Project Proposal

Organization	PU-AMI (PREMIERE-URGENCE-AIDE-MEDICALE-INTERNATIONALE)
Project Title	Provision of life-saving healthcare services in remote and insecure areas of Kunar province
Fund Code	AFG-15/O580/SA1/H/INGO/350

Cluster

Primary cluster	Sub cluster
HEALTH	None

Project Allocation	2015 1st CHF Standard Allocation / Call for Proposals		Allocation Category Type	
Project budget in US$	308,500.00		Planned project duration	12 months
Planned Start Date	01/06/2015		Planned End Date	31/05/2016
OPS Details	OPS Code		OPS Budget	0.00
	OPS Project Ranking		OPS Gender Marker	

Project Summary

The project will provide essential primary health care services to four underserved and insecure areas of Kunar province. The populations of these areas currently have very little or no access to health care services due to security and geographical constraints and barriers and there is no scope for BPHS services to incorporate these areas. PU-AMI therefore proposes the establishment of four health facilities to provide primary health care services including mother and child health and immunisation services Dewoz SHC, in Watapur district; Shuraik SHC, in Manogai district; Aret SHC, in Nurgal district; and Petaw SHC, in Marawara district, all areas under the control of non-state armed actors.

Direct beneficiaries

	Men	Women	Boys	Girls	Total
Beneficiary Summary	12227	11617	3055	2903	**29,802**
Total beneficiaries include the following:					
Host Communities	12219	11613	3055	2903	29790
Other	12	4	0	0	16

Indirect Beneficiaries	0	Catchment Population	29790

Link with the Allocation Strategy

The proposed project links with both the 2015 Strategic Response Plan and the 2015 First Standard Allocation Strategy Paper. Firstly, Strategic Priority 1: Excess morbidity and mortality reduced from the Strategic Response Plan is addressed by extending the provision of essential primary health care services to populations in greatest need in Kunar province. Exactly as outlined in the Plan, the aim is to reduce excess morbidity and mortality through support to basic health care services in areas of high vulnerability, such as Kunar. As essential health care services are vital to prevent excess morbidity and mortality, particularly among communities cut off by conflict or isolated by their remoteness, PU-AMI has outlined a project to open four static health facilities in some of the most isolated and insecure areas of Kunar where access to basic health care is either extremely limited or impossible.

The project is also aligned to the 2015 First Standard Allocation Strategy Paper's Allocation Envelope 1: Supporting the provision of life-saving health care services in contested and underserved areas. One of the Health Strategic Priorities is the establishment of static health facilities in remote, insecure (conflict areas) and underserved areas, exactly the areas which are targeted under this project. The populations living in these areas have very little or no access to primary health care services provided under the Basic Package of Healthcare Services (BPHS) and Essential Package of Hospital Services (EPHS) due to their distance from the nearest BPHS health facilities and the unpredictable security situation. The aim of this project is therefore to reduce morbidity and mortality of the target populations in these contested and underserved areas by establishing four static health facilities to provide life-saving health care services.

In terms of implementation mechanisms, this proposal will also employ the key element of access to vulnerable populations in need. The humanitarian presence of Health actors in Kunar is limited to just two – PU-AMI and ICRC, who operate one mobile health team. PU-AMI is only able to operate safely in Kunar and access the most insecure areas by maintaining a robust conflict analysis and access strategy which is tailored to the realities of each location and reviewed continuously in order to adapt to changing dynamics, and by strict adherence to the humanitarian principles of humanity, neutrality, impartiality and independence. PU-AMI's long-term presence and commitment to Kunar province, with over 20 years of operational experience, demonstrates a clear distinction from any political or military agendas and allows access to areas no other organisation could safely reach.

Sub-Grants to Implementing Partners		Other funding Secured For the Same Project (to date)	

Organization focal point contact details

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BACKGROUND INFORMATION

1. Humanitarian context analysis.. Humanitarian context: Describe the current humanitarian situation in the specific locations where this project will be implemented

PU-AMI has worked in Kunar province for over 20 years implementing numerous projects in the Health, Nutrition, WASH, and Protection sectors and is presently both the BPHS and EPHS implementer for Kunar and is also implementing several other projects in parallel in order to cover unmet gaps. PU-AMI has been implementing the BPHS in Kunar province since 2004 and the EPHS since 2007 and will continue to run both programmes in Kunar until at least 2016. These services currently include a Provincial Hospital (PH), a District Hospital (DH), 8 Comprehensive Health Centres (CHC), 18 Basic Health Centres (BHC), 15 Sub-Health Centres (SHC), one Level 2 prison clinic, and 328 Health Posts in the province.

In addition to those activities, PU-AMI is implementing an ECHO-funded emergency life-saving trauma care project and an Integrated Management of Acute Malnutrition programme, previously part-funded by the European Union, which was aligned with the BPHS programme in August 2012. Additional support is provided by WFP and UNICEF. In 2014, due to funding shortfalls and pipeline difficulties, WFP was forced to reduce its support in food provision from all 15 districts of Kunar province to seven central districts. PU-AMI therefore approached OCHA and CHF and was granted additional funding to cover the remaining eight districts for the Targeted Supplementary Feeding Programme component, and also added related WASH activities in order to tackle the root causes of acute malnutrition in Kunar.

Furthermore, PU-AMI has partnership agreements with IMC, Health Net TPO, UNICEF, WHO, and ACF to implement complementary Nutrition, GBV, and Health activities. From the long history of such interventions and a very well established presence, PU-AMI is able to maintain functional health facilities across all 15 districts, a network of 614 Community Health Workers (CHW), and excellent community relations and acceptance.

Alongside PU-AMI, the ICRC is the only other health actor present in Kunar province, running one mobile health team. PU-AMI is a key stakeholder in the provision of health services throughout Kunar and will remain as such for at least the next two years.

2. Needs assessment. Explain the specific needs of the target group(s), explaining existing capacity and gaps. State how the needs assessment was conducted, list any baseline data and explain how the number of beneficiaries has been developed. Indicates references to assessments such as Multi-cluster/sector Initial Rapid Assessments (MIRA)

The 2014 Human Development Index ranks Afghanistan at 169 of 187 recorded countries, the lowest ranked country outside of Africa, with a Life Expectancy at Birth of 60.9 years. Decades of political instability and armed conflict have led to an extremely concerning humanitarian situation. Despite limited progress in recent years, Afghanistan remains one of the worst places to be a woman and a frontline in the global battle for women's rights. Domestic and sexual violence are commonplace and violent opposition to women's education has resulted in a chronic lack of trained female healthcare personnel. This in turn manifests itself in widespread challenges to accessing appropriate women's, maternal, and newborn healthcare services, the appallingly high maternal and under-five mortality rates, and low life expectancy.

Overall, the security context of Afghanistan continued to deteriorate significantly and markedly so throughout 2014. Last year, INSO recorded more security incidents than any year since their records began. Consequently, the United Nations Assistance Mission in Afghanistan (UNAMA) also reported that the number of civilians killed and injured in 2014 in Afghanistan is the highest ever recorded by the UN, also since it began tracking the statistics - 10,548 civilian casualties were recorded. This represents a 22% increase on 2013 figures, and a 40% increase in children civilian casualties. Using the Health Management Information System (HMIS) as a third source, the situation is even more serious with an estimated 43,953 civilian children, women and men injured or killed in 2014. These casualties

	resulted mostly from ground engagements between parties to the conflict, improvised explosive devices (IED), and suicide and complex attacks. The Eastern Region has been particularly volatile with numerous areas heavily contested. In addition to the IED, suicide, and complex attacks, the security situation in Kunar is characterised by small arms fire, indirect fire, international military forces' (IMF) airstrikes, and cross-border shelling from Pakistan. Though casualty figures are almost certainly underreported, the cost to the civilian population is clearly enormous. OCHA's aggregated Need and Vulnerability Index contained in the 2015 Humanitarian Needs Overview, taking into consideration 20 mortality, morbidity, and vulnerability indicators, rates Kunar as having the highest Overall Need of all Afghanistan's provinces. The profile of Kunar is distinguished by the highest rating for insecurity and civilian casualties, acute diarrhoeal disease, measles, acute respiratory infections (pneumonia), and deliveries without skilled birth attendant, which all contribute to an overall mortality and morbidity rating of 4.7 from 5. Furthermore, the 2014 Humanitarian Needs Overview previously ranked Kunar as 2nd highest, demonstrating the protracted nature of the emergency and ongoing need for humanitarian assistance in the province. The proliferation of non-state armed actors (NSAAs) and often sparse geographic coverage of BPHS health facilities means there are significant numbers of the population living prohibitively far from the nearest health facility. The number and diversity of NSAAs combined with their often unpredictable nature means that access to areas out of government control is extremely limited and the willingness and ability of NGOs to intervene is low as a result. Where NGOs are able to intervene, such as PU-AMI, there are frequently difficulties in recruiting appropriately qualified medical staff, female staff in particular, meaning that the scope of culturally appropriate and gender specific services is often limited. In certain areas, this is compounded by the policies and NSAAs who do not universally allow all PHC services. Particularly contentious are family planning and immunisation services due to the negative perceptions of NSAAs regarding the aims of these services and how they relate to traditional, cul
3. Description Of Beneficiaries	The beneficiaries of this project are the communities living in the catchment areas of the four Sub-Health Centres, in otherwise very isolated areas. The total catchment populations is 29,790 which is disaggregated as follows; Aret: Men 2666; Women 2534; Boys 667; Girls 633 - Total 6500 Dewoz: Men 3281; Women 3119; Boys 820; Girls 780 - Total 8000 Petaw: Men 1846; Women 1754; Boys 461; Girls 439 - Total 4500 Shuraik: Men 4426; Women 4206; Boys 1107; Girls 1051 - Total 10790 Total: Men 12219 (41.02%); Women 11613 (38.98%); Boys 3055 (10.26%); Girls 2903 (9.74%) - Total 29790 (100%) Based on HMIS data from the same health facilities whilst previously functional, PU-AMI has calculated an average of 1.75 new consultations per person per year across the four supported health facilities. This informs the total target of 52,132 for Indicator 1.1.1. However, a number of these beneficiaries will receive more than one consultation each. PU-AMI has therefore included only the maximum number of unique consultation beneficiaries as 29,700. Similarly, as other services such as vaccinations will be offered to the same populations receiving consultations, they have not been included as additional unique beneficiaries and the relevant indicators have been formulated to show the percentage coverage of each. The beneficiaries per activity are calculated as follows; • Percentage of pregnant women receiving at least one antenatal care visit by skill birth attendant during the pregnancy: 29,790 * 4% * 60% national target for ANC1, or 715 women • Percentage of deliveries attended by Skilled Birth Attendant: 29,790 * 4% pregnant women * 40% target, or 477 deliveries • Percentage of pregnant women receiving TT vaccination = 29,790 * 4% pregnant women * 80% target, or 953 women • Percentage of children 0-11 months receiving Measles1 = 29,790 * 4% children <1 * 80% coverage, or 953 children • Percentage of children 0-11 months receiving PENTA1 = 29,790 * 4% children <1 * 80% coverage, or 953 children • Percentage of children <2 vaccinated for PENTA3 = 29,790 * 4% children 12 – 23 months * 80% coverage, or 953 children Furthermore, an additional 12 health facility staff will also be trained, three from each supported facility, giving a total of 29,802 direct beneficiaries.
4. Grant Request Justification.	As noted by OCHA in the 2015 First Standard Allocation Strategy Paper and recent MoPH reports, the "BPHS is covering around 65% of the population, while the remaining 35% are living mainly in insecure areas or areas with difficult terrain. The current package provided is only addressing the basic minimum needs." This is certainly the case for significant areas of Kunar province where geographic and security barriers prevent populations from accessing BPHS health facilities. Furthermore, as is often the case, the most vulnerable members of these populations are at greater risk of morbidities and mortalities resulting from common childhood illnesses and lack of maternal health care services. PU-AMI therefore proposes to implement primary health care services including immunisation services to the populations of underserved "white" areas around Dewoz SHC, in Watapur district; Shuraik SHC, in Manogai district; Aret SHC, in Nurgal district; and Petaw SHC, in Marawara district. These facilities have been chosen because they are located in very isolated and insecure areas of a rural province where access to BPHS services is severely restricted or completely out of reach. The proposed project will ensure the access for the population of those four areas to primary health care services who would otherwise unable to reach an alternative health facility, a strategy which aligns closely with the 2015 Strategic Response Plan and Health Priorities outlined therein. In 2014, PU-AMI opened a total of seven new fixed clinics to provide services to the population of underserved areas in a contract funded by WHO which was due to continue until May 2015. However, due to funding constraints, the project was cut short and PU-AMI was forced to close four of the seven clinics, with the remaining three having been integrated into the BPHS mechanism as originally planned. Unfortunately, there is no further scope, financial or contractual flexibility to allow PU-AMI to also incorporate the remaining four clinics, the busiest of the initial seven. PU-AMI has explained the necessity and urgency of reopening the clinics to WHO who have looked for additional funding to reopen the closed facilities and restart services, though they have not been successful and have indicated they are unable to provide further funding. Via quarterly and final reports to the MoPH and in regular meetings, PU-AMI will advocate that the additional facilities are taken into BPHS support in the future but this is unlikely to happen until the next BPHS contract negotiation, at the earliest in 2017. Reopening these facilities with CHF support would not only allow the immediate provision of health care services to populations otherwise without any access, but also allow PU-AMI to gather additional health data on service utilization and acceptance and the disease burden which could be used to inform and justify future support of the health facilities, be that as part of the wider BPHS mechanism or via another funding avenue. Given the necessity of reopening these health facilities, the importance of accessing health services to the underserved populations in the targeted areas, and the present lack of alternative donors able to provide support for these facilities, PU-AMI has closely reviewed the 2015 First Standard Allocation Strategy Paper and sees close links with the Health Priorities and its own strategy to reopen the four health facilities as quickly as possible. As CHF is an emergency humanitarian fund, PU-AMI understands that this cannot be used or viewed as a long-term funding mechanism for supporting the four health facilities, and as such has already considered the possible future integration of the facilities into the BPHS. Furthermore, PU-AMI will continue to look for alternative sources of funding to cover the gap between the end of this proposed CHF-funded project and the possible BPHS integration in January 2017. However, until such time as alternative fundi
5. Complementarity. Explain how the project will complement previous or ongoing projects/activities implemented by your organization.	As outlined in the Needs Assessment, the four health facilities are not supported under the BPHS programme and constitute a very real gap in the provision of primary health care services. The System Enhancing for Health Actions in Transition (SEHAT) programme for Kunar, which includes both BPHS and EPHS contracts, contains no provision or scope for the expansion of services to underserved areas beyond what has already been incorporated or provided to date. This includes the establishment and maintenance of additional supplementary health facilities to cover white areas. However, in order to make any potential future integration possible, and in order to avoid negatively impacting BPHS health facilities, PU-AMI will adhere strictly to Afghan Ministry of Public Health (MoPH) policies and procedures in relation to the technical implementation of services, HMIS data management, and Human Resources policies, including salary scale and benefit allowances such as holiday entitlement. This is to ensure that a fair and standard salary is paid and avoid drawing health care staff from other BPHS facilities, simply creating gaps there, and to allow for a smooth integration of the health facilities into future BPHS contracts. As PU-AMI is certain of the need to provide services in these facilities, advocacy will be done with the MoPH and, if necessary, the World Bank as back donor to include support for these four facilities in the next SEHAT/BPHS contract for Kunar province. This project is designed specifically as a continuation of activities which were previous begun with the assistance of WHO funding. From June 2014, PU-AMI opened the four proposed clinics as well as an additional three in Dangam, Ghaziabad, and Sheygal Wa Shultan districts along the border with Pakistan under a contract which was initially due to extend until May 2015. The primary focus of the WHO project was to undertake immunisation activities and an additional four border vaccination teams, who provided polio vaccinations to children crossing from Pakistan into Afghanistan, were also supported. However, due to financial constraints, WHO abruptly terminated the contract in January 2015 as it was unable to fulfil its financial commitments to run the clinics and associated vaccination activities. As initially planned, the three health facilities located in Dangam, Ghaziabad, and Sheygal Wa Shultan districts were integrated into the BPHS at that point, meaning that they are currently still operational and providing services. However, as mentioned above, the remaining four facilities were not included under the BPHS financing agreement and therefore cannot be integrated at this stage. At PU-AMI's request, WHO has searched for additional sources of funding though has been unable to find enough to continue support of the health facilities. However, WHO have indicated that they are likely to be able to extend support for the polio vaccination activities, border vaccination teams, and provide the vaccines themselves. Therefore, PU-AMI has made no provision for these activities in this proposal and will instead use CHF funding to concentrate on the provision of primary health care and fixed immunisation services in the four health facilities. It is hoped that WHO will support the polio border vaccination teams and, if so, the CHF-funded health facilities will be used to store vaccines and equipment and record data.

LOGICAL FRAMEWORK

Overall project objective	Ensure the provision of life-saving health care services in four insecure and underserved areas of Kunar province

Logical Framework details for HEALTH

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Objective 1. Reduce incidence of maternal and child mortality and morbidity targeting 1 million	1. Excess morbidity and mortality reduced	100

Outcome 1	Access to essential package of primary healthcare services, including mother and child health, is improved	
Code	**Description**	**Assumptions & Risks**
Output 1.1	Essential package of primary health care services, including mother and child health, is provided in four supported health facilities	• The road access allows the delivery of drugs, medical and non medical items • The security conditions allow the staff to work • Community provide houses for Health facilities • Female staff are willing to work in remote areas

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 1.1.1	HEALTH	Percentage of temporary health facilities having female qualified medical staff					100
	Means of Verification:	HMIS Reports; PU-AMI Monthly Personnel Reports. It is a national target that each HF should have at least one female health worker					
Indicator 1.1.2	HEALTH	Number of outpatient consultations per person per year					52132
	Means of Verification:	HMIS Reports; Patient registers It is a national indicator the target is 1.75 consultations per year (29790 x 1.75 consultations). The verification is done through monthly HMIS report of HF and registers of patients as well as remote call monitoring, direct monitoring.					
Indicator 1.1.3	HEALTH	Number of pregnant women receiving at least one antenatal care visit by skill birth attendant during the pregnancy					715
	Means of Verification:	HMIS Reports; Patient registers This target is set based on the achievement of the BPHS project in Kunar province with similar type of HFs. The verification is done through monthly HMIS report of HF and registers of patients as well as remote call monitoring, direct monitoring. Percentage of pregnant women receiving at least one antenatal care visit by skill birth attendant during the pregnancy: 29,790 * 4% * 60% national target for ANC1, or 715 women.					
Indicator 1.1.4	HEALTH	Per centage of deliveries attended by SBA at facility or by CHW at community level					40
	Means of Verification:	HMIS Reports and health facility Patient Registers HMIS Reports and health facility Patient Registers: the target is sent based on HRP. The verification is done through monthly HMIS report of HF and registers of patients as well as remote call monitoring, direct monitoring • Percentage of deliveries attended by Skilled Birth Attendant: 29,790 * 4% pregnant women * 40% target, or 477 deliveries •					
Indicator 1.1.5	HEALTH	Number of health education sessions on hygiene promotion, hand washing and safe disposal of faeces per HF per month.					25
	Means of Verification:	Health education monthly report. Target is based on 1 session per day when all patients are come together and receive group health education.					

Activities

Activity 1.1.1	Community engagement to gain acceptance of opening four supported health facilities : informal ad hoc meetings will be organised with the local communities, involving the community elders, and formal Community Shura and Local Health Committee/Shura meetings for residents of the areas. PU-AMI's Field Advisor will be primarily responsible for engagement with the communities as he was also heavily implicated in the original negotiations with communities in order to open the facilities. The Field Advisor will ensure that the communities understand the reasons behind the reopening of the facilities and the scope and limitation of the funding including the project end date. The communities will be consulted regarding recruitment of staff to gain their support, though PU-AMI will always seek the best qualified and experienced person for the role. Regular engagement on at least a monthly basis at the Community Shura and Health Shura meetings will continue throughout the project with the Health Facility Director also present in those forums. Oversight is provided by the Project Officer.
Activity 1.1.2	Activation of four health facilities with recruitment and training of health facility staff: PU-AMI will announce the vacancies with ACBAR and locally in Asadabad and Jalalabad as well as at the nearest health facilities with the standard recruitment procedure being undertaken by PU-AMI's National and Provincial HR Departments. Special attention will be given to recruiting female staff including the midwives as PU-AMI is already aware this will be challenging. Incentives and hardship allowances will be offered in the remuneration package of female staff. Training will be organised by the Project Officer in close coordination with PU-AMI's Capacity Building Officer for the following topics; HMIS Practical Training; Infection Prevention; Infant and Young Child Feeding for nurses and midwives; and Management of Drug Supplies; and Rational Prescriptions for nurses only. Salaries and other benefits will conform to the MoPH salary scale in order to prepare the staff for a potential integration into the BPHS system at a later date.
Activity 1.1.3	Procurement and distribution of essential medical supplies and equipment to four health facilities: Procurement for the health facilities will be arranged by the Project Officer based on previous consumption rates with the process undertaken by the Provincial and National Logistics Departments. Medical supplies are most likely to be purchased in Kabul and delivered to Kunar by truck, though more bulky equipment may be found cheaper locally and so purchased in Kunar or Jalalabad if possible. PU-AMI will use the MoPH standard list of drugs and supplies in order to provision the health facilities with items which would also be provided if the facilities are integrated into the BPHS. However, as there is currently no BPHS support or overlap, CHF would provide the financial support for all supplies. Moreover, PU-AMI will procure and provide a solar power system to run the vaccine refrigerators without the need for generators, thereby reducing the environmental impact.
Activity 1.1.4	Delivery of primary health care and mother and child health care services in four health facilities: Services will be implemented by the recruited medical personnel in each health facility which will contain; one nurse; one midwife; and one vaccinator. Services offered will conform to the MoPH standard guidelines and practices in order to maintain a consistent approach throughout the province. Oversight is provided by the Project Officer.
Activity 1.1.5	Conduct awareness raising sessions on health and hygiene promotion within four health facilities: Using standard Information Education Communication materials supplied to the heath facilities, health care personnel - nurses and midwives - will also be responsible for conducting awareness raising sessions on health, nutrition, and hygiene promotion in the supported health facilities. Specific attention will be paid to mother and child health topics which will be provided by the recruited midwives, especially and uniquely for female beneficiaries, in order to provide gender appropriate messaging. The Community Health Workers (CHW) of BPHS HF who are working in the villages close to these proposed clinics, will be linked with staff of these clinics in order to focus on the importance of community awareness especially female CHW who will be responsible for providing health, nutrition, and hygiene messages to women both at health facility level and in the community. Oversight is provided by the Project Officer.
Activity 1.1.6	Project Communication is ensured: Basic communication activities will be conducted during the project implementation. Through its website and its social networks accounts, PU-AMI will communicate on the needs addressed on the field and CHF support will be mentioned. Moreover, valuable stories and pictures from beneficiaries will be integrated to each report. Moreover, PU-AMI will mention CHF project achievements in its bi annual newsletter. This newsletter aims at communicating on PU-AMI's current programs. It will be distributed it in the health facilities in Daykundi and Kunar provinces, and to local authorities and traditional leaders in Kabul, Jalalabad, Kunar and Daykundi. It is also distributed to all PU-AMI partners at national level (authorities, donors, UN agencies and NGOs)

Outcome 2	Immunization coverage of pregnant women and Under 5 children is enhanced	
Code	**Description**	**Assumptions & Risks**
Output 2.1	Immunization services are provided in the 4 targeted health facilities	• The road access allows the delivery vaccines • The security conditions allow the vaccinators to work • MoPH/UNICEF provide vaccines

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries	End-

			Men	Women	Boys	Girls	Cycle Target
Indicator 2.1.1	HEALTH	Percentage of pregnant women receiving TT vaccination					80
	Means of Verification:	HMIS Reports; Patient registers This target is set based on the achievement of the BPHS project in Kunar province with similar type of HFs . Percentage of pregnant women receiving TT vaccination = 29,790 * 4% pregnant women * 80% target, or 953 women					
Indicator 2.1.2	HEALTH	% of children < 2 vaccinated with Penta 3					80
	Means of Verification:	HMIS Reports and health facility Patient Registers It is based on HRP standard target. The verification is done through monthly HMIS report of HF and registers of patients as well as remote call monitoring, direct monitoring. Percentage of children <2 vaccinated for PENTA3 = 29,790 * 4% children 12 – 23 months * 80% coverage, or 953 children					

Activities

Activity 2.1.1	Activation of the fixed vaccination points in four health facilities with recruitment and training of four vaccinators: PU-AMI will announce the vacancies with ACBAR and locally in Asadabad and Jalalabad as well as at the nearest health facilities with the standard recruitment procedure being undertaken by PU-AMI's National and Provincial HR Departments. Special attention will be given to recruiting female staff if possible. Incentives and hardship allowances will be offered in the remuneration package of female staff. EPI Training will be organised by the Project Officer in close coordination with PU-AMI's Capacity Building Officer for each vaccinator.
Activity 2.1.2	Transport and distribution of vaccines to four health facilities: PU-AMI will receive the standard vaccines from the provincial cold chain which is managed by the Provincial EPI Management Team. This is represented by an EPI Officer of the Directorate of Public Health and will deliver the vaccines to the supported health facilities ensuring that the cold chain is respected and the vaccines maintained in the appropriate conditions during their transportation.
Activity 2.1.3	Provision of routine immunisation services in four health facilities: The recruited vaccinators will be responsible for the provision of routine immunisation services inside of the supported health facilities. Due to security constraints in the area, no outreach or mobile vaccinations will be provided. Immunization services will be implemented as per the national technical guidelines provided by the MoPH. Oversight is provided by the Project Officer.
Activity 2.1.4	Conduct awareness raising sessions on immunisation within four health facilities: The recruited vaccinators will also conduct awareness raising sessions using the standard Information Education Communication materials to people visiting the supported health facilities on the importance and schedule of vaccinations. As mentioned above, the vaccinators will also pay special attention to mothers and pregnant women given their unique responsibilities regarding immunisation in order to encourage them to follow the prescribed schedule of vaccinations, both for themselves and children. Specific sessions will be organised to target women in the health facilities and disseminate information directly to them. Oversight is provided by the Project Officer.
Activity 2.1.5	Project communication is ensured (same as in Outcome 1)

WORK PLAN

Project workplan for activities defined in the Logical framework

Activity Description (Month)	Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Activity 1.1.1 Community engagement to gain acceptance of opening four supported health facilities : informal ad hoc meetings will be organised with the local communities, involving the community elders, and formal Community Shura and Local Health Committee/Shura meetings for residents of the areas. PU-AMI's Field Advisor will be primarily responsible for engagement with the communities as he was also heavily implicated in the original negotiations with communities in order to open the facilities. The Field Advisor will ensure that the communities understand the reasons behind the reopening of the facilities and the scope and limitation of the funding including the project end date. The communities will be consulted regarding recruitment of staff to gain their support, though PU-AMI will always seek the best qualified and experienced person for the role. Regular engagement on at least a monthly basis at the Community Shura and Health Shura meetings will continue throughout the project with the Health Facility Director also present in those forums. Oversight is provided by the Project Officer.	2015						X						
	2016												
Activity 1.1.2 Activation of four health facilities with recruitment and training of health facility staff: PU-AMI will announce the vacancies with ACBAR and locally in Asadabad and Jalalabad as well as at the nearest health facilities with the standard recruitment procedure being undertaken by PU-AMI's National and Provincial HR Departments. Special attention will be given to recruiting female staff including the midwives as PU-AMI is already aware this will be challenging. Incentives and hardship allowances will be offered in the remuneration package of female staff. Training will be organised by the Project Officer in close coordination with PU-AMI's Capacity Building Officer for the following topics; HMIS Practical Training; Infection Prevention; Infant and Young Child Feeding for nurses and midwives; and Management of Drug Supplies; and Rational Prescriptions for nurses only. Salaries and other benefits will conform to the MoPH salary scale in order to prepare the staff for a potential integration into the BPHS system at a later date.	2015						X						
	2016												
Activity 1.1.3 Procurement and distribution of essential medical supplies and equipment to four health facilities: Procurement for the health facilities will be arranged by the Project Officer based on previous consumption rates with the process undertaken by the Provincial and National Logistics Departments. Medical supplies are most likely to be purchased in Kabul and delivered to Kunar by truck, though more bulky equipment may be found cheaper locally and so purchased in Kunar or Jalalabad if possible. PU-AMI will use the MoPH standard list of drugs and supplies in order to provision the health facilities with items which would also be provided if the facilities are integrated into the BPHS. However, as there is currently no BPHS support or overlap, CHF would provide the financial support for all supplies. Moreover, PU-AMI will procure and provide a solar power system to run the vaccine refrigerators without the need for generators, thereby reducing the environmental impact.	2015						X			X			X
	2016			X									
Activity 1.1.4 Delivery of primary health care and mother and child health care services in four health facilities: Services will be implemented by the recruited medical personnel in each health facility which will contain; one nurse; one midwife; and one vaccinator. Services offered will conform to the MoPH standard guidelines and practices in order to maintain a consistent approach throughout the province. Oversight is provided by the Project Officer.	2015						X	X	X	X	X	X	X
	2016	X	X	X	X	X							
Activity 1.1.5 Conduct awareness raising sessions on health and hygiene promotion within four health facilities: Using standard Information Education Communication materials supplied to	2015						X	X	X	X	X	X	X

	the heath facilities, health care personnel - nurses and midwives - will also be responsible for conducting awareness raising sessions on health, nutrition, and hygiene promotion in the supported health facilities. Specific attention will be paid to mother and child health topics which will be provided by the recruited midwives, especially and uniquely for female beneficiaries, in order to provide gender appropriate messaging. The Community Health Workers (CHW) of BPHS HF who are working in the villages close to these proposed clinics, will be linked with staff of these clinics in order to focus on the importance of community awareness especially female CHW who will be responsible for providing health, nutrition, and hygiene messages to women both at health facility level and in the community. Oversight is provided by the Project Officer.													
		2016	X	X	X	X	X							
	Activity 2.1.1 Activation of the fixed vaccination points in four health facilities with recruitment and training of four vaccinators: PU-AMI will announce the vacancies with ACBAR and locally in Asadabad and Jalalabad as well as at the nearest health facilities with the standard recruitment procedure being undertaken by PU-AMI's National and Provincial HR Departments. Special attention will be given to recruiting female staff if possible. Incentives and hardship allowances will be offered in the remuneration package of female staff. EPI Training will be organised by the Project Officer in close coordination with PU-AMI's Capacity Building Officer for each vaccinator.	2015						X						
		2016												
	Activity 2.1.2 Transport and distribution of vaccines to four health facilities: PU-AMI will receive the standard vaccines from the provincial cold chain which is managed by the Provincial EPI Management Team. This is represented by an EPI Officer of the Directorate of Public Health and will deliver the vaccines to the supported health facilities ensuring that the cold chain is respected and the vaccines maintained in the appropriate conditions during their transportation.	2015						X	X	X	X	X		X
		2016	X	X	X	X	X							
	Activity 2.1.3 Provision of routine immunisation services in four health facilities: The recruited vaccinators will be responsible for the provision of routine immunisation services inside of the supported health facilities. Due to security constraints in the area, no outreach or mobile vaccinations will be provided. Immunization services will be implemented as per the national technical guidelines provided by the MoPH. Oversight is provided by the Project Officer.	2015						X	X	X	X	X	X	X
		2016	X	X	X	X	X							
	Activity 2.1.4 Conduct awareness raising sessions on immunisation within four health facilities: The recruited vaccinators will also conduct awareness raising sessions using the standard Information Education Communication materials to people visiting the supported health facilities on the importance and schedule of vaccinations. As mentioned above, the vaccinators will also pay special attention to mothers and pregnant women given their unique responsibilities regarding immunisation in order to encourage them to follow the prescribed schedule of vaccinations, both for themselves and children. Specific sessions will be organised to target women in the health facilities and disseminate information directly to them. Oversight is provided by the Project Officer.	2015						X	X	X	X	X	X	X
		2016	X	X	X	X	X							
	Activity 1.1.6 Project Communication is ensured: Basic communication activities will be conducted during the project implementation. Through its website and its social networks accounts, PU-AMI will communicate on the needs addressed on the field and CHF support will be mentioned. Moreover, valuable stories and pictures from beneficiaries will be integrated to each report. Moreover, PU-AMI will mention CHF project achievements in its bi annual newsletter. This newsletter aims at communicating on PU-AMI's current programs. It will be distributed it in the health facilities in Daykundi and Kunar provinces, and to local authorities and traditional leaders in Kabul, Jalalabad, Kunar and Daykundi. It is also distributed to all PU-AMI partners at national level (authorities, donors, UN agencies and NGOs)	2015								X	X	X	X	X
		2016	X	X	X	X	X							
	Activity 2.1.5 Project communication is ensured (same as in Outcome 1)	2015								X	X	X	X	X
		2016	X	X	X	X	X							

M & R DETAILS

Monitoring & Reporting Plan: Describe how you will monitor the implementation of each activity. Describe the tools you plan to use (checklist, photo, questionnaires, interviews, suggestion box etc.) in order to collect data and how you will store data. Explain the frequency type and protocol of reporting (how often do you report about what to whom?). State if, when and how you plan to evaluate your project .	At the inception of the project, a workshop involving key project staff and coordination staff from Kabul will take place in order to review the project design and develop a dedicated Project Monitoring Plan. This plan will include the project outcomes, activities, process based measurable indicators and means of verification, and outline what information is required, where it comes from, who is responsible for collecting it and how frequently. It also describes how this information should be used for managing the project, reporting on progress, and demonstrating results, as well as how to verify and improve the quality of data recorded through multiple sources of verification and triangulation. PU-AMI and MoPH standards are used to prepare simple check lists to monitor activities and recommend action as necessary throughout the implementation of the project. Furthermore, the Logical Framework will be reviewed on a monthly basis at project level and quarterly at country level. Most of the evidence is currently collected by PU-AMI's health teams delivering services. Service and epidemiological data is collected every time a patient visits a facility. This data allows PU-AMI teams to track health needs and adapt services accordingly, monitor health trends and design appropriate interventions to meet changing needs. The main challenge in terms of monitoring is the ability of PU-AMI staff to visit certain areas they are not themselves originally from, whether national or expatriate staff, either due to intense armed conflict or risks associated with entering areas controlled by NSAAs. Furthermore, there is a high assessed risk of kidnap of expatriate staff in Kunar province, meaning expatriate presence there is limited. PU-AMI maintains an Access Tracker tool which is updated at least every two weeks and often more frequently in light of developments in the security context. For example, if large armed clashes or prolonged bouts of shelling or mortar fire occur in a specific area, it may be necessary to alter the frequency of monitoring visits in order to reduce the exposure of staff to the associated risks. Conversely, should an area in which a supported health facility is located come under the control of a less dangerous or less unpredictable actor, the frequency of monitoring visits may be increased. The Access Tracker categorises all facilities in terms of the severity of the security situation and the corresponding frequency of supervisions, as detailed in the Access section below. Each category requires a different monitoring strategy, and some facilities may also require different strategies than other facilities within the same category. PU-AMI has adapted the monitoring strategy to ensure a minimum level of visibility and monitoring in those facilities were PU-AMI is not able to safely send supervisors on a regular basis. This is the case for three of the four proposed health facilities. Therefore, depending on the particular facility and the local dynamics; HF Directors may themselves perform the monitoring and evaluation using the standard tools outlined previously in self-assessments; alternatively, HF Directors may travel to neighbouring facilities with key staff to be evaluated outside of their facility by HF Directors from different facilities; and thirdly, where possible, HF Directors from nearby facilities can visit the HF located in an extremely insecure area and perform the monitoring, the latter two being peer-to-peer monitoring. In all cases, staff in these facilities are in frequent telephone contact with PU-AMI Cluster Supervisors, Project Managers/Officers and all additionally participate in monthly meetings at provincial level where key data is reviewed and the results of the above strategies cross-referenced with other sources of information such as HMIS data and stock consumption reports.

OTHER INFORMATION

Accountability to Affected Populations	The long-term presence of PU-AMI in Kunar province (since 1994) combined with the presence of CHW in all districts and supervision by PU-AMI teams at village level ensures the participation of the community in the design of the Action. Feedback from project staff, Field Supervisors, BPHS Cluster Supervisors, IDP, local authorities, PPHD, and health Shuras on existing and previous PU-AMI projects has been integrated into the proposed project. Close contact with HF Directors, HF staff, and CHW as members of the targeted communities, working in close partnerships with the community leaders, and regular meetings conducted with the Health Shuras at HF level ensure the engagement of beneficiaries with the project and have informed the current proposal. HF staff and PU-AMI's Field Advisor are in regular contact with the Community Shuras and this forum, as well as the Health Shuras, allows interaction with community leaders and representatives and facilitates the identification of gaps in the provision of health services. The community is able to provide recommendations and make requests of HF Directors, and conversely, HF Directors discussed proposed plans with the community members in order to gain acceptance of all decisions and activities implemented at HF and community level by CHW. Without this direct engagement with the community, PU-AMI simply

	could not work in Kunar province or in areas with significant NSAA presences.
Implementation Plan: Describe for each activity how you plan to implement it and who is carrying out what.	Not enough space to detail by activity so please refer to the Annex "Implementation Plan PU-AMI"

Coordination with other Organizations in project area

Name of the organization	Areas/activities of collaboration and rationale
1. PU-AMI BPHS Team	The project team will link closely with the existing wider PU-AMI BPHS Kunar team in order benefit from the established staff network and ensure a coordinated provision of services. As outlined above, MoPH standard procedures, formats, tools, HMIS, and guidelines will be used in the provision of services, collection of data, Human Resources processes, etc. To be as cost-effective as possible, the project team will benefit from the presence of PU-AMI's HR, Logistics, Finance, and Admin staff, as well as the regional Field Coordinator who will ensure good coordination between existing PU-AMI staff and teams.
2. WHO	As mentioned previously, PU-AMI hopes to receive additional funding to support polio vaccination activities and border vaccination teams who would use the CHF-funded health facilities as bases to store vaccines and equipment and record data for reporting into the central HMIS. Coordination is done primarily at regional level from Jalalabad where the WHO Regional Sub Office is situated.
3. OCHA	PU-AMI is an active member of multiple Clusters at both national and regional level. Regionally, PU-AMI participates in the Health, Nutrition, WASH, and Protection Clusters, as well as the IDP Taskforce and Humanitarian Regional Team which allows for good coordination between PU-AMI, UN agencies, and other actors present in the region. PU-AMI also maintains a good relationship with OCHA, especially concerning the existing CHF-funded emergency WASH and Nutrition project for Kunar province.
4. PPHD/PPHC, PDC, PDMC	At provincial level, PU-AMI regularly participates in the Provincial Public Health Committee, Provincial Development Committee, and Provincial Disaster Management Committee meetings. This ensures good coordination with organisations operational in the area, particularly the smaller Afghan NGOs who do not necessarily participate in the regional cluster meetings.
5. MoPH	PU-AMI will coordinate closely with the MoPH to ensure that standards and guidelines are followed in line with the overall national strategy. As outlined above, PU-AMI will also advocate strongly with the MoPH vi quarterly and final reports, meetings, and workshops for the ultimate inclusion of the four CHF-supported health facilities into the winder BPHS mechanism.
6. INSO	PU-AMI has very close coordination with INSO regarding security incidents and management and will logically continue to do so whilst operating in these extremely insecure areas.
7. ACBAR	PU-AMI is an ACBAR member and attends both national and regional forums for general NGO coordination.

Environmental Marker Code	B+: Medium environmental impact with mitigation(sector guidance)
Gender Marker Code	2a-The project is designed to contribute significantly to gender equality
Justify Chosen Gender Marker Code	The project analysis which included a gender analysis examined the health needs of the communities located in the targeted underserved white areas and identified women, pregnant and lactating women, and children as the most vulnerable, as compared to other sections of the population. Consequently, the project has been specifically designed as gender sensitive with activities and outcomes targeting those groups. PU-AMI will recruit one midwife per health facility in order to provide gender appropriate maternal, newborn, and child health care services to women and children. Given the remoteness, security situation, and limited number of qualified female staff in these areas, PU-AMI will provide additional incentives and hardship allowances to all female staff to encourage qualified staff to work in these areas. PU-AMI will also endeavour to recruit female nurses and vaccinators for the supported health facilities if at all possible, though given the difficult security situations and isolated locations of each facility, this will be very challenging. Furthermore, PU-AMI will engage with the local communities to ensure that safe, secure, and culturally appropriate accommodation is secured for any female staff and that they are provided with assurances from the communities that they will be supported in their work. Alongside the provision of mother and child services, PU-AMI will undertake awareness raising education sessions at health facility level on health and hygiene promotion, nutrition, and immunisation services using standard Information Education Communication materials. These sessions will be provided to both men and women, including women only groups, in order to promote the use of available health care services including mother and child services. Men will also receive the messages in order to increase the involvement of fathers in child health and hygiene promotion activities which are traditionally seen as women's responsibilities and also to encourage the uptake of available services, in particular maternal health care services, throughout the broader communities within the catchment areas of the support health facilities. The project therefore has the potential to contribute significantly to gender equality. Environment: The implementation of primary health care services and running of health facilities has a clear potential for negative environmental impact from human faeces, clinic waste, and septic tanks for example, which could potentially affect nearby water sources. However, PU-AMI strictly adheres to best practices, WASH standards, and MoPH health facility guidelines to ensure that each facility follows the appropriate waste management procedure, is equipped with the necessary items such as safety boxes for sharps, needles and blades, buckets for general and infectious waste, incinerators for burning infectious solid waste and holes for the burying organic waste, incinerated materials and non infected sharp materials like vials and ampoules. Furthermore, all nurses and midwives will be given infection prevention training at the beginning of the project. PU-AMI has also budgeted a small amount towards the rehabilitation of the health facilities which will be used to ensure they are up to standard and do not represent any environmental hazard due to poor conditions. Lastly, PU-AMI will procure and install solar battery power systems to each facility in order to reduce the reliance on fossil fuels to power the facilities and provide a more sustainable and durable means of energy provision which will ultimately prove to be more cost effective than the reliance on fossil fuels.
Protection Mainstreaming	PU-AMI proposes to open four health clinics in underserved white areas precisely to address the issue of vulnerable communities and the most vulnerable groups within those communities not having equitable access to primary health care services. PU-AMI will recruit female health staff members with skills and experience working with women and with children in order to provide appropriate services for these groups. Furthermore, as a matter of practice, confidentiality and privacy of beneficiaries are respected in all forms of consultations so as not to expose beneficiaries to protection concerns.
Safety and Security	Afghanistan has seen one of its most deadly years on record as the conflict enters a new phase with the departure of the vast majority of international military forces. This is particularly true of the Eastern Region and Kunar province especially. Serious security incidents take place on a daily basis, some of which have a direct impact on PU-AMI operations and staff. In 2014, two PU-AMI staff members were killed in separate incidents, the second when a mortar round struck the house of a member of staff, killing him, his wife and young child. This is a stark example of UNAMA's report which states that 2014 is the most deadly year on record in terms of civilian casualties, with children particularly affected. In recent months, several PU-AMI health facilities and assets have also been damaged during fighting. Ambulances have been involved in two road accidents as the result of collisions with conflict actors whilst evacuating casualties from war zones. A third ambulance was also damaged by shrapnel from a shell which exploded when impacting a disused external building of a PU-AMI health facility. A PU-AMI guard was also recently abducted from another health facility with his young son by NSAAs who then looted non-medical equipment and set explosive charges in the building, blowing up the facility and repeating the same in a nearby school. Although subsequent mediation and negotiation has indicated PU-AMI was not directly targeted – the attacks were more a punitive measure towards the local community – the immediate risks are evident. Challenges of this kind of extremely insecure operating environment also manifest themselves in the difficulty of recruiting and retaining staff who are prepared to work in such an environment – this is one of the leading difficulties PU-AMI faces in recruiting qualified female healthcare professionals. Kunar is host to large and multiple groups of NSAAs, including foreign groups, which sometimes makes negotiating access very challenging as numerous actors are present with differing motivations and beliefs. The fluidity created by multiple groups, often foreign, and factional fighting within these groups, is a significant challenge in that it makes certain areas unpredictable and accessing them potentially extremely dangerous. This is true for both national and international staff, though there is a higher risk for expatriate staff in Kunar province of abduction and kidnap due to the nature of the groups operating there. Certain activities are highly contentious, particularly family planning and immunisation services due to the negative perceptions of NSAAs regarding the aims of these services and how they relate to traditional, cultural, and religious norms. During the last few months alone several government vaccinators have been abducted and threatened and one vaccinator was also killed in Watapur district. PU-AMI, with a good knowledge of local conditions and through constant community engagement is able to implement immunisation services throughout the province, although in some areas these are restricted to health facilities alone and outreach vaccinations are not undertaken. This is the case for the four proposed health facilities, with the presence of multiple NSAAs, often within the same area and often with differing policies towards vaccinations. PU-AMI will therefore implement immunisation services in the health facilities alone, due to the local security contexts. Such serious risks are logically managed very closely and constant evaluations of the situation take place. PU-AMI has a well developed security management framework, including security plans and uses Security Focal Points for information sharing and incident management. Furthermore, community acceptance is of utmost importance to PU-AMI and only through continuous engagement with communities is PU-AMI able to operate in all areas of Kunar province as is the case today.

Access	Though PU-AMI enjoys access to all Kunar health facilities, the local security context dictates different levels of access for different facilities and monitoring and supervision is not freely available to all facilities, though a degree of access is possible in all of them. This constraint necessitates various strategies which PU-AMI employs to ensure a level of monitoring in all facilities, strategies which have to date permitted continuous operations in the most insecure areas of Afghanistan and, crucially, the continued provision of assistance to the most in need populations. Building acceptance and understanding of the humanitarian principals of neutrality, impartiality, and independence is fundamental to PU-AMI's strategies. PU-AMI has invested lots of time in developing community acceptance and understanding of operations to allow access and monitoring. The use of health facility staff from the local area with excellent knowledge of local dynamics and regular and active participation in Health and Community Shuras has facilitated this. Experience has demonstrated that armed actors in these areas have a full understanding of PU-AMI's work and are aware of the humanitarian principals employed, principals which are respected and accepted and which in turn allows access to otherwise potentially very dangerous areas. PU-AMI continues to take such concrete steps to improve the frequency of monitoring visits. Community engagement through the Shuras remains crucial in maintaining and gaining community support and acceptance of armed groups. This is necessarily a lengthy process, but progress has been made. For example, through intense community engagement and negotiations PU-AMI was able open the four proposed facilities under WHO funding despite their locations in extremely insecure areas.

BUDGET

1 **Staff and Other Personnel Costs** *(please itemize costs of staff, consultants and other personnel to be recruited directly by the implementing partner for project implementation)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost
1.1	Expatriates Support Staff (Kabul)	S	2	4550	1	100.00%	9,100.00
	Logistic Coordinator and Grant Officer. A contribution has been made to the salaries of these two key support staff. The Logistics Coordinator will provide support and oversight of all logistics processes including the medical procurement for the supported health facilities. The Grants Officer will be involved in the collection and dissemination of project information and all interactions with the GMS.						
1.2	Expatriates Program Staff (Kabul)	D	1	4880	2	100.00%	9,760.00
	Medical Coordinator. The Medical Coordinator will provide technical support to programmatic activities, attend the Health Cluster meetings and any other national level coordination meetings, and be a key member of staff involved in the advocacy for a durable exit strategy and longer-term support for the four health facilities. The Medical Coordinator is also responsible for the monitoring and evaluation framework and providing support to its implementation.						
1.3	KBL Admin / Fin / HR Officer	S	1	803.5	2	100.00%	1,607.00
	The officer is responsible for HR issues of satff under this project and is allocated two months salary based on the current actual monthly salary.						
1.4	KBL Log Officer	S	1	784	2	100.00%	1,568.00
	The officer is responsible for Logistics matters to facilitate during the project implementaion. Two months salary based on the current actual monthly salary has been allocated.						
1.5	Deputy Head of Mission	S	1	2755	2	100.00%	5,510.00
	Deputy Head of Mission contributions have been made to these key support functions who will provide oversight and guidance to ensure that the appropriate policies and procedures are adhered to, particularly logistics, procurement, HR, and finance.						
1.6	Admin-HR support	S	1	857	3	100.00%	2,571.00
	This position facilitates HR issues of satff under this project in Kunar and is allocated three months salary based on the current actual monthly salary.						
1.7	Finance support	S	1	857	3	100.00%	2,571.00
	This position facilitates Finance issues of satff under this project in Kunar and is allocated three months salary based on the current actual monthly salary.						
1.8	Logistics support	S	1	625	3	100.00%	1,875.00
	This position facilitates Logistics issues of satff under this project in Kunar and is allocated three months salary based on the current actual monthly salary.						
1.9	Office Guards	S	2	305	3	100.00%	1,830.00
	This position safeguards athe project office and protects project resources of the project in Kunar and is allocated three months salary based on the current actual monthly salary.						
1.10	Office cleaner	S	2	302	3	100.00%	1,812.00
	Provides administrateve support to ensure the cleaness of the project Office and equipments in Kunar and is allocated three months salary based on the current actual monthly salary.						
1.11	National Program Staff	D	21	399	12	100.00%	100,548.00
	Please see BoQ 1.11. 1 Project Officer, 1 Medical Focal Point, 1 Pharmacy Assistant, 4 Midwives, 4 Nurses, 4 Vaccinators, 4 Guards, 1 EPI Supervisor, 1 Field Advisor. Each supported health facility will have one midwife, nurse, vaccinator, and guard each in order to implement the proposed activities, totaling 16 staff at health facility level. The Field Advisor will have the key responsibility of engagement with the local communities in order to secure agreements to open the facilities and allow potentially controversial services. The EPI Supervisor will monitor and evaluate EPI services and provide regular reports and recommendations to improve any highlighted weak points. The Pharmacy Assistant has a three month salary allocation during the procurement and stocking phase of the project to oversee the supply chain. The Medical Focal Point also has a three month salary allocation and will provide technical support and advice to programme staff and the Project Officer. The Project Officer is responsible for the management and implementation of the project in Kunar and coordinates all other functions.						
	Section Total						138,752.00

2 **Supplies, Commodities, Materials** *(please itemize direct and indirect costs of consumables to be purchased under the project, including associated transportation, freight, storage and distribution costs)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost
2.1	Rehabilitation of health facilities	D	4	375	1	100.00%	1,500.00
	Due to the dilapidated condition of four of the four clinic buildings, some small rehabilitation work is planned in order to improve the conditions of three clinics. This will include reparation of damaged walls, doors, and windows, painting and plastering to ensure appropriate standards of cleanliness. 4 x 375 = 1500 USD						
2.2	Medical equipment for 4 sites	D	4	355	1	100.00%	1,420.00
	Please see the BoQ 2.2. Medical equipment is available from the previous project. This budget will cover for maintenance.						
2.3	Drugs for 4 sites	D	4	1351	12	100.00%	64,848.00
	Please see the BoQ 2.3. All four clinics will be provisioned with essential medicines for the provision of primary healthcare services. The projection is calculated based on previous consumption data and the full list of medical procurement is included as an annex to the proposal.						
2.4	Fuel and Gas for 4 sites	S	4	72	12	100.00%	3,456.00
	Please see the BoQ 2.4. Fuel and gas is provided to ensure the maintenance of the cold chain for vaccine storage and the supply of power to the health facilities.						
2.5	Stationeries and basic furniture	S	4	50	12	100.00%	2,400.00
	Please see the BoQ 2.5. Stationary for correct stock, consumption, treatment, and patient records. Basic furniture such as tables, chairs, and cupboards for the storage of drugs and equipment.						
2.6	LHC meeting	D	1	60	12	100.00%	720.00
	Substantial community engagement is required to open and run these facilities, therefore a provision has been made to host Local Health Committee meetings on a monthly basis. This is cost of refreshment (tea, biscuit etc) during the meetings.						

2.7	HMIS tools	D	1	539	1	100.00%	539.00
	Please see the BoQ 2.7. National standard HMIS tools, formats, and registers will be provided to each clinic to facilitate the collection and integration of data into the central HMIS.						
2.8	Staff theoretical and practical training	D	5	149	1	100.00%	745.00
	Please see the BoQ 2.8. Health facility staff will be trained on five key topics; HMIS practical usage; EPI and disease surveillance refresher training; Infection prevention; IYCF; and Management of drugs supply and rational prescription.						
	Section Total						75,628.00

3 **Equipment** *(please itemize costs of non-consumables to be purchased under the project)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost
3.1	Solar panels and batteries for refrigerators	D	4	4000	1	100.00%	16,000.00
	In order to reduce the environmental impact of the project and provide a longer-term, cost-effective solution for energy provision, PU-AMI will provide solar panels and battery systems to power the vaccine refrigerators in each of the four health facilities.						
	Section Total						16,000.00

4 **Contractual Services** *(please list works and services to be contracted under the project)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost
4.1	Stock rental Kabul/Kunar	D	1	400	6	100.00%	2,400.00
	A contribution is allocated to the rental cost of warehouse space in Kabul which will be used to store procured drugs and supplies for the health facilities. This will minimise exposure to the risk of supply chain difficulties by keeping stock in PU-AMI facilities rather than with suppliers.						
4.2	Vehicles costs Base (Kunar)	D	2	714.25	12	100.00%	17,142.00
	Two cars will be rented specifically for use during the implementation of the project. The vehicles will allow for the transportation of vaccines, medical supplies, and equipment to the supported health facilities. They will also be used to conduct supervisions of the health facilities where possible and in order to transport project staff to project related meetings, for example LHC and community meetings. The vehicles will primarily be based in Kunar though also available to travel to other areas if required during project implementation.						
4.3	Transport of supplies and equipment	D	1	1518	1	100.00%	1,518.00
	A provision has been made for truck hire to transport of all supplies and equipment from Kabul or Jalalabad to Asadabad, and secondary transport to the health facilities.						
	Section Total						21,060.00

5 **Travel** *(please itemize travel costs of staff, consultants and other personnel for project implementation)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost
5.1	Transportation Expatriate Staff	S	2	513.75	2	100.00%	2,055.00
	An allowance has been made for the travel costs of expatriate support staff abroad and inside the country of origin which includes the flight cost, visa fees, and hotel should it be necessary. This allowance is made for the Logistics Coordinator and Grants Officer who are key staff responsible for the direct support of the project.						
5.2	Travel allowances for supervision	D	1	89	12	100.00%	1,068.00
	This is the per diem, transportation and accommodation for one supervisor costing USD 89.00 per month for 12 months, total cost USD 1,068.						
5.3	Directors meeting in Asadabad - Transportation	D	4	17	12	100.00%	816.00
	This cost comprises transportation for 4 Directors, costing USD 17 per month for 12 months for a meeting in Asadabad. Total cost is USD 816.00						
5.4	Directors meeting in Asadabad - accommodation	D	4	53	12	100.00%	2,544.00
	This cost comprises accommodation for 4 Directors, costing USD 53 per month for 12 months for a meeting in Asadabad. Total cost is USD 2,544.00						
	Section Total						6,483.00

6 **Transfers and Grants to Counterparts** *(please list transfers and sub-grants to project implementing partners)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost
	Section Total						0.00

7 **General Operating and Other Direct Costs** *(please include general operating expenses and other direct costs for project implementation)*

Code	Budget Line Description	D / S	Unit Quantity	Unit Cost	Duration	Percent Charged to CHF / ERF	Total Cost
7.1	Running and Heating costs	D	4	81	12	100.00%	3,888.00
	Additional fuel cost is provisioned through the winter months. Running costs include the purchase of hygiene and cleaning materials to maintain appropriate standards of cleanliness. Running cost for 4 sites = USD 3,000 and Heating cost for 4 sites = USD 888						
7.2	KBL Office and Guest House rental fee	S	1	6645.7	1	100.00%	6,645.70
	Office rental cost for the Coordination Office in Kabul. The Kabul office cost is monthly USD 3,469 and the Kabul guest house monthly cost is USD 3,176.70						
7.3	KBL Office Running costs	S	2	350	2	100.00%	1,400.00
	Please see BoQ 7.3-Cost of utilities for Kabul office and Kabul Guest House for 2 months.						
7.4	OFFICE-Office Stationeries KBL	S	2	360	2	100.00%	1,440.00
	Please see BoQ 7.4. Cost of stationeries for Kabul office for 2 months.						
7.5	KBL Mobile phone	S	1	983	2	100.00%	1,966.00
	Cost of communication for Kabul office. This is staff communication cost (pre paid top up card) for 38 staff for two months						
7.6	KBL Internet	S	1	893	2	100.00%	1,786.00
	Cost of communication for Kabul office. This is the internet cost for the Kabul office and gust house 1 x 983 x 2 = USD 1786						
7.7	Administrative expenses (ACBAR, QUAMED, SAGA, SAGE…)	D	1	1479.03	1	100.00%	1,479.03
	Rental, communication costs, stationeries, furniture, Administrative fees. For ACBAR membership USD1,000, accounting software maintenance cost USD 479.03						
7.8	Office Support Cost (Kunar)	D	1	3295	2	100.00%	6,590.00
	Rental, communication costs, stationeries, furniture, heating cost. Office monthly rental us estimated USD 1,255 x 2 = USD 2,510, internet monthly fee = USD 620 x 2 = 1,240 x 2 = USD						

	2,480, office furniture = USD 200 x 2 = USD 400, heating cost: 300 liter x 1 USD = 300 x 2 = 600 USD, office stationary printing paper 15 ram x 20 = 300 USD x 2 = USD 600.						
7.9	Vehicles costs Coordination (Kabul)	D	1	643	3	100.00%	1,929.00
	As above, a contribution has been made towards the rental of the Kunar office and guesthouse, communication costs of mobile phones, satellite phone, and internet service, the general provision of stationary including paper and printer ink, as well as general running costs such as cleaning materials for the office and guest house. For Kabul office we estimate USD 643 per months for car rental for 3 months.						
	Section Total						27,123.73

Sub Total Direct Cost	285,046.73
Indirect Programme Support Cost *PSC rate (insert percentage, not to exceed 7 per cent)*	7%
Audit Cost *(For NGO, in percent)*	1.14754098360656%
PSC Amount	19,953.27

Quarterly Budget Details for PSC Amount

2015			**2016**		**Total**
Q2	Q3	Q4	Q1	Q2	
0.00	0.00	0.00	0.00	0.00	0.00

Total Fund Project Cost	305,000.00

Project Locations

Location	Estimated percentage of budget for each location	Beneficiary Men	Women	Boy	Girl	Total	Activity
Kunar -> Watapur	25					0	
Kunar -> Marawara	25					0	
Kunar -> Dara-e-Pech	25					0	
Kunar -> Nurgal	25					0	

Project Locations (first admin location where activities will be implemented. If the project is covering more than one State please indicate percentage per State)

DOCUMENTS

Document Description
1. final.xlsx
2. Implementation Plan PU AMI.pdf
3. NGO XXX Sample Beneficary breakdown CHF proposal CODE XXX.xlsx
4. CHF Afghanistan - Visibility and Communication Guidance.pdf
5. Remote Call Campaigns - Guidance Note for Partners - 22 Sept 14.pdf
6. HMIS BoQ for CHF Kunar.xlsx
7. PU-AMI Kunar Drugs BoQs with estimated cost.xlsx
8. PU-AMI Kunar Equipment BoQs with estimated cost.xlsx
9. Trainning BoQs.xlsx
10. Detail of activities or Implementation Plan.pdf
11. BoQ 1.11.xlsx
12. BoQ 2.2.xlsx
13. BoQ 2.3.xlsx
14. BoQ 2.4.xlsx
15. BoQ 2.7.xlsx
16. BoQ 2.8.xlsx
17. BoQ 7.3.xlsx
18. BoQ 7.4.xlsx