselling groups, thus further ensuring the sustainability of key messaging on key issues for women and girls.	2017											X	X
	2018	X	X	X	X	X	X	X	X	X	X		
Activity 2.1.6: Conduct Hygiene promotion sessions (for boys and girls) in schools ACF recognizes that to ensure sustainability of the WASH programs in schools, the involvement of national authorities, community leaders, communities and parents is crucial. ACF will not only construct/rehabilitate WASH facilities in the most vulnerable schools but will also work the provincial department of education to ensure impactful hygiene promotion sessions in the schools. ACF will conduct special sessions and with different styles for each the different age groups. The topics during the various sessions for students will include care practices on safe handling of drinking water, safe disposal of waste water, safe disposal of human excreta, disposal of solid waste, household sanitation and food hygiene and personal hygiene, and be taught using participatory methods where students actively identify the reasons for these care practices and what supports they need at home and community level to have sustainable practice. Integrated WASH and psychosocial programming will also facilitate children's involvement in youth hygiene clubs within and outside the school; in turn supported by community leaders and committees. To support hygiene promotion in the schools, IEC (materials posters and leaflets) will be distributed and followed up, in order to see how they implement hygiene sessions and provide advise where needed. Linking with above activities, special sessions will also be delivered to teachers to deliver Menstrual Hygiene management clues and advises in a sensitive and objective manner as per context of the project area, with follow up OTJ and supervision – addressing the international MHGap on limited follow up to sensitive topics of training leading to limited impact.	2017												
	2018		X	X	X	X	X	X	X	X			

Activity 2.1.7: Mobile outreach protection services to women, men, girls and boys: Conducting psychosocial education at health facility and community levels Workshops employing adult education models will roll out staged modules on psychosocial and care practices, and protection to local civic organizations and/or coordinated agencies operating in the area. To maximize learning and development for participants, numbers of participants per workshop will be capped at 20 participants per group, with a ratio of 2 trainers to 20 participants. To support the move of the theoretical training content to practical application at field level, ACF master trainers will also train all civil organizations in a two-day orientation training on the core components partner, coordinated and ACF staff are inducted on. On-the-job mentoring and support for facilities and healthcare providers who have received training will then be implemented. Each facility who have received training will be visited at least twice for comprehensive post-training follow-up, mentoring and on-the-job training during the project. Following post training visits and midline project evaluation (as part of a broader monitoring, evaluation, learning and accountability plan), ACF master trainers will also organize refresher trainings for a percentage of trained staff targeting those who receive the lowest marks during post-training visits across the two provinces. The mothers/mothers in law will meet in open area and in a big group prior to and following sessions to discuss their expectations and experiences of the demonstrations with adequate time for open secure discussion to ensure transfer of knowledge and as a comprehensive effort to sustain food preparation practices without creating risks for women and simultaneously being responsive to any protection concerns; all feedback will be incorporated into adapting the suitability of the cooking demonstrations to each target audience to build a sustainable environment to facilitate the targeted sustainable behavior changes and mitigate any GBV triggers as previously discussed potentially found in focusing all knowledge transfer on one mother per household without support mother in law.	2017											X	X
	2018	X	X	X	X	X	X	X	X	X	X		
Activity 2.1.8: Mobile outreach protection services to women, men, girls and boys: Conducting psychosocial counselling for GBV and other protection concerns Where cases of GBV are identified, a response team integrated within the Nutrition team made up of psychosocial counselling staff managed by the psychosocial coordinating officer will provide group and individual counselling at field level securely with best practice response including 1) warmth and acceptance, 2) emotional and practical support within a safe environment, 3) technical understanding of psychological impact of GBV, 4) validation on all reactions – no reaction is wrong or maladaptive, 5) believing the story, 6) confidentiality, 7) technical support on medical and legal supports, and 5) control over their process and choice. This team will also link with advocacy and accompaniment to clinics, police, court, referral to other agencies and finally coordination with those agencies and partners completing workshops with ACF (this coordination list is not limited to these actors and may include any actors under the WHO/MoPH upcoming capacity building of Health Facility staff on GBV).	2017											X	X
	2018	X	X	X	X	X	X	X	X	X	X		

OTHER INFO

Accountability to Affected Populations

ACF will foster accountability to affected populations through provision of timely and detailed information to respondents to the survey on the purpose of the assessments, and what use ACF will make of the results. As much as possible, ACF will encourage partners to provide a feedback to the communities on the results of the surveys, although acknowledging the many challenges to actually do so, in terms of access, resources needed, and workload. Sharing of results with regional cluster coordination meeting forums will also be considered to ensure that the necessary actions are taken to the benefit of the communities.
ACF will ensure constant and timely dissemination of results from the multi-sectoral assessments, to ensure that they are available to be used in program design at provincial level (case load estimation, target calculations) and at National level. ACF will advocate and closely work with the relevant stakeholders to ensure that the data and findings are utilized for the identification of humanitarian needs, also thanks to the use of HRP, HNO and IPC classification, to prioritize needs and allocate resources based on evidence.

Feedback and Complaint: Under the leadership of the Monitoring. Evaluation, Accountability and Learning team, which reports to the Country Management team, this mechanism brings together a set of methods to collect, handle, and report on beneficiary feedback and complaints (e.g. tool box, hotline, email, temporary complaint desks, beneficiary satisfaction surveys, etc.), in a bid to enhance accountability towards beneficiaries, and improve relevance, quality and outcome of the projects implemented.

Participation: ACF implements its project following a participative approach, which allows targeted communities to influence/contribute to the definition of the program, identification of beneficiaries (although with a strong verification process by ACF), and monitoring of the project (through regular community meetings as well as the to-be-established Feedback and Complaint Mechanism).

Design, Monitoring and Evaluation: All projects are designed and implemented in adherence to the principle of “Do no harm”: in the province of Helmand. ACF had on several occasions, as part of its ERM project, to cancel some distributions after assessing that they could cause more harm than good to beneficiaries in a context of highly fluctuating and conflicting local power dynamics.

Implementation Plan

ACF will directly implement the project, only the assessments will be implemented by BPHS IPs. For nutrition screening, ACF will dedicate a team of 2 trained screeners to escort the ERM assessment teams. The HHs flagged by the ERM team as comporting U5 children or PLWs will be referred by the screening team to the nearby mobile clinics. Beyond the anthropomorphic measurements, the team will gather information from caretakers and/or head of HHs in terms of knowledge about availability of services, treatment for illnesses, frequency of visit to HF, and awareness about referral mechanisms in the province. The screening team will include at least 1 female staff to ensure access to HHs. For the mobile teams, 10 villages will be identified through discussions with local leaders and Public Health Department, as well as from ACF's own findings during the KAP survey and ERM screening findings. The KAP survey will be led by the Community Mobilization team with support of ACF MEAL team in Kabul and WASH expert.
2 mobile teams each composed of 1 medical supervisor, 2 nurses and 2 screeners, 2 community promoters (CP), 2 nurses/midwives (for MAM), with a least 2 female staffs among the team will be deployed in selected villages. Supervised by the Nutrition PM and Deputy Nutrition PM will deliver a mobile IMAM service for villages by weekly basis visits treating SAM, MAM and PLW, providing curative consultations for children basic illnesses, screening and admitting new SAM, MAM cases, and following up cases. The estimated caseload is 1,353 SAM children, 2,706 MAM children and 1,270 PLW over 11 months. Based on this, ACF will request supplies of RUTF, RUSF Super Cereal and Micronutrient tablets. For complicated cases that need to be referred to the Provincial Hospital for admission in the TFU, ACF will cover the transport cost for caretakers. The Community Mobilization team will be composed of 2 CP, both skilled and trained in nutrition, health, and hygiene, and supervised by a Deputy PM and a PM. They will mobilize key actors of the BPHS system through provision of training, equipment and incentive. The MHCP activities will be conducted by 2 psychosocial counselors in each mobile team and sectorial experts. The WASH activities both hardware and software will be led by a WASH PM, Deputy PM, building site supervisors (engineers), and CP. Rehabilitation of boreholes at schools and HF will be conducted by Engineers with support of unskilled and skilled laborers. Construction of the boreholes will be implemented by private local contractor who will be selected under ACF procurement procedures. The BSS will monitor the borehole construction regularly and follow the work is done according to the specification and ACF quality standard. The hygiene promotion session will be designed based on the finding of the KAP survey and will be conducted by the CP. BSF and hygiene kit for women will be distributed and post distribution will be conducted. Water quality analysis will be conducted for BSF and water points rehabilitated to ensure the quality of the water. The FS activity will be implemented by 3 staffs (1 supervisor, 2 field officers). The team will conduct registration of the beneficiaries using the HEAT assessment tools and eligible beneficiaries with high vulnerability score will be selected. The cash distribution will be conducted by the Hawala dealer selected according to the logistic procedures. PDM will be conducted a month after the first distribution.
ACF will take lead conducting the 8 SMART, 2 Rapid SMART and 2 SQUEAC assessments in coordination with BPHS IPs in their respective provinces. ACF will be in charge of operational and financial management and donor reporting. ACF team of experts will support the implementation, provide technical support and build partner capacities. BPHS IPs will take the responsibility of implementation of the assessments to enhance their capacity, to ensure that skills and expertise remain sustainable.

Coordination with other Organizations in project area

Name of the organization	Areas/activities of collaboration and rationale
Ministry of Public Health	ACF will sign a Memorandum of Understanding with the MoPH at capital level to delineate clearly duties, rights and responsibilities in the implementation of the project. ACF will involve the MoPH at provincial level in the organization and coordination of activities, and will share the results of all surveys, assessment and progress reports.
UNICEF	ACF will sign a Memorandum of Understanding with UNICEF for supply of RUTF
WFP	ACF will sign MoU with WFP for the supply of RUSF, Supper Cereal and Micronutrient
Directorate of Refugees and Returnees and Directorate of Economy	ACF staff have been coordinating closely with DoRR in Lashkargah, who is coordinating NGOs activities in the field of emergency response to IDPs and returnees. ACF is a registered NGO by the Ministry of Economy. Reporting on ACF strategy, project objectives and outputs are provided on regular basis to the national and local authorities.
Clusters	ACF will be coordinating with the Clusters, and sharing updates about its intervention in monthly meetings. ACF will follow the FSAC Cluster recommendations regarding the amount of cash to be distributed.
BPHS implementers	ACF will continue close coordination at capital and provincial level with BPHS implementers from planning stage up to sharing report for assessments. The BPHS implementers in the targeted provinces are: - AADA in Faryab and Nangarhar - ORCD/ MMRCA in Ghazni - PUI in Kunar - OHPM in Kunduz and Paktika - Cordaid/AHDS in Uruzgan - ORCD in Zabul.
IRC	IRC is operational in Helmand province. ACF will be coordinating with IRC as well, to avoid any duplication of intervention. IRC is currently part of the joint assessment team and involved in the provision of cash and NFI assistance to recently displaced IDPs, as well as income generating activities for IDPs and host communities. ACF will continue to coordinate with IRC to ensure that overlap of activities is avoided and to optimize the use of resources from both agencies, as we have successfully been doing as part of our collaboration in the response for recently displaced IDPs.
OCHA	As the leader of the interagency joint assessment team in Helmand, ACF coordinates with OCHA regional office in Kandahar on a daily basis and acts a focal point and representative to channel all discussions and challenges arising during assessment and distribution processes for IDP response. Notable and sustained progresses have been made through an efficient relationship with OCHA in terms of coordinating and harmonizing response in spite of the different mandates and capacity of participating agencies.

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

At the beginning of the project implementation, ACF will assess through FGDs the behavior of the women on hygiene practices and sanitation, and the advantages or constraints related to the local culture (health seeking behavior, IYCF practices, who is going to fetch water, differences in facilities use, menstrual hygiene practices and behavior). The information will be used to identify the gaps in term of gender equity and addressed during the implementation of the activities through some key messages as above mentioned, in order to highlight the women discrimination. At the end of the project, FGDs will be held to understand the reception of these messages by women and the change in behavior and practices. The women are subjected to discrimination especially during the menstrual period, when they are isolated from the other members of the family: because of the local culture, this period is considered as a disease and a shame. In this manner, they are not allowed to talk or to inform the members about menstruation and they suffer for the consequences: they are using unsafe and unclean old clothes with risk of infections, they cannot go to hospital in case of serious pain or problems, and they do not have a correct diet and proper hygiene.

ACF will apply multiple direct and mainstreamed protection strategies to ensure Gender will be factored in during the beneficiary selection phase, in criteria definition and selection of beneficiaries. Specifically, gender-specific vulnerability criteria have been defined for beneficiary selection such as IDP HHs headed by women, children, elderly, having children under five, and persons with disabilities. In addition, the HH needs assessment collects gender and age disaggregated data that allows beneficiary selection to be informed by specific vulnerabilities associated with different genders and ages to be targeted. Women headed HHs are at the top of the priority list during the selection process.

The project contributes to gender equality in the following ways;
1. ACF will overall apply an age, gender and diversity lens to assessments, targeting, implementation, monitoring and accountability, to ensure that key vulnerability groups with specific needs are identified.
2. Traditional believes are very strong in the rural population in Helmand, therefore an integrated female psychosocial officer in liaison with female and male community facilitators will ensure female-headed HHs are surveyed with security and confidentiality; and that the assessment creates no risk for the HHs (see protection links below).
3. During cash distribution, the distribution plan will include distribution points most accessible to women (and children who may accompany them) and elderly. When present at the distribution site, these at-risk categories of beneficiaries will be prioritized during distribution schedule through a separate queuing line system. They will also be allowed to register their official representatives should they physically not be capable of attending distribution sites
4. During the first allocation CHF project intervention and market, assessment ensured that direct cash modality and delivery mechanism selection has no risk for all the beneficiaries, specifically women, and direct cash distribution is also relevant for all vulnerable groups.
5. Post Distribution Monitoring and Coping Strategy Indexes will seek to represent female and male beneficiaries equally to ensure adequate gender balance monitoring; ACF notes this will be a challenge to fulfill in culturally conservative areas.
6. ACF will establish an accountability mechanism, to ensure that beneficiaries know how to raise their complaint and feedback, specifically for women/children headed household beneficiaries.
During PDM, 50% of female headed HHs will be assessed in order to get detailed information of program impact and their further vulnerability on this group.

Protection Mainstreaming

ACF program implementation strategies envision the need of humanitarian protection and systematically assess different contexts to mainstream protection in its program interventions. The main protection consideration activities are presented as follows:

Avoid causing harm: In improving access to safe water, ACF will seek to prevent the pulling effect, and avoid attracting more individuals. This will be done through extensive discussion with community leaders, to better understand and anticipate potential harming effect of increasing access to safe water in an area of massive displacements. ACF will disseminate clear selection criteria for beneficiary selection communicated to communities and their leaders so they clearly understand the selection process to avoid jealousy and causing tensions within communities we work in. In addition, protection mitigations associated with specific gender groups targeted including women (with their children at times), the elderly and disabled are mainstreamed by ensuring: Cash distribution sites under this project will be systematically assessed to ensure they are physically safe and accessible for all gender groups, including ensuring separate locations for women were required to minimize travel distances, visibility and duration of distribution, as these features common to humanitarian distribution can create risk for attack, sexual assault and robbery. In accordance with local cultural norms, women present for distributions will also be prioritized to further minimize time spent at the distribution. Due consideration will also be given to the environment through which beneficiaries including women will travel following distribution of cash

Equality: In providing integrated health, nutrition, hygiene and sanitation promotion at community level, ACF will seek to ensure equality in participation to decision-making and to the integrated promotion sessions. In implementing the project, ACF will pay particular attention to the needs of women and girls, especially in the selection of water point sites (which should ensure safety and security of women as they fetch water), and tailoring of the integrated promotion messages and implementation to their specific needs (i.e. menstrual hygiene) and capacities to participate in hygiene promotion sessions (house to house visits).

Participation and empowerment: All the sites will be selected with community leaders including CDCs, Shuras, and Mullah, taking into consideration local norms and women opinion (as the primary responsible for water). In a bid to empower communities on hygiene and sanitation, ACF will also seek to actively involve and empower community leaders, mullahs, FHAGs and CHWs, through provision of training, supportive supervision, and distribution of IEC materials. ACF uses participatory approaches to ensure community ownership, prevent harm and promote sustainability of activities/benefits. As such, ACF tries to promote participation of project beneficiaries, target communities, local governance and government entities in the development of beneficiary selection criteria and identification of the most vulnerable segments of the target communities throughout all stage of project implementation. As well as those activities already mentioned (disaggregated data, secure distribution points etc.), ACF will facilitate the establishment of a FSL community based committee supported by the integrated psychosocial officer to ensure consultation with community members at need assessment, distribution and follow up. In linking disaggregation and security assessments of distribution points, ACF will consults area stakeholders and past beneficiaries as well as the FSL committee before selecting a distribution point, identifying one or more central distribution point in residential areas of beneficiaries.

Country Specific Information

Safety and Security

Helmand is one of provinces with the highest attack incidents reported in the last three months (May to July 2017). Intensive fighting and contest ongoing between the ANSF and the AOGs for territorial expansion or maintaining previous hold positions, which constrained the expansion and access to areas beyond the frontlines. The security situation in Helmand is volatile, however, ACF continued to maintain its neutrality and the field team have built strong relationship with beneficiaries to ensure community acceptance and to minimize threats and risks. Moreover, to guarantee the safety and security of its staffs, ACF prioritize local recruitment, validates field movement on a daily basis, closely follow up movements and provide the teams necessary means of communication to allow rapid action where required.This strategy has, over the past years, proven successful in supporting the delivery of emergency assistance to the needy population while ensuring safety of staffs and beneficiaries. ACF will vigilantly following the evolution of the security situation regularly updating the SOP. The ongoing armed conflict and the presence of IED on all roads outside Lashkargah is now preventing a geographic expansion to surrounding and remote districts of the Province, hence ACF intervention is limited in vicinity of Lashkargah where safety and security of staffs and assets is ensured. In the implementation of Cash Based Intervention, ACF has extensive experience and strictly follows its CBI guidelines and protocols. The use of Hawala, preparation of cash distribution plan and design (including schedules, distribution points, and sensitization), and post cash distribution monitoring (survey focused on generating feedback on how cash was distributed, cash usage, and identification of other risks) are among the safety that ACF utilizes for any cash based interventions. The use of the Hawala system in actual cash distribution is by far effective approach thereby minimizing security risks.
Under this CHF project, ACF will also deploy national and expatriate teams in areas where the mission does not have any operational presence. For this reason, ACF heavily relies on partners, and its internal security network (e.g. INSO, other International NGOs), including partnership work with the BPHS partners in areas where ACF does not have permanent presence. Those data will help in preparation of the formal security assessment based on ACF's 'Field Security Assessment. Checklist & guidelines" (attached). Key actors in the communities are identified through security mapping and contacted in order to get their approval and their support in negotiating access to field sites and population. Behavior and strict observance of deontology are considered as key to gain and maintain acceptance of the population. Depending on the outcome of those assessments, ACF will allow or not the presence of staff in the hard to reach and underserved areas. To overcome this challenge, every expatriate position is seconded with a national one. Once in the province, ACF team complies with the security rules and guidance of partner hosting staff, whether National or International NGO. ACF has long experience in assessing and accessing the provinces outside of its permanent basics. As a leading partner in ECHO's Emergency Respond Mechanism, we often work in new locations and, hence, we have well-tested access, assessment and local recruitment tools and mechanisms. The model is being used currently in nutrition surveys, most of which are conducted outside the ACF's permanent presence areas (i.e. in Hard to reach and underserved areas) in partnership with the other NGOs (BPHS implementers).
In order to reduce the risks, ACF and the partners will prepare and submit the Security & Risk Analysis to the HFU by the end of October. Rapid nutrition assessments will be located in provinces and districts which will be decided on the basis of needs and access.

Access

Based on the previous experience in conducting assessments in different provinces of Afghanistan, ACF has found that the main challenge to access is insecurity. Over the years, ACF has gradually adapted its access strategy to optimize its field presence and effectively conduct the assessments. ACF has re-organized its selection strategy and based it on the following principles: (i) A thorough joint security assessment is conducted on villages instead of districts as previously practiced. It is important to mention that taking into consideration the geographical challenge to manage to access the whole province, ACF and its BPHS partners conduct the security assessment from district level to village level. This change has positively contributed to an increased field access for the assessment teams. (ii) The selection of the locations to be assessed is done jointly with the BPHS partners and PND based on clear prioritization criteria based on need. The BPHS partner is expected to work closely with ACF to ensure that access to the entire province is achieved before conducting the assessments. In addition, in provinces where access is difficult, ACF encourages the partner to recruit enumerators from the targeted districts, to foster access and acceptance by communities. To support this approach, ACF covers the enumerators' transport costs from their area of origin to the capital where the training is organized (including for mahram). Experience from previous projects has also revealed the importance of proper community mobilization and prior planning of the assessments to ensure proper access and increase the scope and acceptance of the teams to conduct the surveys in insecure areas.
The foundation of ACF access strategy lies in the principle of acceptance. Building on almost 2.5 years in Helmand provinces, ACF possesses sound understanding of local dynamics, strong local networks, and an approach which relies on local elders and where needed local commanders to foster/secure acceptance of ACF as humanitarian actor in the area delivering essential services in humanitarian sectors, adherence with the do no harm principle. In Helmand province, ACF has developed a clear and detailed access strategy taking into account elements of context, the main stakeholders and powerbrokers, our knowledge of and experience in the areas, the type of programming we can implement by type of area etc. This document guides our intervention approach and is always taken into account before designing new projects. In Helmand, the bulk of households displaced by the conflict have relocated within the central Lashkargah district, perceived as secure environment and unlikely to witness levels of fighting comparable to districts that they fled initially. This perimeter where IDPs are taking refuge has further shrunk since August 2016 where the conflict reached some of the central police districts of Lashkargah city. ACF currently enjoys unfettered access in this area, and has developed a strong network of community leaders through its ongoing programming in WASH, Food security and nutrition projects. Beyond access, they have also proven to be a reliable source of information on movements of IDPs and thus enabled ACF to ensure optimal coverage in areas where several waves of households have been displaced, and disseminated within host communities and IDP households which had already been assessed and assisted. Before establishing any partnership, ACF run the due diligence process, based on its own partnership tool. This is to ensure the partner is reliable and ready to obey the humanitarian principles. In addition, due to the nature of the intervention areas (hard to reach and underserved), the partners will be asked to submit their risk registers. ACF may support them in achieving these requirements, if necessary. This will be the initial step for joint security mapping and Field Security Assessment, as described above and in the Safety and Security section.

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	Country Director	S	1	5,668.56	12	16.67	11,339.39
	Represent ACF (i.e. other international agencies, local organisations, local governments, Embassies, media, donors, etc.) in the country. *Guarantee the definition and implementation of an efficient system of monitoring and evaluation for the different humanitarian programmes directly executed or with partners. Ensure the security management for the country team. Manage the execution of strategic planning (approval and execution of projects and programmes) and operative planning. The unit cost includes the salary and social security according to ACF contract (ACF France, US or Spain) and level, a scarcity bonus of 200 euro and the expatriate taxes paid in Afghanistan.*						

1.2	Deputy Country Director Program	D	1	4,713.63	12	16.67	9,429.15
	Coordinate technical country strategy and ensure operational supervision of projects from proposal, implementation, monitoring to reporting. Represent and liaise for operational strategy and program related issues to donors, authorities, UN, NGOs. Analyze the Humanitarian needs and follow-up on management of program budgets. The unit cost includes the salary and social security according to ACF contract (ACF France, US or Spain) and level, a scarcity bonus of 200 euro and the expatriate taxes paid in Afghanistan.						
1.3	Support Heads of Department	S	3	4,257.96	12	16.67	25,552.86
	The support HoD are Finance, logistics and Human Resources HoDs. for more details please refer to the uploaded BoQ. Small variances between BoQs and budget lines are due to rounding						
1.4	Programs Heads of Department	S	3	4,257.96	12	25.00	38,321.64
	The program expatriate HoD are WASH, Nutrition and MHCP HoDs. for more details please refer to the uploaded BoQ. Small variances between BoQs and budget lines are due to rounding						
1.5	Grant Reporting Officer	S	1	3,775.00	12	16.67	7,551.51
	Facilitating timely and quality reporting, advise and train field teams in the elaboration of reporting documents and internal monitoring tools, develop ACF proposals that correspond to donor guidelines and internal policies, ensuring that the questions and comments from donors are handled properly. The unit cost includes the salary and social security according to ACF contract (ACF France, US or Spain) and level, a scarcity bonus of 200 euro and the expatriate taxes paid in Afghanistan.						
1.6	Southern Region Field expatriate team	D	2	4,258.00	12	25.00	25,548.00
	The expatriate Helmand team is composed of the Field coordinator and the Field Manager. for more details please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
1.7	Expatriate benefits, allowance etc.	S	27.82	813.51	12	20.41	55,429.92
	These costs are including Housing (only the national staff working for the expatriates guesthouse in Kabul), per diem and living allowance, benefits (break flight ticket+break allowance+winter allowance) as well as a child allowance. *For more details please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding.*						
1.8	FSL Team Kabul	D	2	1,773.36	12	16.67	7,094.86
	Composed of the FSL HoD and FSL Deputy HoD, for more details. please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
1.9	Nutrition Team Kabul	D	1	1,580.00	12	16.67	3,160.63
	The Deputy Nutrition HoD provides technical support to the project staff, organize evaluations, survey the medical and nutritional situation and represent ACF. Salary includes basic salary, medical insurance, transport allowance, housing allowance and seniority (7% of basic salary). Grade: SM2Q as senior manager position Level 2 Grade 2						
1.10	MEAL Team Kabul	S	2	1,415.27	12	16.67	5,662.21
	Composed of the MEAL HoD and M&E and data management supervisor, for more details please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
1.11	WASH Team Kabul	D	4	1,443.72	12	16.67	11,552.07
	Composed of the Wash deputy HoD, WASH Expert - hardware *WASH expert - software and Laboratory technician. For more details please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
1.12	MHCP Team Kabul	D	1	1,442.00	12	16.67	2,884.58
	The MHCP HoD provides technical support to integrated project staff, including support on mental health and psychosocial assessments, and supervise implementation of counselling and psychoeducational activities. To support coordination with all key stakeholders on mental health, psychosocial and protection activities including clusters, partners and government offices. Salary includes basic salary, medical insurance, transport allowance, housing allowance and seniority (7% of basic salary). Grade: SM2J as senior manager position Level 2 Grade 1						
1.13	Surveillance Team Kabul	D	8.63	1,591.46	9	90.00	111,247.83
	please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
1.14	WASH Team Helmand	D	11.2	638.21	12	100.00	85,775.42
	please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
1.15	FSL Team Helmand	D	3	477.21	6	100.00	8,589.78

	please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
1.16	MHCP Team Helmand	D	11	738.99	10	100.00	81,288.90
	please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
1.17	Nutrition Team Helmand	D	11.88	605.42	19	87.50	119,573.48
	please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
1.18	MEAL Team Helmand	D	3	555.77	12	83.33	16,672.43
	please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
1.19	Coordination Support Team	S	52	605.26	12	16.67	62,959.63
	please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
1.20	Helmand Support Team	S	22.5	471.31	12	41.67	53,026.62
	please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
1.21	ACF Staff Training	S	10	2,233.00	1	10.00	2,233.00
	please refer to the uploaded BoQ						
	Section Total						**744,893.91**
2. Supplies, Commodities, Materials							
2.1	Technical assessment/survey/workshop	D	3	1,090.22	1	100.00	3,270.66
	Baseline and end-line survey and technical assessments (in total 3 survey/assessment) will be conducted during the project. Project kick off and orientation meetings will be organised for with the field team, provincial leaders and community leaders and part of introducing the project and project team to the community entry strategy. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
2.2	Hygiene sensitization at community level	D	14	3,584.02	1	100.00	50,176.28
	Hygiene promotion and sensitization sessions are organised at community level for all community members and community leaders and these will be in small groups of men and women in 14 villages. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
2.3	Construction of new water points in community and schools	D	5	3,731.85	1	100.00	18,659.25
	The construction of these new water points in 5 villages will include new construction of a lined hand dug wells, installation of hand pumps and construction of apron an drainage as per National standards, and this will be done in selected schools and communities depending on the needs. Please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
2.4	Water points rehabilitation in the community and school	D	16	681.62	1	100.00	10,905.92
	16 Selected water points that are dilapidated will be rehabilitated and rehabilitation unit cost includes repairing of the hand pump, deepening of the wells that run dry in the dry season, repairing of damaged drainage and apron and ensuring that the water points are all inclusive. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
2.5	Training of water points mechanics and caretakers on operation and maintenance including Toolkits and spare parts distribution to Mechanics	D	21	108.10	1	100.00	2,270.10
	All part of sustainability, selected members of the community will be trained during 21 sessions on operation and maintenance of the water points and a set of tools for repairing of the water point will be given to the Water users committees to ensure that the mechanics regularly maintain the water points and attend to any break downs timely. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
2.6	Distribution of Bio Sand Filters to selected IDPs with training on operation and maintenance of BSF	D	590	40.00	1	100.00	23,600.00

	The unit const includes the fabrication of the BSF from galvanized iron, sand, gravel sieving, thermos and a storage container. 590 BSF will be distributed to families with poor access to safe drinking water and all the beneficiaries will be trained on the setting up of the BSF and its operation and maintenance. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
2.7	Latrine construction in target schools and Nutrition Mobile clinics	D	8	5,036.03	1	100.00	40,288.24
	8 sets of new toilets in schools with high population and insufficient facilties be constructed and toilets will ensure gender separation and will be all inclusive. The unit cost includes excavation, lining of the pit, slabbing, superstructure and roofing. All toilets will be fixed with hand washing stations and a privacy wall. The same applies to nutrition Mobile clinics. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
2.8	Chlorination and water analysis	D	16	70.24	1	100.00	1,123.84
	All 16 water points will be chlorinated before they are handed over to the community. Water samples will be collected before and after rehabilitation to ensure that water quality meets the required standards. Water samples from selected BSFs will taken and analysed as part of quality monitoring. The testing will be for bacterial tests, conductivity and turbidity. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
2.9	Cash bases Intervention	D	1000	180.00	1	100.00	180,000.00
	Cash assistance to 1,000 food insecure prolonged IDP households in Lashkargah district, in two instalments through the Hawala system covering their 2 months food needs. ACF has aligned the amount to the FSAC standard package of 2,100 Kcal/person/day (i.e.180 USD per Household). *Please refer to the uploaded BoQ.*						
2.10	Post Distribution Monitoring	D	1	673.00	1	100.00	673.00
	One month after the distribution of cash, ACF MEAL team will carry a PDM on a representative, randomly selected sample of beneficiaries in the area of the project. An independent MEAL unit will lead post-distribution monitoring, with the assistance of female project staff. The PDM will assess beneficiary satisfaction towards (i) the quantity of cash received, (ii) the timeliness of the distribution, (iii) the organization of the distribution, (iii) the cash usage, (iv) complaints and concern of beneficiaries. *Please refer to the uploaded BoQ.*						
2.11	Stationery for Staff Training / Capacity Building Protection activities	D	1	131.00	1	100.00	131.00
	We will buy some stationnary specifically for protection training and capacity building sessions. BoQ can be provided upon request.						
2.12	Psychosocial Counseling Assessment & Sessions materials	D	1	716.00	1	100.00	716.00
	Some stationery and materials will be bought for protection assessments and sessions. *Please refer to the uploaded BoQ.*						
2.13	Deployment of mobile team for direct treatment of malnutrition and basic illnesses	D	2	12,689.61	1	100.00	25,379.22
	Two mobile teams will be deployed covering 10 sites, conduct screening of under 5 year old children, and treat SAM children. More over the mobile team activity includes treating of MAM children, IMNCI and Acute Malnourished PLW. The teams will also provide health education, IYCF messages and psychosocial counseling to mothers and caretakers. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
2.14	Community activity	D	1	17,975.32	1	100.00	17,975.32
	Promotion of the 1000 days (including Infant and Young Child Feeding - IYCF) and micronutrient supplementation, Integrated Management of new natal and child illness. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
2.15	Cooking demonstration for mothers with under 2 years children and Pregnant Lactating Women	D	2	966.18	1	100.00	1,932.36

	ACF will actively implement cooking demonstrations in coordination with the cooking demonstrations implemented by the BPHS, as recommended by the Public Nutrition Department (PND). Cooking demonstrations will emphasize on the complementary feeding from 6 to 24 months following exclusive breastfeeding, thus reinforcing this core message also. It will demonstrate how to prepare a complementary feeding with available seasonal food on the market-using balanced diet recipes suited to the developmental stage of the child. More specifically, a number of cooking demonstrations will be conducted for mothers of children under 2 years old under MAM treatment during to their IMCI consultation. the mobile clinics will ensure the cooking demonstrations for 11 months. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
2.16	Radio Broadcast for nutrition messages prevention	D	3	1,076.03	1	100.00	3,228.09
	The team will organize radio broadcast. The different topics will address messages on detection and prevention of malnutrition. They will include detection by MUAC, IYCF, maternal health, micronutrients, care practice messages. 3 broadcasts will be heard every day for 3 months. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
2.17	Shelter for waiting area and health education	D	7	632.46	1	100.00	4,427.22
	Tents deployment for the mobile clinics present in 7 areas. This includes construction materials, daily workers allowance for the installment and maintenance. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
2.18	Implementation of SMART & SQUEAC (ACF)	D	2	1,396.69	1	100.00	2,793.38
	These costs represent the accommodation costs of the ACF team in provinces where the partners cannot provide accommodations plus some materials for the ACF surveillance team during the whole project. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
	Section Total						**387,549.88**
3. Equipment							
3.1	Laptop	S	5	654.00	1	100.00	3,270.00
	5 laptops needed for the activities implementation/Unit cost estimated according to our price list for low performance unit						
3.2	Photocopier	S	1	700.00	1	100.00	700.00
	1 photocopier will be purchased on this project						
3.3	Camera	D	3	300.00	1	100.00	900.00
	3 cameras will be bought for this project, 1 for FSL activities, 2 for Surveillance activities						
3.4	tablette	D	3	218.00	1	100.00	654.00
	3 tablettes will be purchased for this project for the FSL activities						
	Section Total						**5,524.00**
4. Contractual Services							
4.1	Program Car Rental Protection for psychosocial counselors	D	1	460.00	10	100.00	4,600.00
	We will be renting 1 car at base level for the transport of the psycho-social counselors during 10 months. *The cars will be used in implementing Protection activities in different village of Lashkar Gah district.* *Each sector has specific objective to address and requires specifically dedicate vehicle. On the other hand due high insecurity situation vehicle remain stand by while the team is working in the field.*						
4.2	Program Car Rental WASH	D	4	460.00	9	100.00	16,560.00
	We will be renting 4 cars at base level for WASH activities during 9 months. *The cars will be sued in implementing WASH activities in the different villages of Lashkar Gah district.* *Each sector has specific objective to address and requires specifically dedicate vehicle. On the other hand due high insecurity situation vehicle remain stand by while the team is working in the field.*						
4.3	Program Car Rental FSL	D	3	460.00	5	100.00	6,900.00

	We will be renting 3 cars at base level for FSL activities during 5 months. The cars will be used in implementing FSL activities in different villages of Lashkar Gah district. *Each sector has specific objective to address and requires specifically dedicate vehicle. On the other hand due high insecurity situation vehicle remain stand by while the team is working in the field.*						
4.4	Program Car Rental Nutrition	D	5	441.00	12	100.00	26,460.00
	We will be renting 5 cars at base level for nutrition activities during 5 months. The cars will be used in implementing Nutrition activities in different village of Laskhar Gah district. *Each sector has specific objective to address and requires specifically dedicate vehicle. On the other hand due high insecurity situation vehicle remain stand by while the team is working in the field.*						
	Section Total						**54,520.00**
5. Travel							
5.1	International Freight	S	1	2,000.00	1	100.00	2,000.00
	Average cost for documents & material shipment to/from HQ. All the original hard copies of the project documents (programmatic and administrative: contracts, MoUs, invoices, payments etc.) need to be shipped to ACF HQ in Paris at the end of the implementation to be archived for future audits, history, and reference. Beside archiving and audit reasons, considering Afghanistan security context, we consider it safer to keep original confidential documentation in Paris rather than in Kabul, and ACF policy reflects this.						
5.2	National Freight Nutrition	S	2	299.00	1	100.00	598.00
	Average cost for transport of nutrition materials from coordination to the base. 2 transport are planned for this project						
5.3	National Freight Surveillance	S	1	224.00	12	100.00	2,688.00
	Average cost for transport of surveillance materials from coordination to different provinces the surveillance assessments will take place. One transport of materials will happen per assessment so 12 in total (8 SMART, 2 Rapid SMART and 2 SQUEAC)						
5.4	UNHAS Flight	S	3	400.00	12	100.00	14,400.00
	Average of 3 round trip per month (2 for surveillance team going to various provinces and 1 for other coordination support/program staff going to support the base) on this project. Monthly cost estimated according to the average cost flight tickets to each destination by UNHAS						
5.5	Travel-International/National	S	1.9	1,298.91	12	21.15	6,263.60
	These are the international flights for the expatriates to come and leave the country at the beginning and end of mission. We are also including the national flights of the 2 expatriates based in the province of Ghor for them to arrive and leave their base at the beginning and the end of the mission. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding.*						
	Section Total						**25,949.60**
6. Transfers and Grants to Counterparts							
6.1	SMART assessments implementation and training by partner	D	595.31	31.60	8	100.00	150,494.37
	Partnerships to be implemented in 8 provinces including allowances, transport and material expenses. 2 sessions planned during 7 days (training) and 10 days (data collection), each with a total of 56 participants. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
6.2	Rapid SMART assessments implementation and training by partner	D	236.97	23.46	2	100.00	11,118.63
	Partnerships to be implemented in 2 provinces including allowances, transport and material expenses. 1 session planned during 7 days for 24 participants. Please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
6.3	SQUEAC assessments implementation and training by partner	D	344.23	39.62	2	100.00	27,276.79
	Partnerships to be implemented in 2 provinces including allowances, transport and material expenses. Please refer to the uploaded BoQ. *Small variances between BoQs and budget lines are due to rounding*						
	Section Total						**188,889.79**

7. General Operating and Other Direct Costs							
7.1	Coordination Vehicles Running Costs	S	12	430.00	12	16.67	10,322.06
	2 months of vehicle fleet allocated on this project (out of 12 months for global project). The Cost estimated according to our actual expenses of the 12 vehicle running costs, car depreciation, insurance and maintenance.						
7.2	Helmand Vehicles Running Costs	S	1	673.00	12	41.67	3,365.27
	5 months of vehicle fleet allocated on this project (out of 12 months for global project). The Cost estimated according to our actual expenses of the 1 vehicle running costs, insurance and maintenance and one support car rental.						
7.3	Hawala fees	S	1	180,000.00	1	2.50	4,500.00
	The Hawala is charging us 2.5% of fees for each distribution in Helmand province as per our new contract with them.						
7.4	Security & Energy Equipment	S	1	5,000.00	1	100.00	5,000.00
	Given the wide variety of locations in which ACF implements activities, this fund will be allocated to last minute and unplanned security-related needs and will be needed for base security and energy improvement.						
7.5	Office Rental Kabul	S	1	5,294.00	12	16.67	10,590.12
	2 months of Office rental are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.6	Storage Kabul	S	1	800.00	12	16.67	1,600.32
	2 months of storage rental are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.7	Office Running costs Kabul	S	11.14	4,023.60	1	16.67	7,471.98
	2 months of office running costs are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding*						
7.8	Stationnaries and small equipment Kabul office	S	1	1,905.00	12	16.67	3,810.76
	2 months of office stationnaires costs are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.9	Financial services Kabul	S	1	1,744.00	12	16.67	3,488.70
	2 months of financial services are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.10	Mobile consumption Kabul	S	1	1,793.00	12	16.67	3,586.72
	2 months of mobile consumption are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.11	Internet Kabul	S	1	674.00	12	16.67	1,348.27
	2 months of internet consumption are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.12	Satellite phone consumption Kabul	S	1	436.00	12	16.67	872.17
	2 months of satellite phone consumption are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.13	Computer and Equipment maintenance Kabul	S	1	299.00	12	16.67	598.12
	2 months of Computer and Equipment maintenance are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.14	Office Rental Helmand	S	1	1,000.00	12	41.67	5,000.40

	5 months of Office rental are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.15	Office Repair/Maintenance/Construction Helmand	S	1	100.00	12	41.67	500.04
	5 months of Office rehabilitation are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.16	Office Running costs Helmand	S	1	1,633.00	12	41.67	8,165.65
	5 months of office running costs are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.17	Stationnaries and small equipment Helmand office	S	1	149.00	12	41.67	745.06
	5 months of office stationnaires costs are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.18	Financial services Helmand	S	1	299.00	12	41.67	1,495.12
	5 months of financial services are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.19	Mobile consumption Helmand	S	1	52.00	12	41.67	260.02
	5 months of mobile consumption are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.20	Internet Helmand	S	1	1,050.00	12	41.67	5,250.42
	5 months of internet consumption are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.21	Satellite phone consumption Helmand	S	1	218.00	12	41.67	1,090.09
	5 months of satellite phone consumption are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.22	Computer and Equipment maintenance Helmand	S	1	75.00	12	41.67	375.03
	5 months of Computer and Equipment maintenance are allocated on this project (out of 12 months for global project. The Cost is estimated according to our actual expenses						
7.23	Guesthouse rent and charges for the expatriates	S	11.09	1,023.10	12	20.00	27,230.83
	These costs are including the rent and charges of the Guesthouse of the expatriates. *Please refer to the uploaded BoQ.* *Small variances between BoQs and budget lines are due to rounding.*						
	Section Total						**106,667.15**
SubTotal			3,139.67				**1,513,994.33**
Direct							1,115,330.80
Support							398,663.53
PSC Cost							
PSC Cost Percent							7.00
PSC Amount							105,979.60
Total Cost							**1,619,973.93**

Project Locations

Location	Estimated percentage of budget for each location	Estimated number of beneficiaries for each location					Activity Name
		Men	Women	Boys	Girls	Total	

Nangarhar		2	19	6			25	Activity 1.1.1 : Identification of 8 provinces for 8 integrated multi-sectoral assessments (SMART) and 2 rapid SMART surveys. In 8 provinces, Nutrition Cluster partners and selected staff of government authorities, BPHS IPs and NGOs will benefit from capacity building and on-the-job support on integrated and rapid SMART surveys. Integrated SMART surveys include the following components: Anthropocentric data, Emergency Mortality, Morbidity, basic Health indicators, key WASH and FSL indicators. Under the supervisions of Assessment and Information Management Working Group of Nutrition Cluster, these SMART assessments will be conducted in provinces with hard to access districts and areas in close partnerships of BPHS implementing partners that implementing nutrition programs in their respective districts. A partnership MoU will be developed with each provincial level partner, BPHS implementing agencies with specific roles and responsibilities to conduct these assessments in the provinces. A part of the budget will be transferred to these partners to hire data enumerators and facilitate conducting the assessment like training of data enumerators, providing logistic support, and jointing monitoring the data collection process in field with ACF technical team. They will also help in data feeding and then ACF technical team will develop and share reports to AIM-WG and nutrition cluster for partners to use the data in future planning. Activity 1.1.2 : Identification and capacity building of BPHS partners on SMART assessments. These assessments in close coordination with BPHS IPs will help building their capacity to conduct SMART assessment for their respective provinces in future. On-the-job trainings for BPHS staff, NGOs and local Government will develop a pool of experts in these hard to access areas in country to conduct assessments for their respective program when required after this project. ACF targets 200 people, of which 48 women and 152 men, which includes survey supervisors, team leaders and data enumerators. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SMART Surveys. Activity 1.1.3 : Conduct 8 multi-sectoral assessments (SMART) and 2 Rapid SMART assessments in 8 targeted provinces of Afghanistan. Implementation of 8 multi-sectoral assessments (Nutrition, WASH, Health and FSL) and 2 Rapid SMART by partner with technical support from ACF as part of its new capacity building strategy, ACF will seek to empower and support partners to take the lead on the process of SMART implementation, from the methodology, questionnaire, sampling to data collection, entry, analysis and preliminary report writing. The 8 multi-sectoral assessments will be implemented in hard to reach provinces and as per the Public Nutrition Department request, they will cover the entire provinces of Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul. As for the Rapid SMART, they will be implemented in hard to reach provinces according to needs identified. During the previous project, ACF staff was acting as SMART Manager, directly providing training to supervisors and enumerators in the field, although with compulsory participation of senior level partners, field staff in a bid to enhance their

							capacity. Under the proposed project, ACF will engage the SMART Managers and members of the AIM-WG trained during the previous project to strongly participate to and implement the surveys, with ACF acting as technical backstop. Following the formal training provided to partner's nutrition field staff at central level, ACF will provide field-level practical training to Survey Managers for the implementation of one SMART survey in their province. Capacitated during the formal training, Survey Managers will be supported to take the lead and conduct the 7 days theoretical training for enumerators and supervisors led by the partner Survey Manager, with job shadowing by ACF SMART experts. Partner Survey Manager will also be responsible for planning field work and supervising data collection, including quality checks, and data entry on ENA software. ACF considered that a SMART survey requires the mobilization of 6 supervisors, 6 team leaders, and 12 enumerators (2 enumerators per team, 1 male and 1 female when possible) plus one Public Nutrition Officer/MoPH from each province. The number of staff actually targeted will be verified against attendance lists to the SMART training, and daily worker payment sheets that the partner will provide to ACF at the end of the survey to justify expenses. Activity 1.1.4 : Production and dissemination of 8 integrated and 2 rapid SMART Survey reports Production and dissemination of reports through National and Sub-national Clusters. Processing of shadowing partner's Survey Manager will extend to preliminary report writing for ACF SMART experts will provide continuous hands-on support. Considering the advanced technical knowledge required for writing the full report. ACF will keep the lead on writing the full report, while working in close collaboration and inputs/review/validation with partners. This will ensure timely production and dissemination of the report to the Nutrition Cluster. As co-chair of the AIM-WG, ACF has worked in 2014-17 on establishing quality assurance mechanisms for SMART and Rapid SMART data, the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of nutrition data produced under SMART and Rapid SMARTs by a restricted pool of experts. In line with this approach, and following the current process of validation, results of the SMART and Rapid SMARTs, after validation by ACF and partners, will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Clusters. For integrated SMART surveys, a preliminary report will be released one week after the completion of the data collection, while the final report will be shared within one month through the AIM-WG. For Rapid SMARTs, the report will be produced and shared within a week. As partners will be more involved than before in report writing (until the preliminary report stage), and will have more ownership of the overall survey, results will be jointly presented to the AIMWG, and to the Cluster by ACF and the partner. Acknowledging the need to channel the results down to the provincial level, ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.
Ghazni	2	19	6			25	Activity 1.1.1 : Identification of 8 provinces for 8 integrated multi-sectoral assessments (SMART) and 2 rapid SMART surveys. In 8 provinces, Nutrition Cluster partners and

selected staff of government authorities, BPHS IPs and NGOs will benefit from capacity building and on-the-job support on integrated and rapid SMART surveys. Integrated SMART surveys include the following components: Anthropocentric data, Emergency Mortality, Morbidity, basic Health indicators, key WASH and FSL indicators.
Under the supervisions of Assessment and Information Management Working Group of Nutrition Cluster, these SMART assessments will be conducted in provinces with hard to access districts and areas in close partnerships of BPHS implementing partners that implementing nutrition programs in their respective districts. A partnership MoU will be developed with each provincial level partner, BPHS implementing agencies with specific roles and responsibilities to conduct these assessments in the provinces. A part of the budget will be transferred to these partners to hire data enumerators and facilitate conducting the assessment like training of data enumerators, providing logistic support, and jointing monitoring the data collection process in field with ACF technical team. They will also help in data feeding and then ACF technical team will develop and share reports to AIM-WG and nutrition cluster for partners to use the data in future planning.

Activity 1.1.2 : Identification and capacity building of BPHS partners on SMART assessments.

These assessments in close coordination with BPHS IPs will help building their capacity to conduct SMART assessment for their respective provinces in future. On-the-job trainings for BPHS staff, NGOs and local Government will develop a pool of experts in these hard to access areas in country to conduct assessments for their respective program when required after this project. ACF targets 200 people, of which 48 women and 152 men, which includes survey supervisors, team leaders and data enumerators. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SMART Surveys.

Activity 1.1.3 : Conduct 8 multi-sectoral assessments (SMART) and 2 Rapid SMART assessments in 8 targeted provinces of Afghanistan.

Implementation of 8 multi-sectoral assessments (Nutrition, WASH, Health and FSL) and 2 Rapid SMART by partner with technical support from ACF as part of its new capacity building strategy, ACF will seek to empower and support partners to take the lead on the process of SMART implementation, from the methodology, questionnaire, sampling to data collection, entry, analysis and preliminary report writing. The 8 multi-sectoral assessments will be implemented in hard to reach provinces and as per the Public Nutrition Department request, they will cover the entire provinces of Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul. As for the Rapid SMART, they will be implemented in hard to reach provinces according to needs identified.

During the previous project, ACF staff was acting as SMART Manager, directly providing training to supervisors and enumerators in the field, although with compulsory participation of senior level partners, field staff in a bid to enhance their capacity. Under the proposed project, ACF will engage the SMART Managers and members of the AIM-WG trained during the previous project to strongly participate to and implement the surveys, with ACF acting as technical backstop.

							Following the formal training provided to partner's nutrition field staff at central level, ACF will provide field-level practical training to Survey Managers for the implementation of one SMART survey in their province. Capacitated during the formal training, Survey Managers will be supported to take the lead and conduct the 7 days theoretical training for enumerators and supervisors led by the partner Survey Manager, with job shadowing by ACF SMART experts. Partner Survey Manager will also be responsible for planning field work and supervising data collection, including quality checks, and data entry on ENA software. ACF considered that a SMART survey requires the mobilization of 6 supervisors, 6 team leaders, and 12 enumerators (2 enumerators per team, 1 male and 1 female when possible) plus one Public Nutrition Officer/MoPH from each province. The number of staff actually targeted will be verified against attendance lists to the SMART training, and daily worker payment sheets that the partner will provide to ACF at the end of the survey to justify expenses. Activity 1.1.4 : Production and dissemination of 8 integrated and 2 rapid SMART Survey reports Production and dissemination of reports through National and Sub-national Clusters. Processing of shadowing partner's Survey Manager will extend to preliminary report writing for ACF SMART experts will provide continuous hands-on support. Considering the advanced technical knowledge required for writing the full report. ACF will keep the lead on writing the full report, while working in close collaboration and inputs/review/validation with partners. This will ensure timely production and dissemination of the report to the Nutrition Cluster. As co-chair of the AIM-WG, ACF has worked in 2014-17 on establishing quality assurance mechanisms for SMART and Rapid SMART data, the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of nutrition data produced under SMART and Rapid SMARTs by a restricted pool of experts. In line with this approach, and following the current process of validation, results of the SMART and Rapid SMARTs, after validation by ACF and partners, will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Clusters. For integrated SMART surveys, a preliminary report will be released one week after the completion of the data collection, while the final report will be shared within one month through the AIM-WG. For Rapid SMARTs, the report will be produced and shared within a week. As partners will be more involved than before in report writing (until the preliminary report stage), and will have more ownership of the overall survey, results will be jointly presented to the AIMWG, and to the Cluster by ACF and the partner. Acknowledging the need to channel the results down to the provincial level, ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.
Kunar	2	19	6			25	Activity 1.1.1 : Identification of 8 provinces for 8 integrated multi-sectoral assessments (SMART) and 2 rapid SMART surveys. In 8 provinces, Nutrition Cluster partners and selected staff of government authorities, BPHS IPs and NGOs will benefit from capacity building and on-the-job support on integrated and rapid SMART surveys. Integrated SMART surveys include the following components:

Anthropocentric data, Emergency Mortality, Morbidity, basic Health indicators, key WASH and FSL indicators.
Under the supervisions of Assessment and Information Management Working Group of Nutrition Cluster, these SMART assessments will be conducted in provinces with hard to access districts and areas in close partnerships of BPHS implementing partners that implementing nutrition programs in their respective districts. A partnership MoU will be developed with each provincial level partner, BPHS implementing agencies with specific roles and responsibilities to conduct these assessments in the provinces. A part of the budget will be transferred to these partners to hire data enumerators and facilitate conducting the assessment like training of data enumerators, providing logistic support, and jointing monitoring the data collection process in field with ACF technical team. They will also help in data feeding and then ACF technical team will develop and share reports to AIM-WG and nutrition cluster for partners to use the data in future planning.

Activity 1.1.2 : Identification and capacity building of BPHS partners on SMART assessments.

These assessments in close coordination with BPHS IPs will help building their capacity to conduct SMART assessment for their respective provinces in future. On-the-job trainings for BPHS staff, NGOs and local Government will develop a pool of experts in these hard to access areas in country to conduct assessments for their respective program when required after this project. ACF targets 200 people, of which 48 women and 152 men, which includes survey supervisors, team leaders and data enumerators. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SMART Surveys.

Activity 1.1.3 : Conduct 8 multi-sectoral assessments (SMART) and 2 Rapid SMART assessments in 8 targeted provinces of Afghanistan.

Implementation of 8 multi-sectoral assessments (Nutrition, WASH, Health and FSL) and 2 Rapid SMART by partner with technical support from ACF as part of its new capacity building strategy, ACF will seek to empower and support partners to take the lead on the process of SMART implementation, from the methodology, questionnaire, sampling to data collection, entry, analysis and preliminary report writing. The 8 multi-sectoral assessments will be implemented in hard to reach provinces and as per the Public Nutrition Department request, they will cover the entire provinces of Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul. As for the Rapid SMART, they will be implemented in hard to reach provinces according to needs identified.

During the previous project, ACF staff was acting as SMART Manager, directly providing training to supervisors and enumerators in the field, although with compulsory participation of senior level partners, field staff in a bid to enhance their capacity. Under the proposed project, ACF will engage the SMART Managers and members of the AIM-WG trained during the previous project to strongly participate to and implement the surveys, with ACF acting as technical backstop. Following the formal training provided to partner’s nutrition field staff at central level, ACF will provide field-level practical training to Survey Managers for the implementation of one SMART survey in their province. Capacitated during the

							formal training, Survey Managers will be supported to take the lead and conduct the 7 days theoretical training for enumerators and supervisors led by the partner Survey Manager, with job shadowing by ACF SMART experts. Partner Survey Manager will also be responsible for planning field work and supervising data collection, including quality checks, and data entry on ENA software. ACF considered that a SMART survey requires the mobilization of 6 supervisors, 6 team leaders, and 12 enumerators (2 enumerators per team, 1 male and 1 female when possible) plus one Public Nutrition Officer/MoPH from each province. The number of staff actually targeted will be verified against attendance lists to the SMART training, and daily worker payment sheets that the partner will provide to ACF at the end of the survey to justify expenses. Activity 1.1.4 : Production and dissemination of 8 integrated and 2 rapid SMART Survey reports Production and dissemination of reports through National and Sub-national Clusters. Processing of shadowing partner's Survey Manager will extend to preliminary report writing for ACF SMART experts will provide continuous hands-on support. Considering the advanced technical knowledge required for writing the full report. ACF will keep the lead on writing the full report, while working in close collaboration and inputs/review/validation with partners. This will ensure timely production and dissemination of the report to the Nutrition Cluster. As co-chair of the AIM-WG, ACF has worked in 2014-17 on establishing quality assurance mechanisms for SMART and Rapid SMART data, the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of nutrition data produced under SMART and Rapid SMARTs by a restricted pool of experts. In line with this approach, and following the current process of validation, results of the SMART and Rapid SMARTs, after validation by ACF and partners, will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Clusters. For integrated SMART surveys, a preliminary report will be released one week after the completion of the data collection, while the final report will be shared within one month through the AIM-WG. For Rapid SMARTs, the report will be produced and shared within a week. As partners will be more involved than before in report writing (until the preliminary report stage), and will have more ownership of the overall survey, results will be jointly presented to the AIMWG, and to the Cluster by ACF and the partner. Acknowledging the need to channel the results down to the provincial level, ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.
Kunduz	2	19	6			25	Activity 1.1.1 : Identification of 8 provinces for 8 integrated multi-sectoral assessments (SMART) and 2 rapid SMART surveys. In 8 provinces, Nutrition Cluster partners and selected staff of government authorities, BPHS IPs and NGOs will benefit from capacity building and on-the-job support on integrated and rapid SMART surveys. Integrated SMART surveys include the following components: Anthropocentric data, Emergency Mortality, Morbidity, basic Health indicators, key WASH and FSL indicators. Under the supervisions of Assessment and Information Management Working Group of

Nutrition Cluster, these SMART assessments will be conducted in provinces with hard to access districts and areas in close partnerships of BPHS implementing partners that implementing nutrition programs in their respective districts. A partnership MoU will be developed with each provincial level partner, BPHS implementing agencies with specific roles and responsibilities to conduct these assessments in the provinces. A part of the budget will be transferred to these partners to hire data enumerators and facilitate conducting the assessment like training of data enumerators, providing logistic support, and jointing monitoring the data collection process in field with ACF technical team. They will also help in data feeding and then ACF technical team will develop and share reports to AIM-WG and nutrition cluster for partners to use the data in future planning.

Activity 1.1.2 : Identification and capacity building of BPHS partners on SMART assessments.

These assessments in close coordination with BPHS IPs will help building their capacity to conduct SMART assessment for their respective provinces in future. On-the-job trainings for BPHS staff, NGOs and local Government will develop a pool of experts in these hard to access areas in country to conduct assessments for their respective program when required after this project. ACF targets 200 people, of which 48 women and 152 men, which includes survey supervisors, team leaders and data enumerators. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SMART Surveys.

Activity 1.1.3 : Conduct 8 multi-sectoral assessments (SMART) and 2 Rapid SMART assessments in 8 targeted provinces of Afghanistan.

Implementation of 8 multi-sectoral assessments (Nutrition, WASH, Health and FSL) and 2 Rapid SMART by partner with technical support from ACF as part of its new capacity building strategy, ACF will seek to empower and support partners to take the lead on the process of SMART implementation, from the methodology, questionnaire, sampling to data collection, entry, analysis and preliminary report writing. The 8 multi-sectoral assessments will be implemented in hard to reach provinces and as per the Public Nutrition Department request, they will cover the entire provinces of Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul. As for the Rapid SMART, they will be implemented in hard to reach provinces according to needs identified.

During the previous project, ACF staff was acting as SMART Manager, directly providing training to supervisors and enumerators in the field, although with compulsory participation of senior level partners, field staff in a bid to enhance their capacity. Under the proposed project, ACF will engage the SMART Managers and members of the AIM-WG trained during the previous project to strongly participate to and implement the surveys, with ACF acting as technical backstop. Following the formal training provided to partner’s nutrition field staff at central level, ACF will provide field-level practical training to Survey Managers for the implementation of one SMART survey in their province. Capacitated during the formal training, Survey Managers will be supported to take the lead and conduct the 7 days theoretical training for enumerators and supervisors led by the partner Survey Manager, with job shadowing by ACF SMART experts.

							Partner Survey Manager will also be responsible for planning field work and supervising data collection, including quality checks, and data entry on ENA software. ACF considered that a SMART survey requires the mobilization of 6 supervisors, 6 team leaders, and 12 enumerators (2 enumerators per team, 1 male and 1 female when possible) plus one Public Nutrition Officer/MoPH from each province. The number of staff actually targeted will be verified against attendance lists to the SMART training, and daily worker payment sheets that the partner will provide to ACF at the end of the survey to justify expenses. Activity 1.1.4 : Production and dissemination of 8 integrated and 2 rapid SMART Survey reports Production and dissemination of reports through National and Sub-national Clusters. Processing of shadowing partner's Survey Manager will extend to preliminary report writing for ACF SMART experts will provide continuous hands-on support. Considering the advanced technical knowledge required for writing the full report. ACF will keep the lead on writing the full report, while working in close collaboration and inputs/review/validation with partners. This will ensure timely production and dissemination of the report to the Nutrition Cluster. As co-chair of the AIM-WG, ACF has worked in 2014-17 on establishing quality assurance mechanisms for SMART and Rapid SMART data, the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of nutrition data produced under SMART and Rapid SMARTs by a restricted pool of experts. In line with this approach, and following the current process of validation, results of the SMART and Rapid SMARTs, after validation by ACF and partners, will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Clusters. For integrated SMART surveys, a preliminary report will be released one week after the completion of the data collection, while the final report will be shared within one month through the AIM-WG. For Rapid SMARTs, the report will be produced and shared within a week. As partners will be more involved than before in report writing (until the preliminary report stage), and will have more ownership of the overall survey, results will be jointly presented to the AIMWG, and to the Cluster by ACF and the partner. Acknowledging the need to channel the results down to the provincial level, ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.
Uruzgan	6	38	12			50	Activity 1.1.1 : Identification of 8 provinces for 8 integrated multi-sectoral assessments (SMART) and 2 rapid SMART surveys. In 8 provinces, Nutrition Cluster partners and selected staff of government authorities, BPHS IPs and NGOs will benefit from capacity building and on-the-job support on integrated and rapid SMART surveys. Integrated SMART surveys include the following components: Anthropocentric data, Emergency Mortality, Morbidity, basic Health indicators, key WASH and FSL indicators. Under the supervisions of Assessment and Information Management Working Group of Nutrition Cluster, these SMART assessments will be conducted in provinces with hard to access districts and areas in close partnerships of BPHS implementing partners that implementing nutrition programs in their respective districts. A

partnership MoU will be developed with each provincial level partner, BPHS implementing agencies with specific roles and responsibilities to conduct these assessments in the provinces. A part of the budget will be transferred to these partners to hire data enumerators and facilitate conducting the assessment like training of data enumerators, providing logistic support, and jointing monitoring the data collection process in field with ACF technical team. They will also help in data feeding and then ACF technical team will develop and share reports to AIM-WG and nutrition cluster for partners to use the data in future planning.

Activity 1.1.2 : Identification and capacity building of BPHS partners on SMART assessments.

These assessments in close coordination with BPHS IPs will help building their capacity to conduct SMART assessment for their respective provinces in future. On-the-job trainings for BPHS staff, NGOs and local Government will develop a pool of experts in these hard to access areas in country to conduct assessments for their respective program when required after this project. ACF targets 200 people, of which 48 women and 152 men, which includes survey supervisors, team leaders and data enumerators. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SMART Surveys.

Activity 1.1.3 : Conduct 8 multi-sectoral assessments (SMART) and 2 Rapid SMART assessments in 8 targeted provinces of Afghanistan.

Implementation of 8 multi-sectoral assessments (Nutrition, WASH, Health and FSL) and 2 Rapid SMART by partner with technical support from ACF as part of its new capacity building strategy, ACF will seek to empower and support partners to take the lead on the process of SMART implementation, from the methodology, questionnaire, sampling to data collection, entry, analysis and preliminary report writing. The 8 multi-sectoral assessments will be implemented in hard to reach provinces and as per the Public Nutrition Department request, they will cover the entire provinces of Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul. As for the Rapid SMART, they will be implemented in hard to reach provinces according to needs identified.

During the previous project, ACF staff was acting as SMART Manager, directly providing training to supervisors and enumerators in the field, although with compulsory participation of senior level partners, field staff in a bid to enhance their capacity. Under the proposed project, ACF will engage the SMART Managers and members of the AIM-WG trained during the previous project to strongly participate to and implement the surveys, with ACF acting as technical backstop. Following the formal training provided to partner’s nutrition field staff at central level, ACF will provide field-level practical training to Survey Managers for the implementation of one SMART survey in their province. Capacitated during the formal training, Survey Managers will be supported to take the lead and conduct the 7 days theoretical training for enumerators and supervisors led by the partner Survey Manager, with job shadowing by ACF SMART experts. Partner Survey Manager will also be responsible for planning field work and supervising data collection, including quality checks, and data entry on ENA software. ACF considered that a SMART survey requires the mobilization of 6

supervisors, 6 team leaders, and 12 enumerators (2 enumerators per team, 1 male and 1 female when possible) plus one Public Nutrition Officer/MoPH from each province. The number of staff actually targeted will be verified against attendance lists to the SMART training, and daily worker payment sheets that the partner will provide to ACF at the end of the survey to justify expenses.

Activity 1.1.4 : Production and dissemination of 8 integrated and 2 rapid SMART Survey reports

Production and dissemination of reports through National and Sub-national Clusters. Processing of shadowing partner's Survey Manager will extend to preliminary report writing for ACF SMART experts will provide continuous hands-on support. Considering the advanced technical knowledge required for writing the full report. ACF will keep the lead on writing the full report, while working in close collaboration and inputs/review/validation with partners. This will ensure timely production and dissemination of the report to the Nutrition Cluster.
As co-chair of the AIM-WG, ACF has worked in 2014-17 on establishing quality assurance mechanisms for SMART and Rapid SMART data, the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of nutrition data produced under SMART and Rapid SMARTs by a restricted pool of experts. In line with this approach, and following the current process of validation, results of the SMART and Rapid SMARTs, after validation by ACF and partners, will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Clusters. For integrated SMART surveys, a preliminary report will be released one week after the completion of the data collection, while the final report will be shared within one month through the AIM-WG. For Rapid SMARTs, the report will be produced and shared within a week. As partners will be more involved than before in report writing (until the preliminary report stage), and will have more ownership of the overall survey, results will be jointly presented to the AIMWG, and to the Cluster by ACF and the partner. Acknowledging the need to channel the results down to the provincial level, ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.

Activity 1.2.1 : Identification of priority areas for conducting 2 SQUEAC assessments

2 SQUEAC will be implemented in 2 of the targeted provinces, to allow for compressive analysis of barriers and boosters of IMAM program in targeted provinces and to support informed decision making of the BPHS partner on the ground as to where and how to improve IMAM services within the province. The coverage of SQUEAC (e.g. number of districts) will be discussed bilaterally with partners during project inception, considering access and review of secondary data. The main criteria for selection of a province for SQUEAC assessment will be the existence of both SAM and MAM services in the province. It will be discussed with partners in AIM-WG of nutrition cluster before planning and signing MoU with BPHS IP or any other IMAM program implementing partner. A MOU will be signed with the partner for its respective province SQUEAC arrangement to facilitate the ACF technical team to work with partner organization to conduct the assessment. The MoU will clarify the role and responsibilities of IP and ACF including the financial management of the

							activity. Activity 1.2.2 : Identification and capacity building of BPHS partners on SQUEAC assessments Conduction of capacity building and on-the-job trainings for BPHS staff, NGOs and Government line departments like provincial level staff of PND. ACF targets 50 people, of which 12 women and 38 men. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SQUEAC Surveys. The capacity building of partner organizations will involve the partner staff who have attended previous managerial level SQUEAC training organized by ACF with CHF funding. These training of partner staff and data enumerators at provincial level build capacities of local experts to be present in their respective provinces to support nutrition program conducting SQUEAC in future. Activity 1.2.3 : Conduct SQUEAC in the two targeted provinces of Zabul and Uruzgan in support of partners. Once area of SQUEAC identified in the provinces of Zabul and Uruzgan, MoU signed and partner staff and data enumerators are trained, they will formally start with support of partner organizations and locally hired data enumerators. ACF technical staff will be present in province to train the partner organization's staff and data enumerators and technically support data collection for quality data, monitor the data collection and feeding process as well as work with partner organization to clean and analyze data for first draft report of the each of 2 SQUEACs. Partners will provide logistic support and ACF technical team will be there for technical support of the process as well as building capacities of partner organization to conduct SQUEAC in their respective provinces to monitor barriers and boosters of IMAM program being implemented there. Activity 1.2.4 : Production and dissemination of reports through National and Sub-national Clusters ACF will be responsible in guiding the trained partner staff in producing the SQUEAC report, with active involvement of the partner for review/validation prior external dissemination. For SQUEAC evaluations, draft report will be released with a month after the completion of the survey, while the full report should be completed within the following month. In an attempt to capacitate partner staff on SQUEAC, and encourage ownership of the findings, results will be presented jointly by ACF and the partner to the AIM-WG, and to the Cluster. As co-chair of the AIM-WG, ACF has supported the establishment of quality assurance mechanisms for SQUEAC; the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of SQUEAC evaluation - by a restricted pool of experts. In line with this approach, and following the current process of validation results of the SQUEAC will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Cluster. Acknowledging the need to channel down the results to provincial level, ACF will encourage partners to disseminate the report at sub-national level, through the Provincial Clusters and relevant health and nutrition authorities.
Zabul	6	38	12			50	Activity 1.1.1 : Identification of 8 provinces for 8 integrated multi-sectoral assessments (SMART)

and 2 rapid SMART surveys.

In 8 provinces, Nutrition Cluster partners and selected staff of government authorities, BPHS IPs and NGOs will benefit from capacity building and on-the-job support on integrated and rapid SMART surveys. Integrated SMART surveys include the following components: Anthropocentric data, Emergency Mortality, Morbidity, basic Health indicators, key WASH and FSL indicators.
Under the supervisions of Assessment and Information Management Working Group of Nutrition Cluster, these SMART assessments will be conducted in provinces with hard to access districts and areas in close partnerships of BPHS implementing partners that implementing nutrition programs in their respective districts. A partnership MoU will be developed with each provincial level partner, BPHS implementing agencies with specific roles and responsibilities to conduct these assessments in the provinces. A part of the budget will be transferred to these partners to hire data enumerators and facilitate conducting the assessment like training of data enumerators, providing logistic support, and jointing monitoring the data collection process in field with ACF technical team. They will also help in data feeding and then ACF technical team will develop and share reports to AIM-WG and nutrition cluster for partners to use the data in future planning.

Activity 1.1.2 : Identification and capacity building of BPHS partners on SMART assessments.

These assessments in close coordination with BPHS IPs will help building their capacity to conduct SMART assessment for their respective provinces in future. On-the-job trainings for BPHS staff, NGOs and local Government will develop a pool of experts in these hard to access areas in country to conduct assessments for their respective program when required after this project. ACF targets 200 people, of which 48 women and 152 men, which includes survey supervisors, team leaders and data enumerators. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SMART Surveys.

Activity 1.1.3 : Conduct 8 multi-sectoral assessments (SMART) and 2 Rapid SMART assessments in 8 targeted provinces of Afghanistan.

Implementation of 8 multi-sectoral assessments (Nutrition, WASH, Health and FSL) and 2 Rapid SMART by partner with technical support from ACF as part of its new capacity building strategy, ACF will seek to empower and support partners to take the lead on the process of SMART implementation, from the methodology, questionnaire, sampling to data collection, entry, analysis and preliminary report writing. The 8 multi-sectoral assessments will be implemented in hard to reach provinces and as per the Public Nutrition Department request, they will cover the entire provinces of Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul. As for the Rapid SMART, they will be implemented in hard to reach provinces according to needs identified.

During the previous project, ACF staff was acting as SMART Manager, directly providing training to supervisors and enumerators in the field, although with compulsory participation of senior level partners, field staff in a bid to enhance their capacity. Under the proposed project, ACF will engage the SMART Managers and members of

the AIM-WG trained during the previous project to strongly participate to and implement the surveys, with ACF acting as technical backstop. Following the formal training provided to partner's nutrition field staff at central level, ACF will provide field-level practical training to Survey Managers for the implementation of one SMART survey in their province. Capacitated during the formal training, Survey Managers will be supported to take the lead and conduct the 7 days theoretical training for enumerators and supervisors led by the partner Survey Manager, with job shadowing by ACF SMART experts. Partner Survey Manager will also be responsible for planning field work and supervising data collection, including quality checks, and data entry on ENA software. ACF considered that a SMART survey requires the mobilization of 6 supervisors, 6 team leaders, and 12 enumerators (2 enumerators per team, 1 male and 1 female when possible) plus one Public Nutrition Officer/MoPH from each province. The number of staff actually targeted will be verified against attendance lists to the SMART training, and daily worker payment sheets that the partner will provide to ACF at the end of the survey to justify expenses.

Activity 1.1.4 : Production and dissemination of 8 integrated and 2 rapid SMART Survey reports

Production and dissemination of reports through National and Sub-national Clusters. Processing of shadowing partner's Survey Manager will extend to preliminary report writing for ACF SMART experts will provide continuous hands-on support. Considering the advanced technical knowledge required for writing the full report. ACF will keep the lead on writing the full report, while working in close collaboration and inputs/review/validation with partners. This will ensure timely production and dissemination of the report to the Nutrition Cluster.
As co-chair of the AIM-WG, ACF has worked in 2014-17 on establishing quality assurance mechanisms for SMART and Rapid SMART data, the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of nutrition data produced under SMART and Rapid SMARTs by a restricted pool of experts. In line with this approach, and following the current process of validation, results of the SMART and Rapid SMARTs, after validation by ACF and partners, will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Clusters. For integrated SMART surveys, a preliminary report will be released one week after the completion of the data collection, while the final report will be shared within one month through the AIM-WG. For Rapid SMARTs, the report will be produced and shared within a week. As partners will be more involved than before in report writing (until the preliminary report stage), and will have more ownership of the overall survey, results will be jointly presented to the AIMWG, and to the Cluster by ACF and the partner. Acknowledging the need to channel the results down to the provincial level, ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.

Activity 1.2.1 : Identification of priority areas for conducting 2 SQUEAC assessments

2 SQUEAC will be implemented in 2 of the targeted provinces, to allow for compressive analysis of barriers and boosters of IMAM program in targeted provinces and to support informed decision making of the BPHS partner

on the ground as to where and how to improve IMAM services within the province. The coverage of SQUEAC (e.g. number of districts) will be discussed bilaterally with partners during project inception, considering access and review of secondary data. The main criteria for selection of a province for SQUEAC assessment will be the existence of both SAM and MAM services in the province. It will be discussed with partners in AIM-WG of nutrition cluster before planning and signing MoU with BPHS IP or any other IMAM program implementing partner. A MOU will be signed with the partner for its respective province SQUEAC arrangement to facilitate the ACF technical team to work with partner organization to conduct the assessment. The MoU will clarify the role and responsibilities of IP and ACF including the financial management of the activity.

Activity 1.2.2 : Identification and capacity building of BPHS partners on SQUEAC assessments

Conduction of capacity building and on-the-job trainings for BPHS staff, NGOs and Government line departments like provincial level staff of PND. ACF targets 50 people, of which 12 women and 38 men. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SQUEAC Surveys. The capacity building of partner organizations will involve the partner staff who have attended previous managerial level SQUEAC training organized by ACF with CHF funding. These training of partner staff and data enumerators at provincial level build capacities of local experts to be present in their respective provinces to support nutrition program conducting SQUEAC in future.

Activity 1.2.3 : Conduct SQUEAC in the two targeted provinces of Zabul and Uruzgan in support of partners.

Once area of SQUEAC identified in the provinces of Zabul and Uruzgan, MoU signed and partner staff and data enumerators are trained, they will formally start with support of partner organizations and locally hired data enumerators. ACF technical staff will be present in province to train the partner organization's staff and data enumerators and technically support data collection for quality data, monitor the data collection and feeding process as well as work with partner organization to clean and analyze data for first draft report of the each of 2 SQUEACs. Partners will provide logistic support and ACF technical team will be there for technical support of the process as well as building capacities of partner organization to conduct SQUEAC in their respective provinces to monitor barriers and boosters of IMAM program being implemented there.

Activity 1.2.4 : Production and dissemination of reports through National and Sub-national Clusters

ACF will be responsible in guiding the trained partner staff in producing the SQUEAC report, with active involvement of the partner for review/validation prior external dissemination. For SQUEAC evaluations, draft report will be released with a month after the completion of the survey, while the full report should be completed within the following month. In an attempt to capacitate partner staff on SQUEAC, and encourage ownership of the findings, results will be presented jointly by ACF and the partner to the AIM-WG, and to the Cluster. As co-chair of the AIM-WG, ACF has supported the establishment of quality assurance mechanisms

							for SQUEAC; the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of SQUEAC evaluation - by a restricted pool of experts. In line with this approach, and following the current process of validation results of the SQUEAC will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Cluster. Acknowledging the need to channel down the results to provincial level, ACF will encourage partners to disseminate the report at sub-national level, through the Provincial Clusters and relevant health and nutrition authorities.
Paktika	2	19	6			25	Activity 1.1.1 : Identification of 8 provinces for 8 integrated multi-sectoral assessments (SMART) and 2 rapid SMART surveys. In 8 provinces, Nutrition Cluster partners and selected staff of government authorities, BPHS IPs and NGOs will benefit from capacity building and on-the-job support on integrated and rapid SMART surveys. Integrated SMART surveys include the following components: Anthropocentric data, Emergency Mortality, Morbidity, basic Health indicators, key WASH and FSL indicators. Under the supervisions of Assessment and Information Management Working Group of Nutrition Cluster, these SMART assessments will be conducted in provinces with hard to access districts and areas in close partnerships of BPHS implementing partners that implementing nutrition programs in their respective districts. A partnership MoU will be developed with each provincial level partner, BPHS implementing agencies with specific roles and responsibilities to conduct these assessments in the provinces. A part of the budget will be transferred to these partners to hire data enumerators and facilitate conducting the assessment like training of data enumerators, providing logistic support, and jointing monitoring the data collection process in field with ACF technical team. They will also help in data feeding and then ACF technical team will develop and share reports to AIM-WG and nutrition cluster for partners to use the data in future planning. Activity 1.1.2 : Identification and capacity building of BPHS partners on SMART assessments. These assessments in close coordination with BPHS IPs will help building their capacity to conduct SMART assessment for their respective provinces in future. On-the-job trainings for BPHS staff, NGOs and local Government will develop a pool of experts in these hard to access areas in country to conduct assessments for their respective program when required after this project. ACF targets 200 people, of which 48 women and 152 men, which includes survey supervisors, team leaders and data enumerators. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SMART Surveys. Activity 1.1.3 : Conduct 8 multi-sectoral assessments (SMART) and 2 Rapid SMART assessments in 8 targeted provinces of Afghanistan. Implementation of 8 multi-sectoral assessments (Nutrition, WASH, Health and FSL) and 2 Rapid SMART by partner with technical support from ACF as part of its new capacity building strategy, ACF will seek to empower and support partners to take the lead on the process of SMART implementation, from the methodology,

questionnaire, sampling to data collection, entry, analysis and preliminary report writing. The 8 multi-sectoral assessments will be implemented in hard to reach provinces and as per the Public Nutrition Department request, they will cover the entire provinces of Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul. As for the Rapid SMART, they will be implemented in hard to reach provinces according to needs identified.

During the previous project, ACF staff was acting as SMART Manager, directly providing training to supervisors and enumerators in the field, although with compulsory participation of senior level partners, field staff in a bid to enhance their capacity. Under the proposed project, ACF will engage the SMART Managers and members of the AIM-WG trained during the previous project to strongly participate to and implement the surveys, with ACF acting as technical backstop. Following the formal training provided to partner's nutrition field staff at central level, ACF will provide field-level practical training to Survey Managers for the implementation of one SMART survey in their province. Capacitated during the formal training, Survey Managers will be supported to take the lead and conduct the 7 days theoretical training for enumerators and supervisors led by the partner Survey Manager, with job shadowing by ACF SMART experts. Partner Survey Manager will also be responsible for planning field work and supervising data collection, including quality checks, and data entry on ENA software. ACF considered that a SMART survey requires the mobilization of 6 supervisors, 6 team leaders, and 12 enumerators (2 enumerators per team, 1 male and 1 female when possible) plus one Public Nutrition Officer/MoPH from each province. The number of staff actually targeted will be verified against attendance lists to the SMART training, and daily worker payment sheets that the partner will provide to ACF at the end of the survey to justify expenses.

Activity 1.1.4 : Production and dissemination of 8 integrated and 2 rapid SMART Survey reports

Production and dissemination of reports through National and Sub-national Clusters. Processing of shadowing partner's Survey Manager will extend to preliminary report writing for ACF SMART experts will provide continuous hands-on support. Considering the advanced technical knowledge required for writing the full report. ACF will keep the lead on writing the full report, while working in close collaboration and inputs/review/validation with partners. This will ensure timely production and dissemination of the report to the Nutrition Cluster.
As co-chair of the AIM-WG, ACF has worked in 2014-17 on establishing quality assurance mechanisms for SMART and Rapid SMART data, the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of nutrition data produced under SMART and Rapid SMARTs by a restricted pool of experts. In line with this approach, and following the current process of validation, results of the SMART and Rapid SMARTs, after validation by ACF and partners, will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Clusters. For integrated SMART surveys, a preliminary report will be released one week after the completion of the data collection, while the final report will be shared within one month through the AIM-WG. For Rapid SMARTs, the report will be produced and shared within a week. As partners will be more involved than before in report writing (until the preliminary

							report stage), and will have more ownership of the overall survey, results will be jointly presented to the AIMWG, and to the Cluster by ACF and the partner. Acknowledging the need to channel the results down to the provincial level, ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.
Faryab	2	19	6			25	Activity 1.1.1 : Identification of 8 provinces for 8 integrated multi-sectoral assessments (SMART) and 2 rapid SMART surveys. In 8 provinces, Nutrition Cluster partners and selected staff of government authorities, BPHS IPs and NGOs will benefit from capacity building and on-the-job support on integrated and rapid SMART surveys. Integrated SMART surveys include the following components: Anthropocentric data, Emergency Mortality, Morbidity, basic Health indicators, key WASH and FSL indicators. Under the supervisions of Assessment and Information Management Working Group of Nutrition Cluster, these SMART assessments will be conducted in provinces with hard to access districts and areas in close partnerships of BPHS implementing partners that implementing nutrition programs in their respective districts. A partnership MoU will be developed with each provincial level partner, BPHS implementing agencies with specific roles and responsibilities to conduct these assessments in the provinces. A part of the budget will be transferred to these partners to hire data enumerators and facilitate conducting the assessment like training of data enumerators, providing logistic support, and jointing monitoring the data collection process in field with ACF technical team. They will also help in data feeding and then ACF technical team will develop and share reports to AIM-WG and nutrition cluster for partners to use the data in future planning. Activity 1.1.2 : Identification and capacity building of BPHS partners on SMART assessments. These assessments in close coordination with BPHS IPs will help building their capacity to conduct SMART assessment for their respective provinces in future. On-the-job trainings for BPHS staff, NGOs and local Government will develop a pool of experts in these hard to access areas in country to conduct assessments for their respective program when required after this project. ACF targets 200 people, of which 48 women and 152 men, which includes survey supervisors, team leaders and data enumerators. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SMART Surveys. Activity 1.1.3 : Conduct 8 multi-sectoral assessments (SMART) and 2 Rapid SMART assessments in 8 targeted provinces of Afghanistan. Implementation of 8 multi-sectoral assessments (Nutrition, WASH, Health and FSL) and 2 Rapid SMART by partner with technical support from ACF as part of its new capacity building strategy, ACF will seek to empower and support partners to take the lead on the process of SMART implementation, from the methodology, questionnaire, sampling to data collection, entry, analysis and preliminary report writing. The 8 multi-sectoral assessments will be implemented in hard to reach provinces and as per the Public Nutrition Department request, they will cover the

entire provinces of Faryab, Ghazni, Kunar, Kunduz, Nangarhar, Paktika, Uruzgan and Zabul. As for the Rapid SMART, they will be implemented in hard to reach provinces according to needs identified.

During the previous project, ACF staff was acting as SMART Manager, directly providing training to supervisors and enumerators in the field, although with compulsory participation of senior level partners, field staff in a bid to enhance their capacity. Under the proposed project, ACF will engage the SMART Managers and members of the AIM-WG trained during the previous project to strongly participate to and implement the surveys, with ACF acting as technical backstop. Following the formal training provided to partner's nutrition field staff at central level, ACF will provide field-level practical training to Survey Managers for the implementation of one SMART survey in their province. Capacitated during the formal training, Survey Managers will be supported to take the lead and conduct the 7 days theoretical training for enumerators and supervisors led by the partner Survey Manager, with job shadowing by ACF SMART experts. Partner Survey Manager will also be responsible for planning field work and supervising data collection, including quality checks, and data entry on ENA software. ACF considered that a SMART survey requires the mobilization of 6 supervisors, 6 team leaders, and 12 enumerators (2 enumerators per team, 1 male and 1 female when possible) plus one Public Nutrition Officer/MoPH from each province. The number of staff actually targeted will be verified against attendance lists to the SMART training, and daily worker payment sheets that the partner will provide to ACF at the end of the survey to justify expenses.

Activity 1.1.4 : Production and dissemination of 8 integrated and 2 rapid SMART Survey reports

Production and dissemination of reports through National and Sub-national Clusters. Processing of shadowing partner's Survey Manager will extend to preliminary report writing for ACF SMART experts will provide continuous hands-on support. Considering the advanced technical knowledge required for writing the full report. ACF will keep the lead on writing the full report, while working in close collaboration and inputs/review/validation with partners. This will ensure timely production and dissemination of the report to the Nutrition Cluster.
As co-chair of the AIM-WG, ACF has worked in 2014-17 on establishing quality assurance mechanisms for SMART and Rapid SMART data, the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of nutrition data produced under SMART and Rapid SMARTs by a restricted pool of experts. In line with this approach, and following the current process of validation, results of the SMART and Rapid SMARTs, after validation by ACF and partners, will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Clusters. For integrated SMART surveys, a preliminary report will be released one week after the completion of the data collection, while the final report will be shared within one month through the AIM-WG. For Rapid SMARTs, the report will be produced and shared within a week. As partners will be more involved than before in report writing (until the preliminary report stage), and will have more ownership of the overall survey, results will be jointly presented to the AIMWG, and to the Cluster by ACF and the partner. Acknowledging the need to channel the results down to the provincial level,

							ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.
Hilmand	2	36	12			48	Activity 1.1.1 : Identification of 8 provinces for 8 integrated multi-sectoral assessments (SMART) and 2 rapid SMART surveys. In 8 provinces, Nutrition Cluster partners and selected staff of government authorities, BPHS IPs and NGOs will benefit from capacity building and on-the-job support on integrated and rapid SMART surveys. Integrated SMART surveys include the following components: Anthropocentric data, Emergency Mortality, Morbidity, basic Health indicators, key WASH and FSL indicators. Under the supervisions of Assessment and Information Management Working Group of Nutrition Cluster, these SMART assessments will be conducted in provinces with hard to access districts and areas in close partnerships of BPHS implementing partners that implementing nutrition programs in their respective districts. A partnership MoU will be developed with each provincial level partner, BPHS implementing agencies with specific roles and responsibilities to conduct these assessments in the provinces. A part of the budget will be transferred to these partners to hire data enumerators and facilitate conducting the assessment like training of data enumerators, providing logistic support, and jointing monitoring the data collection process in field with ACF technical team. They will also help in data feeding and then ACF technical team will develop and share reports to AIM-WG and nutrition cluster for partners to use the data in future planning. Activity 1.1.2 : Identification and capacity building of BPHS partners on SMART assessments. These assessments in close coordination with BPHS IPs will help building their capacity to conduct SMART assessment for their respective provinces in future. On-the-job trainings for BPHS staff, NGOs and local Government will develop a pool of experts in these hard to access areas in country to conduct assessments for their respective program when required after this project. ACF targets 200 people, of which 48 women and 152 men, which includes survey supervisors, team leaders and data enumerators. Pre and post tests will be conducted to assess the effectiveness of the training in enhancing technical knowledge of enhancing technical knowledge of trainees authorities on SMART Surveys. Activity 1.1.4 : Production and dissemination of 8 integrated and 2 rapid SMART Survey reports Production and dissemination of reports through National and Sub-national Clusters. Processing of shadowing partner's Survey Manager will extend to preliminary report writing for ACF SMART experts will provide continuous hands-on support. Considering the advanced technical knowledge required for writing the full report. ACF will keep the lead on writing the full report, while working in close collaboration and inputs/review/validation with partners. This will ensure timely production and dissemination of the report to the Nutrition Cluster. As co-chair of the AIM-WG, ACF has worked in 2014-17 on establishing quality assurance mechanisms for SMART and Rapid SMART data, the aim is to ensure the existence of a formalized and cluster-approved feedback system and process of validation of nutrition data produced under SMART and Rapid SMARTs by

							a restricted pool of experts. In line with this approach, and following the current process of validation, results of the SMART and Rapid SMARTs, after validation by ACF and partners, will be presented to the AIM-WG, for review and endorsement. Upon validation by the AIM-WG, reports will be disseminated through the Clusters. For integrated SMART surveys, a preliminary report will be released one week after the completion of the data collection, while the final report will be shared within one month through the AIM-WG. For Rapid SMARTs, the report will be produced and shared within a week. As partners will be more involved than before in report writing (until the preliminary report stage), and will have more ownership of the overall survey, results will be jointly presented to the AIMWG, and to the Cluster by ACF and the partner. Acknowledging the need to channel the results down to the provincial level, ACF will encourage partners to disseminate the report at sub- national level, through the Provincial Clusters and relevant health and nutrition authorities.
Hilmand -> Lashkargah	74	5,248	4,945	17,030	20,360	47,583	Activity 1.1.1 : Mobilization of the communities, selection of sites in schools and villages, and signing of MoU with the respective ministry and with each selected villages of Lashkargah district During project inception, a technical assessment of all existing water sources of the selected area will be carried out, in order to acquire deep knowledge about quantity and quality of water available to population, functionality and condition of water points (hand pump, apron, and surrounding area), habits of people with regards to fetching water, water chain and conservation (containers cleanness, transport, water use). In assessing these, due attention will be reflected on women and children's roles as primary collectors of water, the safety of water collection points including shade where there are queues. Facilitated by an integrated psychosocial officer in the WASH sector per base to reflect GBV action for WASH 2 - the informed mobilisation of communities and the selection of sites linked to women and girls protection and dignity, ACF will ensure equal participation from different gender groups in the location, design and maintenance of WASH facilities to ensure women are not overburdened with these roles in addition to the typical gender daily calendar, facilitate different gender groups to identify the full scope of risky hygiene practices and their subsequent community appropriate mitigation, and advocate to ensure a gender balance in committees – to be comprised of 50% women. Results of all committee findings, lessons learned from earlier water point constructions, and best practices will be member checked with Health Facility (HF) management staff, schools directors, and community members, and a final dissemination to all groups for last inputs before construction begins. In communities identified as water-stressed, site selection will be done jointly with CDC and PRRD to guarantee full involvement of communities and key focal community engaged authorities including the Department of Women's Affairs, which currently leads in different provinces on interventions for the reduction of GBV, as well as transparency and respect of local culture and norms. Upon selection of sites, a MoU will be signed with each community in order to clarify and acknowledge roles and responsibility of each party to the project with particular focus on clear definitions of integrated roles. Local authorities and technical bodies of Helmand Province (PRRD) will be invited during discussions with the communities regarding the MoU and the project action plan.

Activity 1.1.1 : Screening, referral and treatment of SAM and MAM children and malnourished PLW through mobile clinics integrated with psychosocial support and care practices

ACF will directly implement mobile nutrition services in IDP Mukhtar settlement and in other villages outside the camp, composed of one supervisor (medical doctor), two certified Nurses/midwifes, 2 measurers/screeners, 1 for health education and 1 psychosocial officer with the aim of (i) conducting passive case finding of SAM-MAM children (in support to CHWs that ACF will train and supervise), and (ii) delivering SAM, MAM and acute malnutrition PLW treatment at community level integrating psychosocial support and care practices to account for the many barriers including potential social norms acting as barriers (e.g. Mother's in law not supporting exclusive breastfeeding sessions) to accessing such services identified in Helmand.
Mother's in law have been consistently identified during Helmand based GBV workshop and Ghor based Gender Analysis lead by ACF Gender/GBV expert to be consistent triggers in GBV at home level.
Acute malnourished children with medical complications and/or poor appetite who require intensive care it will be referred to an inpatient facility and receive follow up treatment at mobile clinics.

During the consultation child measurement, appetite test, medical consultation, postnatal depression assessment (where needed), assessment of understanding of care practices (where needed), observation of mother-child relationship, distribution of medical and nutritional treatment in line with the national guideline, and referred to any psychoeducation or counselling groups where needed. ACF will be entirely accountable for the performance of this team, and report on the number of children screened, admitted, and OTP and basic general and psychosocial health performance indicators (i.e. number of medical consultations, psychosocial assessments, GBV referrals, cured rate, defaulter rate, progression in care practices, and death rate).
Activity 1.1.1 : MoUs with local authorities (DoRR) on project

ACF will develop and sign a mutual MoU with assigned rules and responsibilities of DoRR and ACF for the selection of beneficiaries and cash distribution.

Activity 1.1.1 : Provision of mainstreamed mobile outreach protection services

There is a notable lack of research on the links between WASH and GBV, therefore, an ACF WASH KAP will also explore lack of access to WASH and increased vulnerability to physical violence, early marriages, access to education. The surveyors will mostly be women, facilitating women and children's participation will promote claimed rights on WASH access and mitigated GBV. Women's involvement and children's involvement in data provision and subsequent decision making based on this data is critical to their empowerment. Informed mobilisation of communities and the selection of sites linked to women and girls protection and dignity, ACF will ensure equal participation from different gender groups in the location, design and maintenance of WASH facilities to ensure women are not overburdened with these roles, facilitate different gender groups to identify the full scope of risky hygiene practices and their subsequent community appropriate mitigation, and advocate to ensure a gender balance in committees.

Results of all committee findings including lessons learned and best practices will be member checked with Health Facility management staff, Schools directors, and community members. Water stressed site selections will be coordinated with Department of Women's Affairs which currently leads in different provinces on interventions for the reduction of GBV, we well as transparency and respect of local culture and norms. Training for schoolteachers, community leaders, Community Development Councils and health Workers will lead to increased outreach of health and hygiene promotion, as ACF will work with authorities to supervise, monitor and support aforementioned actors for sensitizing pupils/students and the community members on personal and environmental hygiene in both communities and schools. Supported by active supervision, provision of IEC material, and refresher/on-the-job training. Increasing the frequency of outreach of hygiene promotion sessions in schools and at community levels.
Activity 1.1.2 : Provision of mainstreamed static protection services

During Construction/Rehabilitation of water sources in schools, health facilities and communities, reflecting GBV action for WASH 3, the location of the water points will be in areas that are accessible and safe for all, to that end the decision regarding the location of the new water points will actively involve discussion with all members of the community, and in general no more than 500 meters from households. Due consideration to safety and protection of users (e.g. ideally located in close to mosques or in the centre of villages to ensure safety of those responsible for water collection – essentially women and children). Before rehabilitation or construction of the water points, ACF will facilitate a community with members to have their inputs in the issues concerning the rehabilitation or construction of the water point. ACF will use its WASH team of female staff to go to selected households to collect view of women, who are restricted from attending community meetings. Hiring local people as daily workers will also contribute to supporting community members' income and purchasing power. All the construction/rehabilitation of water points will be monitored by ACF, Shuras and CDCs; as well as provincial technical bodies PRRD (Provincial Rural Rehabilitation and Development) in addition to the Head of the Department of Woman's affairs in order to ensure the quality of the works and respect of MRRD standards and maintained equity of access for women and girls. At the end of the project, all the structures will be formally handed over to the communities, in the presence of relevant local authorities, again supported by the Department of Woman's Affairs. With this support, mainstreamed violence prevention messages on water sources in schools, health facilities and communities, will develop dignity and safety standards specific to each space e.g. different standards for young girls in schools compared to PLWs in health facilities. Conducting Hygiene promotion sessions (for boys and girls) in Schools, ACF reorganizes that to ensure sustainability of the WASH programs in schools, the involvement of national authorities, community leaders, communities and parents is crucial. ACF will not only construct/rehabilitate WASH facilities in the most vulnerable schools but will also work the provincial department of education to ensure impactful hygiene promotion sessions in the schools. ACF will conduct special sessions and with different styles for each the different age groups. The mainstreamed topics during the various sessions for students will include care practices on safe handling of drinking water, safe

							disposal of wastewater, safe disposal of human excreta, disposal of solid waste, household sanitation and food hygiene and personal hygiene. These topics will be taught using participatory methods where students actively identify the reasons for these care practices and what supports they need at home and community level to have sustainable practice. Integrated WASH and psychosocial programming will also facilitate children's involvement in youth hygiene clubs within and outside the school; in turn supported by community leaders and committees. To support hygiene promotion in the schools, IEC (materials posters and leaflets) will be distributed and followed up, in order to see how they implement hygiene sessions and provide advise where needed. Linking with above activities, special sessions will also be delivered to teachers to deliver Menstrual Hygiene management clues and advises in a sensitive and objective manner as per context of the project area, with follow up OTJ and supervision – addressing the international MHGap on limited follow up to sensitive topics of training leading to limited impact. Activity 1.1.2 : Selection and registration of food insecure beneficiaries based on assigned criteria Having identified the need for cash assistance, in response ACF will start the process of screening the prolonged IDPs households and selecting the most vulnerable and eligible prolonged IDPs households for this assistance. The process will be started with screening internal lists (as part of the ERM project). ACF team will do cross check individually, through household visit and administration of HEAT questionnaire based on which ACF will extract the final list of beneficiary households. The cash assistance will be delivered for food insecure prolonged IDPs households' targeted based on vulnerability criteria. To target the prolonged food insecure conflict induced IDPs households who have been staying in Helmand, ACF will apply vulnerably scoring technical using weigh for each vulnerability criteria identified. Then the data collection will be carried out on paper and enter into excel data base, analysis and scoring will be conducted to identify the eligible beneficiaries. The pre identified criteria for selecting prolonged vulnerable households is as followings: 1. Status (displaced for more than 6 months up to 2 years), 2. Size and composition of the family (large households with more than 8 members) 3. Female/disabled/headed households 4. Households with no working age adults 5. Sources of income (no income or earning main income from either borrowing, casual unskilled non-construction labor, begging, casual construction labor, small business, or others non-specified jobs used as proxy indicator for poverty) 6. Households with more than 2 children under 5 years old 7. Household with more than 1 pregnant woman 8. High rCSI of 18 or above scores/ or using more than one food base coping strategy 9. Household with poor food consumption score 10. Households living in shelter with mud walls and tarpaulin roof, or households living in tents 11. Household with less than 3 weeks food stock 12. Households with more than 1 elderly person 13. Households with more than 1 disabled person 14. Households with more than 1 chronically ill person Activity 1.1.2 : Integrated IMNCI services for children through mobile clinics The mobile teams will also provide medical treatment for children affected by common and basic illnesses who do not need to be referred to an inpatient facility, and engage the local partner in order to facilitate the referral of children

needing admission in therapeutic feeding units or pediatric wards. From the actual project in Helmand, an average of 2 consultations per child per year will be done.

Activity 1.1.2 : Construction/Rehabilitation of water sources in schools, health facilities and communities

The construction/rehabilitation of 21 water sources will take in consideration the characteristics of underground water, and will cover schools, HF and most vulnerable IDPs and host communities with lack or poor access to safe and clean water. The intervention will focus on the rehabilitation of existing water points, according to needs (e.g. physical condition of the water point), suitability of access for different gender groups, and priority ranking of the institutions depending on the number of students. Where no water point exists in the school compound, a new bore well will be constructed. In HF, ACF will rehabilitate the existing water sources, install a solar powered submersible pump for water pumping and ensure that water is available in the key areas including the delivery rooms, toilets, hand washing stations and the clinical laboratory. The design and construction of the water points will be done in consultation with the intended users. The criteria for selecting communities for water point construction will be safe water coverage, considering availability of functional protected water points, as well as the distance to the water point. In addition, reflecting GBV action for WASH 3, the location of the water points will be in areas that are accessible and safe for all, to that end the decision regarding the location of the new water point will actively involve discussion with all members of the community, and in general no more than 500m from HH. ACF will consider the safety and protection of users (e.g. ideally located near mosques or in the centre of villages to ensure safety of those responsible for water collection – essentially women and children). Rehabilitation activities will entail improving the water points to reduce the possibility/risk of contamination (reinforcement and plastering of well, construction of apron, drainage channel and soak pits, disinfection of the well and installation of hand pump). A water quality analysis before and after rehabilitation of water points will be conducted for all them before handover. ACF will construct/rehabilitate water points with the involvement of the communities, as opposed to sub-contracting the work to private contractors. During implementation, all the unskilled workers will be recruited from the community and for the skilled workers, priority will be given to those based in the communities where the water points are to be rehabilitated/constructed. ACF acknowledges that relying on community mobilization offers multiple advantages: full control on the supply chain and close monitoring of equipment/material use, increased sense of ownership by beneficiaries, acquisition of knowledge by community members on water point infrastructures and subsequent improvement in maintenance. ACF will facilitate community members to have their inputs in the issues concerning the works on the water points. ACF will use its female staff to go to selected HH to collect view of women, who are restricted from attending community meetings. Hiring local people as daily workers will also contribute to supporting community members' income and purchasing power. All the construction/rehabilitation of water points will be monitored by ACF, Shuras and CDCs; as well as provincial technical bodies in addition to the Head of the Department of Women's Affairs (DOWA) in order to ensure the quality of the works and respect of MRRD standards and

maintained equity of access for women and girls. At the end of the project, all the structures will be formally handed over to the communities, in the presence of relevant local authorities, again supported by the DOWA to mainstream violence prevention messages on water sources in schools, health facilities and communities, and develop dignity and safety standards specific to each space e.g. different standards for young girls in schools compared to PLWs in HF.
Activity 1.1.3 : Distribution of 570 Bio Sand Filters (BSF) to selected households and training on operation and maintenance, with a particular focus on female-headed households.

According to ACF experience, the Bio Sand Filter is the most suitable Household Water treatment (HWT) in this context. Since 2015, ACF has distributed 3,710 BSFs in Helmand. The Bio-Sand-Filters will be locally produced, and assembled by ACF technical team following established technical design standards. After having thoroughly checked their quality the BSFs, ACF technical team will then install the BSFs in targeted families' houses, and train recipients on how to operate and maintain them. Experience gained by ACF in promoting this technique in Afghanistan shows BSFs are one of the most cost-efficient options to improve access to safe water, with the following advantages: (i) easy operation and maintenance not associated with any cost, (ii) long life-span (ACF distributes metallic galvanized BSFs) and capacity to provide clean water for many years (40-80 liters daily and 10 years life expectancy).The provision of BSF will guarantee a better quality of the water especially for women as they use also for personal hygiene, decreasing their exposure to water related diseases. This approach is a further dimension of WASH and psychosocial integration, and will proactively respond to the physical risks and threats accessing water and other sanitation facilities can present for women (ACF Gender Analysis 2017). Households will be prioritized according to their vulnerabilities, with a specific focus on cumulative and compound vulnerabilities such as female-headed households with limited or no income. The rationale for distributing BSF is as follow: (i) poor quality of the water collected from the wells (very often salty or contaminated by E.Coli), forcing individuals to fetch water from unsafe sources (river, channel ,unprotected kanda/karez ,water pond, etc.), (ii) difficulty of providing safe and clean water from boreholes and hand dug wells in areas where water is scarce and digging/drilling is associated with high costs (need to go very deep), and (iii) population pressure on water sources linked to population migration and displacement, where numbers of users and frequency of use exceeds the operational capacity of the water point (like in Lashkargah), creating queues and breakdowns of the pump, forcing again families to fetch from unprotected sources of water. Considering (i) the high density of population in Helmand linked to economic migration and conflict induced displacement, (ii) the high rate of non-functional water points, reflecting poor capacity for maintenance, and (iii) the local geology (few springs and deep water table), Therefore, in a bid to durably improve access to safe water and reduce incidence of water borne diseases, ACF will continue the distribution of BSFs to households.
Activity 1.1.3 : IYCF message given through mobile clinics

The current majority of admissions into nutrition programs are children aged 2 years or less. There is a gap on the successful dissemination of key messages on the 1,000 days (7 ENA, including IYCF). ACF integrated programming

							will strengthen the methodology for dissemination through more participatory and psychosocial methods and the purposive targeting of key groups including husbands, fathers and mothers-in-law as a mitigation strategy against GBV at household level where otherwise the mother trained would be entirely responsible for transferring knowledge to the household and sustaining IYCF related household behavior change. These messages will be delivered during specialized psychoeducation sessions on care practices during mobile clinic activity. The messages will include topics on maternal and personal health care, infant and young child feeding including exclusive breastfeeding, and health care complemented with corresponding topics on mother self-care (using this specific module as a means of distribution on GBV awareness), mother-child attachment, balance food preparation and person and home hygiene. A system of messages, building on previous sessions, will be organized every week targeting all caretakers accessible including those with the child independent form IMCI consultation or nutrition program. Addressing the Mental Health Gap in education and training from a global mental health and psychosocial services (MHPSS) perspective, during follow up, if the mother requests or indicates further supports/training is needed. Or if integrated Health, Nutrition and Psychosocial team identify additional or ongoing need, further appropriate support by specialized education will be provided. Where the ongoing need or additional need is rapidly contributing to infant's reduced or stagnant weight, the infant will be referred to the therapeutic feeding unit at the hospital immediately, while the mother is supported. Activity 1.1.3 : Cash assistance to food insecure prolonged IDP HH in Lashkargah district, Helmand province Once the eligible beneficiaries based on vulnerability scoring techniques are identified for this intervention, ACF will disburse the cash in two months. The market systems continue to function in targeted area of Helmand. Cash has been proven an effective tool to deliver aid in a way that empowers vulnerable people to meet their needs with mainstreamed protection supported by an integrated psychosocial officer to ensure more flexibility, dignity and choice. In addition, cash transfer programming supports local markets and stimulate trade. ACF has advocated for the use of cash transfers as an emergency response and have been appropriate and successful due to its suitability in terms of community acceptance, market access and capacities, and availability of various transfer mechanisms. However, ACF is aware and commits to mitigate risks women and girls where cash is distributed. ACF has a long experience and experienced staff in CBI sector. Moreover, ACF implemented numerous projects in different provinces of Afghanistan. In order to avoid duplication, ACF will consult and coordinate with DoRR and active NGOs in Helmand. Furthermore, ACF has maintained and strengthened regular coordination and communication with OCHA regional offices, regional/national clusters and other partners working in Helmand. The new field staff to be recruited will undergo series of training and orientations on the project objectives and technical inputs, including protection in emergency and mainstreamed protection in FSL. ACF will hire female staff to be engaged in the fieldwork and conduct the beneficiary verification and post distribution

monitoring surveys (PDM will be led by an independent MEAL unit, with the assistance of female project staff) to mitigate exposure to risks for women and girls during data collection thus ensuring the female voice is represented and integrated to program activities. Traditional beliefs are very strong in the rural population in Helmand, male staff cannot survey and contact female member of households. ACF has been conducting market surveillance under ERM and CHF project in Helmand province concerning supply and price conditions that has confirmed the availability of food and NFIs. As items were found to be available in sufficient quantity and at affordable prices. Lashkargah, being the province capitals, host a major market that continues to function even during massive conflict around Lashkargah city. This led to the adoption of a CBI approach for the IDPs against in-kind assistance. The CBI modality chosen for this intervention is DIRECT CASH to be provided to the beneficiaries using the existing Hawala system. There will be two tranches for cash distribution for each beneficiary household selected: The cash distribution will take place after beneficiaries are identified based on assigned vulnerability criteria and vulnerability scoring techniques. ACF has aligned the amount to the FSAC standard package of 2,100 Kcal/person/day (i.e.180 USD per HH for a total of 2 months covered). The cash will be distributed in two installments covering their 2 months food needs. 1,000 food insecure prolonged conflict IDPs households of Helmand will benefit from this UCT activity. Delivery of cash to the beneficiaries will be through the existing Hawala system (with presence of ACF staffs), an informal remittance system, prevalent and effective in the country and in Helmand province. ACF has been using the Hawala system since 2008. A distribution plan will be developed to include the scheduling, cash distribution points taking careful consideration on security, mitigate risks, and not to disrupt market prices. ACF will be conducting monthly price monitoring on the markets to monitor the impact of the intervention and potential inflation of prices.
Activity 1.1.4 : Post cash distribution monitoring survey

One month after the distribution of cash, ACF MEAL team will carry a Post Cash Distribution Monitoring on a representative, randomly selected sample of beneficiaries in the area of the project. An independent MEAL unit will lead post-distribution monitoring, with the assistance of female project staff. The PDM will assess beneficiary satisfaction towards (i) the quantity of cash received, (ii) the timeliness of the distribution, (iii) the organization of the distribution, (iii) the cash usage, (iv) complaints and concern of beneficiaries. Results will be used to evaluate the quality of targeting (the level of use of the cash can be used as proxy indicator to understand whether the project effectively targeted the most vulnerable prolonged IDPs households), effectiveness of the intervention in responding to priority needs of targeted families (same comment), and support a short lesson learnt document to serve for future implementation of similar project.
For PDM, 106 beneficiaries, representing 10% of the targeted beneficiaries as representative sample, will be selected for the interview. The sample size was drawn using a confidence level of 95% and a confidence interval of 9. This is the minimum percentage that ACF will include in the sampling for the PDMs to be conducted.
A baseline survey will be conducted during the beneficiary selection in order to determine the current food security situation and conditions of the population. A Final survey together with PDM

will be undertaken to compare with the baseline data, and to measure the impact of the project on beneficiaries. The baseline and final survey will contains food security indicators (i.e. FCS, rCSI and food stock).

ACF has already started utilizing the PDM tool recently created by the Afghanistan Cash Voucher Working Group, endorsed by the ICC, and will submit a PDM report to the CHF and further sharing with the Afghanistan Cash Voucher Working Group and the Clusters.

Activity 1.1.4 : Implementation of integrated programming

Mental Health and Care Practices (MHCP) department will conduct coordinated implementation of integrated programming with psychosocial and care practices components and conduct trainings and program design support for any implementing actor on psychosocial counselling services including the support for integrated psychosocial officer in Water, Sanitation and Hygiene (WASH), Emergency, Monitoring, Evaluation, Accountability and Learning (MEAL) and Food Security and Livelihood (FSL) departments.

Activity 1.1.4 : Establishment/reinforcement of WSUCs, mechanics and caretakers

ACF will facilitate the establishment and/or support of water committees (one per targeted village or per school supported by the psychosocial officer to ensure different needs are properly voiced with sensitized monitoring and capacity building), who will be responsible for the overall organization, planning, and supervision of the operation and maintenance of the public water points, to promote the sustainability of the intervention. Low maintenance was identified during several ACF WASH surveys as one of the main barriers to accessing safe water for targeted communities. To strengthen the capacity of communities on operation and maintenance of water point, ACF will establish/reinforce the Water and Sanitation Users Committees (WSUCs), ensuring the presence of female members as foreseen by MRRD policies. ACF will coordinate with PRRD and CDC members to ensure that WSUC members are selected from the respective villages the water points are situated. The water committees will be trained on water point management and involved during activities implementation in order to ensure sustainability. The WSUCs will also be supplied with spare parts and tools to guarantee the repair of the hand-pumps. The training will include operation and maintenance of the hand pump, environmental hygiene of the water point, coordination with community members to contribute to the maintenance of the community water point. In schools, guards, cleaners, selected members from the community, the responsible teachers or health facility staff will be trained on the operation and maintenance of the pump. Mechanic and caretakers will be trained according to their competences and technical skills, and equipped with tools for maintenance (broom, bucket, shovel, and trowel - for caretakers) and repair (spanners, hacksaw, glue, sand paper, finishing tools, etc. - for mechanics). Responsible for planning and overseeing maintenance and repair operations, the WSUC will also be equipped with spare parts (PVC pipes and sockets, rods, centralizers, valves and rubbers, etc.) - which donation will be formalized into a Memorandum of Understanding with the Community development Committee (CDC). Under protection, utilising CDC as a means of distribution on GBV with info sharing on available

resources within the local community related to GBV proactive (e.g. anti-violence messages available at water points) and reactive support (ACF psychosocial counselling service for GBV cases), sensitizations for disaggregated gender groups on GBV issues related to water access including general workshops on lack of safe WASH causes up to 50% of malnutrition creating burdens for families and communities and specialized sessions for key groups on lack of clean water for PLWs where there is no equal access or balanced distribution of water increases risk for hookworm infestation leading to reduced health and survival rates of both mother and child, and engaging communities on the topic under overall WASH work.
Activity 1.1.5 : Chlorination and water analysis of water points and Bio Sand Filters

The quality of water will be tested at each water point constructed or rehabilitated in the schools and communities, as per MRRD standards and protocols upon completion of the work and before installation of the hand pump. Analysis consists in pH, turbidity (NTU), electro-conductivity (µS) and bacteriological tests (E.Coli), sampling three times for each test. The water points will be chlorinated as required and tested one month after the intervention. At household level, ACF team will analyse the quality of water on a sample of BSFs beneficiaries (10%), one month after the installation, using three samples in the inlet (fetched water) and three after the treatment (drinking water), in order to verify the functionality of the BSF and its efficiency as household water treatment device. A total of 99 water samples will be analysed (57 for BSF and 42 samples for water points constructed or rehabilitated).

Activity 1.1.5 : Conducting psychosocial education and/or counselling sessions

Workshops employing adult education models will roll out staged modules on psychosocial and care practices, and protection to local partners and/or coordinated agencies operating in the area. To maximize learning and development for participants, numbers of participants per workshop will be capped at 20 participants per group, with a ratio of 2 trainers to 20 participants. To support the move of the theoretical training content to practical application at field level, ACF master trainers will also train all APA managers in a two-day orientation training on the core components partner, coordinated and ACF staff are inducted on. On-the-job mentoring and support for facilities and healthcare providers who have received training will then be implemented. Each facility where the partner is providing psychosocial counselling that has been trained will be visited at least twice for comprehensive post-training follow-up, mentoring and on-the-job training during the project. Following post training visits and midline project evaluation (as part of a broader monitoring, evaluation, learning and accountability plan), ACF master trainers will also organize refresher trainings for a percentage of trained staff targeting those who receive the lowest marks during post-training visits across the two provinces.

In addition, where cases of GBV are identified, a response team integrated within the Health team made up of psychosocial counselling staff managed by the psychosocial coordinating officer will provide group and individual counselling at field level securely with best practice responses including 1) warmth and acceptance, 2) emotional and practical support within a safe environment, 3) technical understanding of psychological impact of GBV, 4)

validation on all reactions – no reaction is wrong or maladaptive, 5) believing the story, 6) confidentiality, 7) technical support on medical and legal supports, and 5) control over their process and choice. This team will also link with advocacy and accompaniment to clinics, police, court, referral to other agencies and finally coordination with those agencies and partners completing workshops with ACF (this coordination list is not limited to these actors and may include any actors under the World Health Organization/ Ministry of Public Health (WHO/MoPH) upcoming capacity building of Health Facility staff on GBV).

GBV is defined here as violence that involves men, women, boys and girls where the violence is perpetrated because the target belongs to the gender group e.g. she is beaten because she is a woman, or the violence affects a particular gender groups disproportionately e.g. during a conflict, victim ratio is 20:80 men to women. WHO Classifications of GBV include Rape, Sexual assault, Physical assault, Forced marriage, Denial of resources, and/or Psychological/emotional abuse.

Activity 1.1.5 : Monthly market monitoring survey

ACF will be conducting monthly price monitoring on the markets to monitor the impact of the intervention and potential inflation of prices.

ACF has been conducting market surveillance under ERM and CHF project in Helmand province with regards to supply and price conditions which has confirmed the availability of food and NFIs. As items were found to be available in sufficient quantity and at affordable prices. Lashkargah, being the province capitals, host a major market that continues to function even during massive conflict around Lashkargah city. This led to the adoption of a Cash Based Intervention approach for the IDPs against in-kind assistance.

Activity 1.1.6 : Establish beneficiary and stakeholder feedback and complaint mechanism

As a part of its general policy, ACF will establish a feedback mechanism to enable beneficiaries to make a suggestion or make complaints. ACF will introduce a range of ways that is contextually feasible including introduction of a telephone complaint line, feedback e-mail address for stakeholder and beneficiaries, and interviews with beneficiaries. MEAL Department will oversee and the establishment and/or management of the feedback mechanism to ensure that a more formalized system of asking, receiving, processing and responding to the feedback and complaints is, independently, in place.
The feedback mechanism well be clearly communicated to staffs, communities and government institutions about why ACF has a feedback mechanism, what it is for and how it works. As such, information sharing about the feedback mechanism will be integrated into the community mobilization of the project. Similarly, MEAL Department will communicate with the target groups about their right to complain and raise their concern how we work. The department will also discuss what constitutes an ACF related and non-ACF related feedback/complaints and how ACF will deal with feedback and complaints.
In addition, ACF MEAL department will conduct regular individual face-to-face meeting during monitoring visits at community levels. This will allow beneficiaries with no access to phone or being illiterate to provide their feedback.
As with all feedback mechanisms established,

every effort will be made to prevent harm and unintended negative consequences on those making complaints, protect confidentiality and encourage reporting of complaints and concerns in a safe environment.

Activity 1.1.6 : 7 Essential Nutrition Actions (ENA) are given by promoters through the community HH by HH (house to house approach)

1000 days (including IYCF messages), Nutrition cluster and PND are working towards harmonization of approaches to IYCF promotion. While ENA is one of the recommended approaches, it would be worthwhile to highlight that ENA will be implemented in harmony with national IYCF strategy (work in progress) and counseling package and not in parallel.
ACF recognizes a cultural barrier significant in limiting humanitarian access to the majority of primary care givers; female members of the household whole household role includes the responsibility for children (ACF Gender Analysis 2017) who often cannot leave their homes without permission from the head of the family – husband, father/father in law or at times mother in law. The transmission of the 1000 days message and how it can contribute to reducing emergency needs by the use of door-to-door promoters. The promoters will be females to transmit messages to the females at household (HH) level, further sensitizing information transmission, and will be technically trained on sensitivity and whole household engagement where possible by the integrated psychosocial officer within ACF Nutrition team. Community Health Workers and Family Health Action Groups are at the forefront of the MoPH community outreach strategy, and have a key role to play in the expansion of coverage of nutrition services. Acknowledging this, ACF will seek to enhance their capacity to conduct screening and referral (for Community Health Workers), and promotion of Essential Nutrition Actions (for Family Health Action Groups), as well as ensure active supervision/monitoring - seen as instrumental to boost their motivation and performance. While supporting Community Health Supervisors (CHS) to monitor CHWs and FHAGs, ACF will also get directly involved into supervising them.

As part of its integrated approach, ACF will also be working with CHWs and FHAGs, HF staff and community leaders on GBV, core care practices, hygiene education and WASH-related topics. The aim is to foster broader understanding of targeted child illnesses, and the linkages between the two (i.e. the vicious diarrhea-malnutrition cycle) and between care practices that can either exacerbate or mitigate targeted child illnesses. Community base nutrition program (CBNP) recently reviewed by the PND will be used to train the CHW and FHAG. Working through these actors, as well as community leaders, possess the advantages of strengthening (i) recognition of community members who are perceived as legitimate sources of knowledge and skill in passing on such key nutrition messages, (ii) adaptability of the messages to local circumstances and norms; linked with other activities above, community actors are in best position to tailor the messages to their specific audience ensuring messages are processed, understood and applied correctly at a fundamental level, and (iii) outreach through these different actors to facilitate ACF's humanitarian access to reach a larger percentage of the community than direct ACF to Community sensitization allows.

Activity 1.1.7 : Screening through Mother led MUAC strategy

							Mothers with children under 5 years old will be trained on how to conduct the measurement of MUAC and edema as early detection signs of malnutrition. Training mothers on early warning signs of health issues has a strong evidence base, specifically for ACF and the successful sustainable treatment of malnutrition; the demand and coverage of the nutrition program increases. The rationale for ACF aiming to teach mothers how to perform MUAC is to achieve an early diagnosis of SAM, which if acted upon in a timely manner would decrease mortality and morbidity related to malnutrition, reduce program costs due to shorter treatment times, lower the proportion of children requiring expensive in-patient care for SAM with complications. The aim is to keep the structure at community level, going through CHW and FHAG. They will be trained on the mother strategy and it will be the first step. Instead of the CHW go house to house doing screening (which in reality is not done), the mother will come to see the CHW and FHAG to receive confirmation of the diagnostic and if it is not the case to receive a refreshment on the MUAC and edema technique. For the mothers, the training will focus on three key execution strategies (i) training of mothers through door to door visits by Family Hygiene Action Groups members and (ii) organized group training of mothers during mass community sensitization and demonstration exercises in the settlements for WASH and nutrition messages (e.g. cooking demonstrations) (iii) use of media to pass messages to maintain the regularity of the screening activities (radio spot messages and posters). In order to minimize false referrals by mothers ACF will establish a control mechanism where there will be a multi-step screening and identification of malnourished cases before admission to the nutrition program. The first step being the mother's screening of their own child, the second step if possible the mother will see the CHW or FHAG of the villages to confirm the detection and refer to the mobile clinic or HF and the third step is the verification of the child's MUAC and WHZ by a screener from the mobile team before admission to the program. The ability of mothers to assess the nutrition status of their children is also considered to have a positive deviance effect on the community's understanding and appreciation of the nutrition program. ACF expects that by mothers gaining knowledge on how to the nutrition status of their own children coupled with key sensitization on IYCF and proper hygiene they will understand better the importance of proper nutrition and diet as a measure of avoiding their children from being malnourished. This in effect will influence the mothers feeding practices and lead to adoption of better feeding practices and improved health seeing behavior. At the mobile clinics and at the community a regular evaluation on the quality of MUAC screening will be done. If the quality screening done by the mother is low, a refreshment training will be done.

Documents

Category Name	Document Description
Project Supporting Documents	ACF - FSL Endorsement letter_signed.pdf
Project Supporting Documents	ACF - FSL LFA_signed.pdf
Project Supporting Documents	ACF - Nutrition - Endorsement letter_signed.pdf
Project Supporting Documents	ACF - Nutrition LFA_signed.pdf
Project Supporting Documents	ACF - Protection LFA_Endorsement letter_signed.pdf

Project Supporting Documents	ACF - WASH LFA_Endorsement letter_signed.PDF
Project Supporting Documents	ACF - Field_security_assesment_checklist-guideline.pdf
Project Supporting Documents	Total number of beneficiaries - breakdown.xlsx
Project Supporting Documents	ACF Gender analysis_Ghor Province_2017.pdf
Project Supporting Documents	ACF - Helmand market monitoring report.pdf
Project Supporting Documents	Cluster Priority HTR Districts-Compiled-Updated - 12 Aug 17_Updated 16Aug17.xlsx
Project Supporting Documents	MoU SMART assessement - template.docx
Project Supporting Documents	ANNEX 2 - Partnership Financial Guidelines.doc
Project Supporting Documents	ANNEX 3 - Partnership Procurement Guidelines.doc
Project Supporting Documents	MoU CHF_ACF Payment Request_Template.docx
Project Supporting Documents	Helmand_Baseline KAP Survey report.pdf
Project Supporting Documents	ACF - Partner assessment_MMRCA.pdf
Project Supporting Documents	ACF - Assessments - Endorsement letter_signed.pdf
Project Supporting Documents	ACF - Assessments LFA_signed.pdf
Project Supporting Documents	ACF - List of acronyms.pdf
Project Supporting Documents	ACF - Partner Assessment - AADA.pdf
Project Supporting Documents	ACF_Helmand_HEAT assessment report.pdf
Project Supporting Documents	ACF WASH needs Assesment in Lashkar Gah June 2017.pdf
Project Supporting Documents	Helmand SQUEAC Final Report_March 2017.pdf
Project Supporting Documents	ipc_afghanistan_2016_final.pdf
Project Supporting Documents	sfsa_2016_final_report.pdf
Project Supporting Documents	Helmand Rapid SMART assessment Report Aug-2016.pdf
Budget Documents	BoQ Chapter 2 v2.xlsx
Budget Documents	BoQ chapter 6 V2.xlsx
Budget Documents	BoQ HR program national staff v2.xlsx
Budget Documents	BoQ HR support national staff v2.xlsx
Budget Documents	BoQ chapter 5.xlsx
Budget Documents	BoQ chapter 7 v2.xlsx
Budget Documents	BoQ Expat v4.xlsx
Grant Agreement	ACF - 6749 - GA - Signed by HC.pdf
Grant Agreement	ACF - 6749 - GA - Signed by HC & IP.pdf