Project Proposal

Organization	WHO (World Health Organization)
Project Title	Emergency health services for displaced pop and returnees and trauma care enhanced in areas affected by disasters (natural and societal) with special focus on the needs of women and children
Fund Code	AFG-15/O580/SA1/H/UN/332

Cluster

Primary cluster	Sub cluster
HEALTH	None

Project Allocation	2015 1st CHF Standard Allocation / Call for Proposals	Allocation Category Type	
Project budget in US$	2,829,646.56	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

1.Respond to the needs of men women and children in areas affected by displacement, cross-border movements (IDPs, returnees and refugees) (cost shared with ECHO and USAID) through sub-contracting SHRDO for provision of basic health services in KIS 28 camps total beneficiaries 30393 (displaced people due to recent conflict and natural disaster and people from the local vulnerable communities) see attached proposal
2. Undertake the 2nd phase Health facility rationalization survey in additional 12 high risk provinces. The assessment will include physical verification of all facilities in targeted provinces. The health facility rationalization working group within the MoPH will play the role of coordinating body on behalf of the MoPH. Assessment team will be selected by the implementing organization in consultation of MoPH and WHO. The project aims to assess the rationality and proper distribution of BPHS health facilities as well to understand the level of HFs functionality in 12 high risk provinces. This survey should have an impact on new BPHS contracts, since decisions will be made on whether the facilities are operational and at which level, do they need to be upgraded or downgraded. Additionally it should also impact the 2016 HRP and strategic decisions made by the health cluster.
3. Support provision of life-saving trauma services in areas of active fighting with a high number of civilian casualties cost shared with USAID and ECHO
a. Train 30 surgeons (male/female) on trauma care and 100 CHC health staff on Basic Life support and training of 42 nurses on triage 2 persons each province 2 per hospital total 42 (training provided by EMERGENCY)
b. WHO to train Health Cluster partners (male/ female) on GBV in emergencies total 50 health staff for three days
c. Provision and preposition 10 Trauma kits A+B each kit caters for 100 surgeries to support access to trauma services
d. Monitoring visit to previously supported blood Banks under CHF 2014 (WHO/MoPH)
e. Undertake 5 Simulation exercises to test developed MCM plans in Herat, Faryab, Laghman, Khost, Kabul
4. Respond to public health threats (nationally) especially among displaced; vulnerable population with special focus on the needs of women, men and children. The main diseases to be addressed are ARI, pneumonia Diarrhea which usually target children 5 years of age ; (cost shared with ECHO and USAID)
5. Provision of kits targeting 851,500 persons through procurement of 150 Inter-agency emergency health kits (Basic) each for 3,000 pop for 1 months, 20 Inter-agency supplementary emergency health kit each for 10,000 pop, 20 Diarrheal disease kit each kit for 700 Diarrhea cases 250 Acute respiratory Infection kit A+B and Miscellaneous drugs (incl trauma care PHC level, lab reagents and medicines) Lump Sum 100,000. The kits should cater for the different needs of men./ women / boys and girls.
6. Refresher training of 380 health staff (men/women) ; training 100 members of the EPR team at provincial level), 60 health staff on outbreak investigation and response, 100 on Diarrhea and ARI guideline, 120 on infection prevention and control and health care waste management at facility level at provincial and district hospitals. (conducted by WHO)
7. Undertake community awareness campaigns (addressing different needs) including developing printing and distribution of health education material targeting vulnerable population affected by natural disasters and public health outbreaks (5 high risk provinces for floods and earthquakes and measles outbreaks).(cost shared with USAID) the messages and mode of communication will be tailored to the needs of men/ women and even children.
8. Providing technical and logistical support to 50 disease outbreak investigation response. The investigation teams will devise special response plans that addresses the different vulnerabilities

Direct beneficiaries

	Men	Women	Boys	Girls	Total
Beneficiary Summary	346649	360267	86546	90033	**883,495**
Total beneficiaries include the following:					
Internally Displaced People	11914	12400	2979	3100	30393
Other	334268	347732	83567	86933	852500
Other	400	202	0	0	602

Indirect Beneficiaries	The direct beneficiaries include 1- Those served by SHRDO clinic 30393 people. 2- those that will benefit from the kits and supplies around 852,500 3- around 602 will receive formal training	Catchment Population	The indirect beneficiaries will be the catchment population of that area families attending to patients in their household. Hence it would be the direct pop X 7 (which is average family members in Afghanistan) The capacity building activities will contribute towards sustaining the gains of the project even after the cessation of the project.

Link with the Allocation Strategy

The proposal focuses on addressing the most acute lifesaving needs, with the aim of preventing avoidable deaths and morbidity for communities impacted by conflict (internal and external) and natural disasters. The project is in line with the 3 health sector Strategic priorities responding to the health needs of vulnerable population in areas affected by mass displacement, Provision of life-saving trauma services and Responding to public health threats. And it's in line with the Health sector specific objectives As per the recent reports of HMIS the current BPHS is covering around 65% of the country, while the remaining 35% are living in areas of conflict or inaccessible . WHO is proposing to support SHRDO in KIS which is providing access to around 30393 individual in KIS, SHRDO is not a BPHS implementer, and the camp has been receiving displaced families from Helmand and other conflict areas. SHRDO is currently funded under WHO to support these camps, hence, this is a continuation of its activities in KIS In 2014 the HMIS reported a 27% increase in number of war wounded and killed casualties some of the main reasons for the increase in number of deaths are lack of skilled personnel, supplies and equipment, and inadequate availability of trauma care and referral services. Through this proposal WHO is aiming to raise the capacity of health workers starting from the Community supported by ECHO (First aid , stabilization , referral services) to Health facility level CHCs and surgeons (trauma care) to be supported by this proposal. Mass Casualty plans have been developed for 13 provinces and in two months additional 5 provinces will be ready. These plans are being tested and adjusted accordingly through simulation exercises (2 completed in Jalal Abad and Wardak). To ensure timely response to trauma, kits and supplies will have to be prepositioned hence the provision of supplementary kits and trauma kits. Other major gap identified was the inadequacy of provincial blood banks. Using ECHO 2014 and CHF 2014 funding 8 BB will be fully equipped and 14 received supplies and more than 136 staff has been trained. Under CHF 2015 we are requesting support for monitoring and follow up of the work implemented in the provinces in supported BB. The training, and procurement and support to BBs will contribute towards the implementation of the MCM plans in targeted provinces. It is estimated that half a million children are dying of preventable diseases such as Acute Diarrhoea affects nearly 1.7 million and acute respiratory infection some 750,000 children under 5 years per year. To ensure timely response to outbreaks, kits and supplies will be prepositioned at provincial level, refresher trainings will be conducted (due to high turnover of staff) . Health promotion packages (standard) has been developed for health under CHF 2014, Hence, in 2015 proposal this package will be used in the HE campaigns to change health seeking behaviors, and some key messages will also target the head of the families and the females. Hence, the trainings, provision of kits, and the health education campaigns in areas affected by disasters will contribute towards timely response to emergencies. Undertake the HFR survey which is in line with the 4th strategic allocation priority support collection of high quality data accurate and relevant evidence" this is to inform and support effective humanitarian response and enable ethical and accountable use of limited resources Data availed will be used for HNO HRP 2015 planning process.

Sub-Grants to Implementing Partners

Partner Name	Partner Type	Budget in US$
SHRDO	National NGO	320,000.00

Other funding Secured For the Same Project (to date)

Source	US$
ECHO	2,500,000.00
USAID	2,000,000.00

Consultancy Firm for HFR	Private Contractor	300,000.00
		620,000.00

4,500,000.00

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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	As per recent MoPH reports, BPHS is covering around 65% of the population, while the remaining 35% are living mainly in insecure areas or areas with difficult terrain. Conflict continued unabated in 2014, expanding and changing in its nature as power struggles between state and non-state armed actors intensified and military power transitioned from international to national control. The conflict in Afghanistan has killed and injured an estimated 43,953 civilian children, women and men in 2014 It is also estimated that there is at least a 27% increase in the number of weapon wounded and killed cases in 2014 as compared to 2013. An additional 225 000 people fled to Afghanistan following the start of military operations in Pakistan's North Waziristan Agency. An overall increase of 12 % percent was registered for war-wounded casualty during this year in EMERGENCY facilities. In the past two month October and November an increase was registered in patient admitted for war injuries; + 19% in October and + 25% in November. This increase is registered mostly in Kabul hospital in November were the percentage reach + 40%. Kabul Informal settlement is an area of displacement that has received new displaced pop during the last few months from Helmand conflict. These camps are not supported by BPHS and the designated partner is serving more than 40525 (annually) displaced and host communities in these camps out of which more than 4000 will be women at child bearing age and will benefit from ANC... For support to trauma care especially in the area of building capacities, provinces targeted for Basic Life Support are inline with CHF alloc strategy Farah, Faryab, Ghazni, Helmand, Kabul, Kapisa, Khost, Kunar, Laghman, Logar, Nangarhar, Paktia, Paktika, Uruzgan, and Wardak which included around 36,485 casualties in 2014 (around 84% of total casualties). While for trauma care we will train health staff working in areas affected by conflict displacement, areas of returnees Badakshan, badghis- Eligible province HSP 1 charasyab, saroubi , karabagh, Faryab-Eligible provinces HSP2 -Herat, Nimroz, Zabul, Daikundi, Bamyan, Ghor and Kunduz (area of returnees) are additionally identified areas to train since they are areas of conflict, areas affected by natural disasters (28% of total war wounded casualties are in t6hese provinces additionally more than 650,000 are in critical need (HNO 2015) out of which more than 300,000 are women). In 2014 there were 249 outbreaks (66 died (80% measles)) reported by the system this is 25% higher than the 189 outbreaks recorded in 2013 from which 41 people died and 24% of events were measles). The major outbreaks in 2014 included measles (132 outbreaks with 1947 cases and CFR of 2.7%), CCHF (42), Pertussis (18). Measles outbreaks pose a major threat to public health system in Afghanistan. To maintain the measles case fatality rate under the international standard of 5% and cholera CFR at 0 surveillance, timely investigation and response is critical. To address water borne diseases training and capacity building activities, distributing of IEC material and per-positioning of kits will be important High quality, accurate and reliable data for evidence-based planning remains a challenge due to limited real time country-wide field assessments. This is partly due to restricted physical access, erratic population movements, insecurity and limited partner capacity and resources. As a result, the analysis of needs and gaps for the Humanitarian Needs Overview of the HRP 2015 relied heavily on secondary data which are out of date and are not necessarily reflective of the humanitarian situation. Systematic assessments and monitoring is essential to enable comparison of results and understand changes in needs over time. Good quality data is vital to inform and support effective humanitarian response and enable ethical and accountable use of limited resources.
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)	For KIS People living in these camp like settlements are displaced from Helmand, Zabul, Urozgan, Kandahar Nangarhar,Laghman, Kapisa, Parwan Herat, Ghazni, Balkh , Bamyan and Kabul provinces. And recently more than hundred families displaced from Helmand Sangin district and are allocated in Poli Company and Poli Shina living as IDP. The targeted camps are located away from any type of public health facilities and the IDPs cannot afford private health services and even they cannot afford to pay transportation to see public health facilities. Women and children do not have chance to see health care provider in the camps most of the pregnant women delivering their babies under the tent or mud houses which is not safe for both infant and mother, the complication of delivery is high enough in the KIS sites. The living conditions in the targeted camps are very poor, mud houses covered with plastic sheets, or shelters made only from plastic sheets: there is no sanitation system, and the access to potable water is very limited. Men are earning their living as daily workes (around 0.35 $/day), keeping animals, garbage collection, and bird- cages selling. Most of the families of 5-6 people are living on an income less than 1-2 US dollar/day. More than 65% of the registered morbidities are infectious communicable diseases such as ARI , AWD, mother and child diseases skin and eye infections related to poor hygiene, nutrition and living conditions. The living conditions combined with poor access to basic health care, and of any preventive health interventions put the IDPs as well as the surrounding host communities at a high risk of communicable diseases outbreak. Children and Pregnant/ Lactating women are the most under risk groups. There is no public health facility close to the camps, and the IDPs can't afford to attend private clinics or the transport fees, The access to essential PHC services is ensured through temporary static clinics (tented). In the area of trauma care – several mechanisms are being used to monitor the situation on the ground the first is HMIS reporting and this is further corroborated by reports received from partners such as EMERGENCY and other. It is well known that there is inadequate capacity in dealing with mass casualties and trauma which is also mentioned in the HNO 2015. While availability of service is scarce, the availability of skilled health cadre was also seen as one of the main reasons for the high mortality among war casualties – wrong practices before and during referral of patients and after admission to emergency ward in the hospitals. Hence, strengthening national capacities in the area of trauma, basic life support , triage will contribute towards a higher survival rate among war wounded cases . It is estimated using DEWS data and HMIS report for 2014 that Half a million children dying of preventable diseases annually. Additionally, acute diarrhoea affects nearly 1.7 million and acute respiratory infection some 750,000 children under 5 years per year. Simple, appropriate and inexpensive treatments can significantly reduce both conditions and the associated excess mortality among children in Afghanistan. Hence support to diseases outbreaks, and provision of supplies and trainings will contribute towards early identification and response to outbreaks. In totality last year we had over 180 The supply procured through the support from CHF will towards the total need identified through the health cluster based on historical data winter and spring contingency plans) the procured kits will cater for around 852,500 million pop (38% of the needs are going to be covered by this allocation) WHO will receive funding from USAID and ECHO and the remaining will be financed by these two donors.
3. Description Of Beneficiaries	For SHRDO the beneficiaries are those that will directly benefit from the clinics. In KIS they are the displaced and host communities residing in the 28 locations served by the 7 mobile health teams for 9 months. For remaining 3 months this will be supported by USAID funding through WHO. All beneficiary figures are calculated based on historical annual (adjusted for 9 months) data of these clinics. 30393 displaced people due to recent conflict and natural disaster andpeople from the local vulnerable communities60% of target population are women/children . For trainings this is based on the required qualification per training. For example for trauma care its surgeons, for Basic life support its medical staff, for triage its nurses and for GBV its health providers and community health workers. Other trainings such as those targeting EPR teams will include staff from provincial health office and NGOs. Training on Public health guidelines and outbreak investigation, RAF, Infection control and health care waste management will target health providers working in areas affected by conflict, natural disasters and disease outbreaks. For prepositioning of kits; it will serve areas affected by conflict or areas historically affected by natural disasters and disease outbreaks. The kits will serve the general pop and will focus on areas of displacement, returnees and disease outbreaks. Special consideration to the needs of women and children will be undertaken. Diarrhea and ARI usually are killer diseases for children and pregnant women if not treated more than ½ million children die annually due to simple preventable diseases. The kits will cater for the needs of the men and the women, those affected by conflict make use of trauma care and those affected by diseases will utilize the basic health kits and misc drugs. While Health education campaigns will target provinces affected by conflict, natural disasters and displacement. The campaigns will have special sessions targeting women, and elders, and community leaders. The main beneficiaries for the HFR are the health facilities that will be assessed around 1000 Health facilities (all health facilities, excluding EPHS and private, these provinces selected are based in conflict zones, high numbers of trauma cases, mass casualty and availability of funds. Summary of beneficiaries: 1- SHRDO contracts – 40525 pop and all segments of the pop will benefit (men/women and children) 2- Training – this will include on adults and with special qualification 602 will be trained 3- Procurement of supplies and kits 852,500 will benefit 4- Community awareness campaigns- although not included in the beneficiaries but we anticipate that 5% of pop in the province using different channels like mass media, print material, mass gatherings, meetings and group discussions will benefit from this tool . Special messages will be developed for women and will be delivered by female CHW through small groups meetings and house visits, social gatherings.
4. Grant Request Justification.	-KIS is an area of displacement & has recently received new families as a result for the most recent ongoing conflict in Helmand. SHRDO is not eligible for CHF funding and is not part of the BPHS / EPHS system. Additionally Kabul is part of the CHF allocation strategy. As per recent report of UNHCR , Kabul is among the top 5 destination of returnees, in addition to the fact that KIS is receiving many displaced pop from Helmand. SHRDO have been previously subcontracted by WHO and have been providing good services. -For trauma care, the main objective is to ensure availability of skilled personnel that could deal effectively with trauma to build the capacity starting from the community until we reach the highest level of health skilled cadre (surgeons) the provinces selected are those that have high level of casualties in 2014 and low coverage by skilled health staff (HNO 2015). This is a continuation of capacity building activities initiated in 2014 in the area of trauma care. By the end of 2015 and with the additional support from USAID 2015 all provinces will have trained staff to deal with mass casualty. The Gender based violence training will target all active 34 health Partners in order to ensure awareness and sensitivity to the different needs of vulnerable population especially those affected by conflict or natural disasters. The pre-positioning of trauma kits supplies will target areas of emergencies based on historical data for pre-positioning and based on need in response to natural and societal hazards. Around 602 health staff will receive training (different topics and staff categories), these staff will acquire new skills in dealing with trauma and mass casualty and will receive refresher training on communicable disease control and prevention. -For public health interventions, all trainings will target provinces affected by disease outbreaks in 2014 addressing the most prominent diseases - such as cholera in Badakshan, Pkatika, Ghazni, Kandahar, measles in Jalalabad, Heart, Ghor, Badghis, Zabul and Helmand, Paktika, Nouristan, CCHF in Heart and Kandahar, Brucellosis in Hirat, Typhoid in Badakshan - that affect the vulnerable segment of the pop mothers and children. Pre-positioning of kits (benefiting around 851,500 men/ woman and children) will be based on historical data and provincial plans (developed by EPR committees) and respond to needs if disease outbreaks occur. Pre-positioning will be done in high-risk provinces with NGOs, PHDs and WHO regional offices. Health awareness campaigns will focus on areas affected by disease outbreaks historically. Cost shared with USAID. -Despite increasing number of HFs under BPHS still around 40% of population is left out of access to basic services Insecurity is one of the major challenges that not only negatively affect the access of people to HFs, but also the health personnel are often unable to reach areas of the country where the need for care is high and the ability to provide the health services is low. The survey of health facilities allows validation of facility functionality assessment as to the level of services being provided and estimation of population coverage to feed into the HNO and HRP 2015
5. Complementarity. Explain how the project will complement previous or ongoing projects/activities implemented by your organization.	This project is a continuation of what we have been implementing in 2014 the BLS, triage and trauma care trainings which were supported in 2014 will continue to be supported under this proposal in different high risk provinces, additionally due to high turnover of staff in some specific provinces new staff will be trained (request from IMC to train new staff in their hospital). Additionally this proposal is complimented with activities implemented under other donors funding see annex 1especially in the following areas 1- Support access to PHC services in areas affected by conflict or PH risks 2- Identification and reporting of disease outbreaks through support to EPR committees 3- Provision of kits and supplies 4- Capacity building activities especially those targeting trauma care starting from the community till we reach the high level of health professionals

	5- For public health, WHO has been building national capacity in the area of identification and responding to public health risks of international concern. These activities will continue throughout 2015 -16. 6- Monitoring activities especially those targeting blood banks – since the blood banks were heavily supported in 2014 with equipment and supplies (using ECHO and CHF funding) this year the main activity will be monitoring their performance and quality of service provided. 7- Health education campaigns especially in emergency provinces

LOGICAL FRAMEWORK

Overall project objective	support access to trauma health care services through buidling health staff capacity

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	35
Objective 2. Reduce mortality and disability due to conflict through provision of timely access to effective trauma care	2. Conflict related deaths and impairment reduced	35
Objective 3. Timely (within 48-72hrs) identification and response initiated to emergencies and public health risks	3. Timely response to affected populations	30

Outcome 1	Men, women and children living in areas affected by mass displacement and or cross-border movements (IDPs, returnees and refugees) have access to basic emergency services.	
Code	**Description**	**Assumptions & Risks**
Output 1.1	Ensure availability of emergency health service through partners working in targeted areas taking into consideration the needs of women, men and children during planning and delivery of service.	assuming that the current displaced population will remain in KIS for 2015 risk - security situation deteriorates which will prevent access to the 28 camps

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 1.1.1	HEALTH	% of children < 2 vaccinated with Penta 3					80
	Means of Verification:	>80% overall Vaccination coverage in project locations in KIS Baseline will be provided at outset and results will be verified during and at the end of the project implementation					
Indicator 1.1.2	HEALTH	Number of facilities where functionality survey undertaken					1000
	Means of Verification:	WHO and MoPH reports results verified during and at the end of the project					
Indicator 1.1.3	HEALTH	% of women coverage with 2 ANC visits per pregnancy					80
	Means of Verification:	NGO reports for KIS sites only Baseline provided and target will be verified during and at the end of the project implementation					
Indicator 1.1.4	HEALTH	Number of consultation per beneficiary per year					30393
	Means of Verification:	NGOs reports taking into consideration that this is a 9 months contract - target is 1 Baseline provided at outset, targets will be verified during and at the end of the project implementation					
Indicator 1.1.5	HEALTH	Report of survey completed and disseminated					1
	Means of Verification:	WHO records results verified during and at the end of the project					

Activities

Activity 1.1.1	Subcontract SHRDO for provision of basic health services in Kabul Informal settlements in 28 camps total beneficiaries 30393 displaced people due to recent conflict and natural disaster and people from the local vulnerable communities This camp has received around 2,200 person recently (displaced from areas such as Helmand and others)
Activity 1.1.2	Undertake Health Facility Functionality/ rationality Survey in 12 high risk provinces (phase 2). Data collected from 12 high risk provinces from all health facilities except EPHS and private clinics that would validate facilities functionality and level of services provided
Activity 1.1.3	Support field Monitoring teams (MoPH and WHO) for monitoring and validation of HFR survey results.

Outcome 2	Men, women and children living in areas of active fighting and high number of civilian casualties have access to life-saving trauma services	
Code	**Description**	**Assumptions & Risks**
Output 2.1	Support access to trauma care and basic life support in areas with active fighting and high number of casualties taking into consideration the diverse needs of men/women and children during planning and implementation of activities.	The assumption is that there will be enough skilled staff willing to undertake all these trainings we are also assuming if we consider the mahram - women will also participate equally in the trainings. risk - security situation deteriorates and staff cannot leave their posts to attend a training.

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 2.1.1	HEALTH	Number of health professionals receiving training in stabilization and management of war trauma					222
	Means of Verification:	WHO / NGOs records - 172 for trauma care and 50 GBV verification will be done during and at the end of the project implementation					
Indicator 2.1.2	HEALTH	Emergency kits procured and pre-positioned in targeted provinces					100
	Means of Verification:	WHO record. NGO / MoPH reports target is 100 % will be verified during and at the end of the project implementation					

Indicator 2.1.3	HEALTH	% of voluntary blood donation in targeted blood banks					51
	Means of Verification:	HMIS reports and WHO records Will be verified during and at the end of the project implementation. WHO encourage voluntary blood donation to ensure blood safety. Additionally the higher % indicates friendliness of facility, trust of community. the current national baseline is 41% and the target is 51% in targeted provinces. By increasing the % we are contributing to enhanced access to safe blood during emergencies.					
Indicator 2.1.4	HEALTH	Simulation exercises conducted					5
	Means of Verification:	WHO and NGOs records will be verified during and at the end of the project implementation					

Activities

Activity 2.1.1	Training of 172 health staff in the area of trauma care as follows Training of 30 surgeons on trauma care. The training will be conducted by EMERGENCY while all administrative procedures will be conducted by WHO. This is a 16 days training usually targets surgeons working in hospitals. Targeted provinces are also part of the Mass casualty management plans which are being developed with support of ECHO and CHF 2014 standard allocation. This is a continuation of trainings conducted under CHF 2014 WHO proposal. To-date 161 surgeon have been trained and to support the implementation of the MCM plans additional surgeon should be trained to support access to quality trauma services at hospital level. Hence we are planning to train 3 surgeons from each province Kunduz, faryab, herat, badghis, charasyab, saroubi , karabagh, badakshan, nimroz, zabul, daikundi, bamyan, ghor.and charasyab, saroubi , karabagh districts of Kabul province . Train 100 medical staff working in CHC on Basic Life support. The training will be conducted by EMERGENCY while all administrative procedures will be conducted by WHO. this training includes (triage, stabilization and referral) we will target 1 persons from each CHC targeting 100 CHC in Farah, Faryab, Ghazni, Helmand, Kabul, Kapisa, Khost, Kunar, Laghman, Logar, Nangarhar, Paktia, Paktika, Uruzgan, and Wardak; . This activity is cost shared with USAID. While ECHO funding will be used to train Community health supervisors on First Aid. By doing that we will have skills at different level enhanced (starting from community till we reach the surgeons) which should contribute to the reduction in morbidity and mortality due to trauma. Train 42 nurses on Triage training. the training will be conducted by EMERGENCY while all administrative procedures will be undertaken by WHO the training is for one week participants will be from 21 provinces 2 per hospital (thirteen provinces have been included in CHF 2014 funding) Badghis, Badakshan, Baghlan, Daikundi, Faruyab, Ghor, Herat, Jawzgan, Kapisa, Kunduz, Balkh, Nimroz, Uruzgan, Panjsher, parwan, Samangan, Saripul, Takhar , Zabul.
Activity 2.1.2	Training of Health Cluster partners on Gender Based Violence in emergencies total 50 persons for three days this will be cost shared with USAID funding . Funding. the target are the 34 active health cluster partners, 3 per agency this training will be conducted by WHO staff
Activity 2.1.3	Procurement of Emergency Trauma kits A+B quantity 10 kits (each kit for 100 surgeries)- these kits will be pre-positioned in WHO regional warehouses targeting areas of conflict to support trauma care and mass casualty management
Activity 2.1.4	Monitoring visit to previously supported blood Banks (WHO/MoPH) this activity is to monitor and follow up on the 2014 investment in these blood banks. Trainings have been completed, equipment will be in place, hence under this budget line we are recommending regular missions and evaluation (using an approved checklist) on the facility operation. See attached document
Activity 2.1.5	Support the implementation of 5 simulation exercises in 5 provinces to test the Mass Casualty plans developed under CHF 2014-15

Outcome 3	Response to public health emergencies /hazards enhanced especially among conflict affected, displaced and vulnerable pop with special consideration for the diverse needs of men, women and children.	
Code	**Description**	**Assumptions & Risks**
Output 3.1	All public health threats are identified , and if above emergency threshold then response initiated within 48-72 hours	Assuming that telephone lines- mobile work to report tehthe outbreak. the risk is that security situation doesn't allow access to the area to investigate the outbreak

Indicators

Code	Cluster	Indicator	End Cycle Beneficiaries				End-Cycle Target
			Men	Women	Boys	Girls	
Indicator 3.1.1	HEALTH	% of outbreak alarms investigated within 48 hours from notification					100
	Means of Verification:	DEWS report, NGOs reports will be verified during and at the end of the project implementation					
Indicator 3.1.2	HEALTH	Case fatality rate during epidemics are maintained within internationally agreed standards Cholera <1% measles <5%					5
	Means of Verification:	DEWS and HMIS reports will be verified during and at the end of the project implementation					
Indicator 3.1.3	HEALTH	All kits procured before floods and winter seasons target 100%					100
	Means of Verification:	WHO records , NGOs and MOPH reports will be verified during and at the end of the project implementation					
Indicator 3.1.4	HEALTH	Number of disease outbreaks responded to in a timely manner					50
	Means of Verification:	WHO records and EPR committee reports in 2014 we had 247 outbreaks out of which 60% was measles and we responded to them - hence under CHF we will respond to 50 outbreaks and the remaining if needed will be supported through USAID and ECHO funding will be verified during and at the end of the project implementation					
Indicator 3.1.5	HEALTH	Number of staff trained in the area of Emergency preparedness and response Health Care Waste Management, Infection control, CD outbreak investigation, Diarrhea and ARI guidelines					380
	Means of Verification:	WHO records. MoPH and NGO reports will be verified during and at the end of the project implementation					
Indicator 3.1.6	HEALTH	All kits pre-positioned in targeted provinces before floods and winter seasons in targeted provinces					100
	Means of Verification:	WHO/NGO/MoPH reports will be verified during and at the end of the project implementation					

Activities

Activity 3.1.1	Provision and ore-positioning of; 150 of Inter agency emergency health kits (Basic) each for 3,000 pop for 1 months these kits are used to support emergency basic service delivery at BPHS level. 20 Inter agency supplementary emergency health kit each for 10,000 pop these kits include the equipment and supply part that is needed at BPHS level, 20 Diarrheal disease kit each kit for 700 Diarrhea cases 250 Acute respiratory infection kit A+B (annex 1)

	Miscellaneous drugs (these supplies usually compensate for the gaps in the above kits especially pediatric medicines and additional items needed for trauma care (annex 1)
Activity 3.1.2	Conduct refresher training for 260 staff in the area of public health (by WHO and cost shared with USAID) EPR team at provincial level targeting 100 staff targeting 20 high risk provinces (5 per province) this training will focus on the members of the EPR committee at provincial level (includes DEWS staff, CDC, BPHS/EPHS implementers) topics discussed is Hazard, risk and vulnerability assessment at provincial level, Response mechanisms, Information management and early warning systems, Resource mapping and mobilization, Community-Based disaster preparedness initiatives including rescue, evacuation and first aid. (training conducted by WHO staff Conduct training of DEWS and CDC officers at provincial level on communicable disease outbreak investigation and response, Qty 60 refresher training are needed for those who participated last year in these capacity building activities . Additionally due to high turnover in staff there is a need to train new comers at provincial level. Conduct refresher training on the use of the recently developed Diarrhea and ARI guideline (100 staff). Refresher training is needed for those who participated last year in these capacity building activities. Additionally due to high turnover in staff there is a need to train new comers at provincial level.
Activity 3.1.3	Conduct training on health care waste management HCWM for all cluster members (34 active members) and Infection prevention control at PH and DH level, quantity 120 staff. HCWM training is important in order to increase partners' awareness on correct mechanisms of waste disposal in their facilities. Additionally same staff will be also trained on infection prevention and control in the facilities they are currently supporting which will contribute towards a decrease in acquired infection in hospitals, hence should also contribute to the reduction in morbidity and mortality at facility level.
Activity 3.1.4	Community awareness and health education sessions/ campaigns including printing and distribution of health education material targeting vulnerable population affected by natural disasters and public health outbreaks (5 high risk provinces for floods and earthquakes and measles outbreaks) this activity is cost shared with USAID
Activity 3.1.5	Support 50 missions (EPR committees , DEWS officers, WHO) targeting areas of emergency and disease outbreaks investigation,response and monitoring

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 Subcontract SHRDO for provision of basic health services in Kabul Informal settlements in 28 camps total beneficiaries 30393 displaced people due to recent conflict and natural disaster and people from the local vulnerable communities This camp has received around 2,200 person recently (displaced from areas such as Helmand and others)	2015							X	X	X	X	X	X
	2016	X	X	X	X								
Activity 2.1.1 Training of 172 health staff in the area of trauma care as follows Training of 30 surgeons on trauma care. The training will be conducted by EMERGENCY while all administrative procedures will be conducted by WHO. This is a 16 days training usually targets surgeons working in hospitals. Targeted provinces are also part of the Mass casualty management plans which are being developed with support of ECHO and CHF 2014 standard allocation. This is a continuation of trainings conducted under CHF 2014 WHO proposal. To-date 161 surgeon have been trained and to support the implementation of the MCM plans additional surgeon should be trained to support access to quality trauma services at hospital level. Hence we are planning to train 3 surgeons from each province Kunduz, faryab, herat, badghis, charasyab, saroubi , karabagh, badakshan, nimroz, zabul, daikundi, bamyan, ghor.and charasyab, saroubi , karabagh districts of Kabul province . Train 100 medical staff working in CHC on Basic Life support. The training will be conducted by EMERGENCY while all administrative procedures will be conducted by WHO. this training includes (triage, stabilization and referral) we will target 1 persons from each CHC targeting 100 CHC in Farah, Faryab, Ghazni, Helmand, Kabul, Kapisa, Khost, Kunar, Laghman, Logar, Nangarhar, Paktia, Paktika, Uruzgan, and Wardak; . This activity is cost shared with USAID. While ECHO funding will be used to train Community health supervisors on First Aid. By doing that we will have skills at different level enhanced (starting from community till we reach the surgeons) which should contribute to the reduction in morbidity and mortality due to trauma. Train 42 nurses on Triage training. the training will be conducted by EMERGENCY while all administrative procedures will be undertaken by WHO the training is for one week participants will be from 21 provinces 2 per hospital (thirteen provinces have been included in CHF 2014 funding) Badghis, Badakshan, Baghlan, Daikundi, Faruyab, Ghor, Herat, Jawzgan, Kapisa, Kunduz, Balkh, Nimroz, Uruzgan, Panjsher, parwan, Samangan, Saripul, Takhar , Zabul.	2015							X	X	X	X	X	
	2016	X	X	X									
Activity 2.1.2 Training of Health Cluster partners on Gender Based Violence in emergencies total 50 persons for three days this will be cost shared with USAID funding . Funding. the target are the 34 active health cluster partners, 3 per agency this training will be conducted by WHO staff	2015							X	X	X			
	2016												
Activity 2.1.3 Procurement of Emergency Trauma kits A+B quantity 10 kits (each kit for 100 surgeries)- these kits will be pre-positioned in WHO regional warehouses targeting areas of conflict to support trauma care and mass casualty management	2015							X	X	X	X		
	2016		X	X									
Activity 2.1.4 Monitoring visit to previously supported blood Banks (WHO/MoPH) this activity is to monitor and follow up on the 2014 investment in these blood banks. Trainings have been completed, equipment will be in place, hence under this budget line we are recommending regular missions and evaluation (using an approved checklist) on the facility operation. See attached document	2015						X	X	X	X	X	X	X
	2016	X	X	X	X	X							
Activity 3.1.1 Provision and ore-positioning of; 150 of Inter agency emergency health kits (Basic) each for 3,000 pop for 1 months these kits are used to support emergency basic service delivery at BPHS level. 20 Inter agency supplementary emergency health kit each for 10,000 pop these kits include the equipment and supply part that is needed at BPHS level, 20 Diarrheal disease kit each kit for 700 Diarrhea cases 250 Acute respiratory infection kit A+B (annex 1) Miscellaneous drugs (these supplies usually compensate for the gaps in the above kits especially pediatric medicines and additional items needed for trauma care (annex 1)	2015							X	X	X	X		
	2016		X	X	X								
Activity 3.1.2 Conduct refresher training for 260 staff in the area of public health (by WHO and cost shared with USAID) EPR team at provincial level targeting 100 staff targeting 20 high risk provinces (5 per province) this training will focus on the members of the EPR committee at provincial level (includes DEWS staff, CDC, BPHS/EPHS implementers) topics discussed is Hazard, risk and vulnerability assessment at provincial level, Response mechanisms, Information management and early warning systems, Resource mapping and mobilization, Community-Based disaster preparedness initiatives including rescue, evacuation and first aid. (training conducted by WHO staff Conduct training of DEWS and CDC officers at provincial level on	2015							X	X	X	X		
	2016		X	X									

	communicable disease outbreak investigation and response, Qty 60 refresher training are needed for those who participated last year in these capacity building activities . Additionally due to high turnover in staff there is a need to train new comers at provincial level. Conduct refresher training on the use of the recently developed Diarrhea and ARI guideline (100 staff). Refresher training is needed for those who participated last year in these capacity building activities. Additionally due to high turnover in staff there is a need to train new comers at provincial level.													
	Activity 3.1.3 Conduct training on health care waste management HCWM for all cluster members (34 active members) and Infection prevention control at PH and DH level, quantity 120 staff. HCWM training is important in order to increase partners' awareness on correct mechanisms of waste disposal in their facilities. Additionally same staff will be also trained on infection prevention and control in the facilities they are currently supporting which will contribute towards a decrease in acquired infection in hospitals, hence should also contribute to the reduction in morbidity and mortality at facility level.	2015												
		2016	X	X	X	X								
	Activity 3.1.4 Community awareness and health education sessions/ campaigns including printing and distribution of health education material targeting vulnerable population affected by natural disasters and public health outbreaks (5 high risk provinces for floods and earthquakes and measles outbreaks) this activity is cost shared with USAID	2015								X	X			
		2016		X	X									
	Activity 3.1.5 Support 50 missions (EPR committees , DEWS officers, WHO) targeting areas of emergency and disease outbreaks investigation,response and monitoring	2015						X	X	X	X	X	X	X
		2016	X	X	X	X	X							
	Activity 2.1.5 Support the implementation of 5 simulation exercises in 5 provinces to test the Mass Casualty plans developed under CHF 2014-15	2015								X	X		X	X
		2016		X										
	Activity 1.1.2 Undertake Health Facility Functionality/ rationality Survey in 12 high risk provinces (phase 2). Data collected from 12 high risk provinces from all health facilities except EPHS and private clinics that would validate facilities functionality and level of services provided	2015							X	X	X	X	X	X
		2016												
	Activity 1.1.3 Support field Monitoring teams (MoPH and WHO) for monitoring and validation of HFR survey results.	2015							X	X	X	X	X	X
		2016												

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 .	• This proposal will be directly managed by WHO emergency unit in Kabul. Monitoring and reporting will be done from provincial level by WHO technical officers or the local health authorities. Monthly reporting of contracted NGO to a set of indicators agreed upon (inc those in the monitoring framework for HRP) reported and shared with PHCC and WHO (through email) • EPR committees will review DEWS weekly report, analyze the data and design action for any outbreak/disaster. They will ensure proper assessments are undertaken, assign a member to join the assessment team. The committee will coordinate health action and agreeing on strategies in response to emergency they will Identify of gaps in response and ensuring they are filled including restoring basic health functions (led by PHD). The committee will draft and share feedback to the district level health facilities in regards to performance through PHD and NGOs and monitor emergency situation and alert threshold. The committee will request support if the disaster is beyond the provincial capacity. • Trends will be identified especially using the DEWS weekly information which will report any increase in PH risks which will trigger an immediate action to investigate and respond. • WHO from Kabul and at regional level monitoring visits verify and or subcontract a partner to undertake monitoring visits in far outreach areas. WHO focal points wherever they are available to support and strengthen provincial / regional health cluster coordination • Procurement, distribution to all partners across the country, and monitoring of effective use of supplies will be done by WHO regional offices in collaboration with PHD. The feedback reports will be used to estimate number of population served and efficiently that was done. • Capacity building activities will be monitored by WHO and evaluated using appropriate reviews and feedback tools. Additionally future impact of trainings will also be assessed at a later stage. • Feedback from Partners, evaluation of output data, timeliness and completeness will be used to validate the project implementation. • Review action points arising from provincial health coordination committee, HMIS, EPR, EPI, and pharmaceutical subcommittees' meetings notes. • SHRDO will provide monthly reports on a set of indicators. All data provided will be disaggregated by age and gender

OTHER INFORMATION

Accountability to Affected Populations	The project is addressing access to health services in KIS- the pop selected do not have too many alternatives in terms of access to service delivery. SHRDO has been working these for a couple of years and his services are seen to be good and responsive to the needs of displaced population in the camp. For training the qualification of the health staff is what will determine him or her being selected for that training. All trainings have been previously discussed with MoPH and almost all partners – and they are in agreement for the need to undertake them in order to increase national capacity in responding to emergencies (natural and societal) All supplies procured will be used mainly for responding to unforeseen emergency as well as pre-positioning for floods and winter. The kits procured have been discussed with MoPH and also partners on the ground are aware that WHO can support them if an emergency arises that is above routine operations (supported by BPHS). The health education campaigns will target different needs of different people. Hence, for women and children – the best place to address them might be in social gatherings or in the health clinic. The type of message and mechanism of delivery should also match the culture and acceptance of local community. Hence Female health workers will be requested to provide these messages to females in the community and so on. The more specific the target pop for each mode of delivery the more efficient and effective the health message will be. Complaints are usually collected through the health cluster meetings or through field visits by WHO technical officers. These complaints if received will be processed using WHO rules and regulations for investigation and action. The project will focus on no harm policy such as preserving the environment from health waste from clinics supported.
Implementation Plan: Describe for each activity how you plan to implement it and who is carrying out what.	• • WHO works in close collaboration with the Ministry of Public Health and emergency NGOs, other UN agencies, bilateral agencies and Civil Society Organizations (CSO), providing technical, financial, and material assistance through its country and sub-offices . Through cluster coordination meetings and proximity to MoPH and strong working relation with health partners WHO is committed to avoid duplication and synergize the resources. WHO also will capitalize on the 3Ws tool which provides detailed information on who is doing what and where. This information will be verified by WHO regional and provincial offices with their partners on the ground. • WHO will subcontract SHRDO to provide health services in KIS. SHRDO will provide monthly update on a set of indicators. They also report to WHO and MoPH any alarming public health issue that could lead to an increase in mortality and morbidity. • Supervision is usually done through WHO regional and provincial offices in the field. But a monitoring plan (which will also be aligned with the accountability framework) will be developed. Partners will be familiarized with the indicators and method of reporting. • Some of the training activities will be done through EMERGENCY such as Triage, trauma care and BLS. Still all administrative procedures for these training will be undertaken by WHO. Other trainings such as GBV and all training related to PH and outbreak investigation will be conducted by WHO. The training will include health partners' staff in the selected provinces. The initial participation request usually is written by MoPH this is done in close coordination with partners on the ground in order not to affect their service delivery plan. • WHO staff will continue to support disease surveillance. DEWS reports are usually reported through sentinel sites/focal points from health facilities run by NGOs and BPHS implementer. DEWS system is a joint WHO/MOPH staff trained by WHO earlier. DEWS report for any outbreak is shared with WHO and MOPH to take actions for investigate and respond to this outbreak will include the province local authorities and the partner in the field. • For kits they will be procured through WHO HQ and these kits are usually delivered to Kabul main warehouse. WHO usually transfers these kits to the provinces and are usually pre-positioned at the PHD warehouse and WHO warehouses whenever available and in some cases with health partners especially in prep for winter. • The HFR survey this will be subcontracted , while a review committee has been developed under HFR phase 1 to monitor work implemented and provide the consultancy agency with timely feedback and comments
Coordination with other Organizations in project area	**Name of the organization** / **Areas/activities of collaboration and rationale** 1. SHRDO — Coordinate with them to provide services in KIS 2. Ministry of public health — Implemnttaion of DEWS, HMIS data collection reports, identification and response to public health risks, co-chairing Health cluster meetings

3. Provincial health director	Conduct provincial health meetings and plan response to emergencies.
4. Health cluster	Participate and contribute technically to the health cluster meeting
5. Nutrition cluster	Coordinate activities with nutrition cluster
6. Wash cluster	Coordinate activities with WASH cluster

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	This project will address gender in several areas 1- in health awareness campaigns - the type of messages and delivery mechanisms will be developed to ensure their full participation and understanding of these messages 2- In all training we will strive to ensure gender equality in terms of number of women participating - in case that Mahram is required for females to travel we will try to accommodate that. 3- All kits procured will address the needs of the most vulnerable population (men/ women and children) who have been affected by conflict and or displacement. 4- Female health workers will be recruited in all subcontracted facilities run by NGOs. 5- this project is supporting the operations of one maternity facility in area of conflict , this should contribute towards the reduction in maternal morbidity and mortality. 6- it was reported in HNO 2015 that more than 500 mil child dye due to preventable diseases, this project is focusing on the main diseases mentioned Acute diarrhoea which affects nearly 1.7 million and acute respiratory infection some 750,000 children under 5 years per year. Simple, appropriate and inexpensive treatments can significantly reduce both conditions and the associated excess mortality among children in Afghanistan. 7- In conflict areas women at child bearing age that might need EOC will also benefit from the availability of safe blood from the supported BB
Protection Mainstreaming	Subcontracted health facilities and mobile health teams will located in a safe area that is accessible to women. The dignity of women will be preserved through recruitment of female health workers to provide them with services. Awareness messages will be culturally sensitive as well as the mechanism selected for message transfer. The kits procured are standard WHO kits are of high quality – since global WHO procedures for procurement using a list or approved suppliers is adopted – and should not cause any harm. In case of any adverse effect WHO globally will ask country offices to withdraw a certain batch or brand from the supplied kits. All training and capacity building activities are based on vetted standard curriculum that was developed by WWHO/MoPH and Health partners, all messages delivered during training are standard messages that are in line with MoPH guidelines and should not pose any harm to patients in the field. This project initially ensure equal access to health services (men/women/ boys and girls) and educational material. The invitation to capacity building activities will includes females although this will be problematic in some cases there are no female working staff especially in emergency provinces (almost all DEWS officers are males except for one) or they don't like to travel without mahram, WHO will try to include a mahram in the invitation to encouraged
Safety and Security	Many of the areas that this project will target are insecure and inaccessible, still under public health international regulation IHR safety of pop and neighboring countries have to be addressed during any disease outbreak .WHO will maximize the opportunities that lie within the security management policies to take acceptable risks when warranted, and to use creative approaches to reduce risk. Additionally many of the public health threats are also coordinated with neighboring countries through WHO country offices, bulletins and sitreps shared and boarder operations (such as vaccination posts) are placed to protect displaced pop and host communities from public health risks. Moreover most of the kits distributed are pre-positioned in PHD and WHO regional offices, especially in emergency provinces. Hence, the risk of losing or stocks mismanagement is low. Supplies are distributed based on identified needs and assessments conducted and reports received. During monitoring missions, we will capitalize on the local knowledge and the local staff to ensure WHO staff safety and avoid putting them at risk. Some training will be conducted at provincial level / city center if security situation permits. Otherwise all training will be conducted in kabul. The Health facility rationalization survey trains local health staff to collect data on existing facilities. The data collection teams are usually equipped with letter from the MoPH and PHD and the governor that explain the objectives of the survey and expected outcomes
Access	This proposal is being implemented in areas affected by conflict or displacement . WHO is working in close collaboration with the Ministry of Public Health providing technical, financial, and material assistance through its national and regional offices in Kabul, Jalalabad, Gardez, Faizabad, Kunduz, Mazari Sharif, Bamyan, Kandahar and Herat. Hence, this proposal can be implemented due to WHO proximity of local and National health authority, historical knowledge and impartial relationships which are crucial at both the local and strategic level. For example polio program is being implemented by areas supported by Taliban or the current regime, although some accidents might occur but in general WHO is being perceived as an impartial and independent agency. Communication with Afghan communities and their leaders is essential to build a positive perception. Communities and humanitarian actors share an interest in identifying the people most in need of assistance and developing a contextually tailored programme design.

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	International emergency coordinator P5	D	1	25500	12	25.00%	76,500.00
	who will have the overall responsibility of project implementation, adherence to standards in all guidelines, SOP and messages generated. This officer will also monitor the quality of trainings undertaken in the field, will be responsible for reporting and ensuring complementarity with other ongoing projects implemented by WHO such as ECHO and USAID grants. He/she will ensure coordination with different partners and MoPH senior level engagement						
1.2	National emergency officer NPO	D	1	6600	12	50.00%	39,600.00
	National NOC public health officer (Using UN salary scale) that works closely with MoPH and the field, balance will be paid from other funding sources						
1.3	National project assistant	S	1	3000	12	40.00%	14,400.00
	Support all the admin and finance activities of the project at the level of NOB 6 months salary and allowances will be paid, balance will be paid from the other funding sources						
1.4	International Public Health officer P4	D	1	22500	12	27.00%	72,900.00
	International officer at P4 level as per UN salary scale , to provide technical support for all WHO activities to be implemented in Kabul and in the field. this includes public health related activities, Capacity building of national staffs on project related activities. Balance will be paid from other funding sources						
1.5	Program monitoring and reporting at HQ/RO P3 and G6	D	2	15000	12	20.00%	72,000.00
	One finance assistant 20% of his time (P3) and one technical officer 20% of his/her time (G6)						
1.6	National information management officer G6	S	1	2000	12	40.00%	9,600.00
	Support the project via collecting data related to the project activities (HMIS and DEWS) maintaining a tracking systems to follow up and monitor the implementation of HFR WHO SSA salary scale used						
	Section Total						285,000.00

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	Procure Emergency Trauma kits A+B	D	15	22861	1	70.00%	240,040.50
	These are standard WHO kits (composition is annexed)will be purchased through WHO procurement system (WHO standard catalogue prices). Each kit will cater for 100 surgical interventions during mass casualty and are distributed in areas with ongoing conflicts or upon request of partners if new emergencies arise. this is cost shared with ECHO						
2.2	Procure Inter agency emergency health kits (Basic)	D	250	500	1	70.00%	87,500.00
	These are standard WHO kits (composition is annexed)will be purchased through WHO procurement system (WHO standard catalogue prices) each kit should cater for 3000 pop for one months. This is cost shared with ECHO. these kits will be used at BHC or mobile health team to provide emergency basic services. these are usually pre-positioned in preparation of floods and winter, and or provided to NGOs who are working in white areas affected by emergencies , conflict or displacement						
2.3	Procure 20 Interagency supplementary emergency health kit	D	20	6600	1	100.00%	132,000.00

	These are standard WHO kits (composition is annexed)will be purchased through WHO procurement system (WHO standard catalogue prices). Each kit caters for 10,000 pop. this will ensure availability of supplies to be used at BHC level						
2.4	Procure Diarrheal disease kit	D	35	8612	1	70.00%	210,994.00
	These are standard WHO kits (composition is annexed)will be purchased through WHO procurement system (WHO standard catalogue prices)each kit for 700 Diarrhea cases. this is cost shared with ECHO, these kits are pre-positioned in prepration for winter and floods - since that is when the number of ARI and Diarrhea cases increase. the total annual need is for 35 kits kits but this is cost shared with ECHO and USAID						
2.5	Procure Acute respiratory infection kit A+B	D	350	780	1	60.00%	163,800.00
	These are standard WHO kits (composition is annexed)will be purchased through WHO procurement system (WHO standard catalogue prices) each kit supports treatment for 350 case. this is cost shared with ECHO these kits are pre-positioned in prepration for winter and floods - since that is when the number of ARI and Diarrhea cases increase. Total need 350 kits and this is cost shared with ECHO and USAID funding						
2.6	Miscellaneous drugs - list attached	D	2	100000	1	50.00%	100,000.00
	Essential drugs and supplies recommended for usage during emergencies and are short in supply in the above kits c will be purchased and prepositioned (list attached) cost based on 2014 prices.this is cost shared with ECHO						
2.7	Training of surgeon on trauma care to be conducted by EMERGENCY	D	70	100	16	45.00%	50,400.00
	This is a 16 days training, the cost of training one person is 100 USD per day this (Including venue, transportation, meals printing material materials) , cost of facilitators (national + international + translators) targeting two- three doctors from each province (11 provinces) this activity is cost shared with USAID This activity is cost shared total need is to train 70 while 30 will be trained under CHF and 40 will be funded by other sources						
2.8	Training on Basic Life Support for staff working at CHC level to be conducted by EMERGENCY	D	173	100	10	60.00%	103,800.00
	This is an 10 days training , that includes triage, stabilisation and referral of casualties;the cost of training one person is 100 USD per day this (Including venue, transportation, meals printing material materials) , cost of facilitators (national + international + translators) targeting 100 CHCs one person per facility. This activity is cost shared with USAID.total need is to train 173 . hence 100 will be trained from CHF and 73 from other sources						
2.9	Train nurses on Triage to be conducted by EMERGENCY	D	42	100	7	100.00%	29,400.00
	under CHF 2014 ; 13 provinces where addressed now under this proposal remaining 21 provinces will be supported with triage training. Two per province will be trained for 7 days . the cost of training one person is 100 USD per day this (Including venue, transportation, meals printing material materials) , cost of facilitators (national + international + translators)						
2.10	Training of health partners on Gender Based Violence awareness	D	100	100	3	50.00%	15,000.00
	this is a three days training of one or two staff per partner for 3 days - conducted by WHO the cost of training one person is 100 USD per day this (Including venue, transportation, meals printing material materials). this activity is cost shared with USAID funding. we have 34 partners and we estimated at least three from each agency (34*3 = unit quantity) will be trained but since this is cost shared with USAID (50%) hence only 50 will be trained under CHF						
2.11	Refresher training of EPR team	D	100	100	3	100.00%	30,000.00
	Refresher Training of 5 persons from EPR team for three days from each province targeting 20 provinces including training on RAF (cost shared with USAID) the cost of training one person is 100 USD per day this (Including venue, transportation, meals printing material materials)						
2.12	Refresher training of health staff on disease outbreak investigation	D	102	100	2	60.00%	12,240.00
	Refresher training on Outbreak investigation and response for two days on all main diseases this includes 1 person from NGO one person from PHD and one from DEWS surveillance office 3X20(cost shared with USAID) the aim is to train staff representing all 34 provinces.the cost of training one person is 100 USD per day this (Including venue, transportation, meals printing material materials) the aim is to train 60 under CHF and the remaining using other sources of funding						
2.13	Refresher training of health staff on PH guidelines	D	170	100	2	60.00%	20,400.00
	Refresher training on Diarrhea and ARI guideline focusing on prevention and control of diarrhea and ARI prone provinces such as kandahar, nanagrhar, paktika, ghazni, mazar, kunduz etc… 5 persons from each province(cost shared with USAID) the aim is to train representatives fro all 34 provinces.the cost of training one person is 100 USD per day this (Including venue, transportation, meals printing material materials) this activity is cost shared with ECHO and USAID.the target is to training 100 using CHF funding and remaining will be trained using other sources of funding						
2.14	Refresher training of health staff on HCWM and Infection prevention	D	170	100	6	70.00%	71,400.00
	Refresher training on HCWM and Infection prevention at provincial hospitals 20 provincial hospitals Total 6 persons per provinces - 5 days + 1 day for HCWM (cost shared with USAID the cost of training one person is 100 USD per day this (Including venue, transportation, meals printing material materials) this activity is cost shared with ECHO and USAID the target is to training 120 (70% of 170) using CHF funding and remaining will be trained using other sources of funding						
	Section Total						1,266,974.50

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
	Section Total						0.00

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	Subcontract one consultancy firm to undertake the HFR survey in 12 high risk provinces	D	12	25000	1	100.00%	300,000.00
	HPRO was subcontracted from phase one. WHO will look into the possibility of extending their current contract for phase 2 or else new bidding procedure will have to be undertaken it is not possible to provide specific break down for the work to be implemented since it needs to be competitively advertised,. still i am attaching the BOQ for first phase as an indicative document (HRF CN)						
	Section Total						300,000.00

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	Twelve Monitoring visit to the targetd provinces to monitor the implementation of HFR survey in the field	D	12	800	1	100.00%	9,600.00
	this includes one visit to each province hence in total 12 visit . each visit will include one or two staff and the cost will include air ticket fare if needed and transportation inside the provinces to the remote villages and perdiem						
5.2	Support 30 monitoring visist to supported Blood banks	D	68	350	1	45.00%	10,710.00
	support 30 monitoring visits to BB supported in 2014 (2 visits per province) in Farah, Faryab, Ghazni, Helmand, Kabul, Kapisa, Khost, Kunar, Laghman, Logar, Nangarhar, Paktia, Paktika, Uruzgan, and Wardak to ensure operationality and response to needs in areas of conflict were ancillary services is mostly needed these visits will include MoPH staff and WHO hence the cost will be perdiem of those traveling plus travel and logistic cost inside the province. the aim is to visit all 34 provinces twice a year. CHF will be supporting 15 provinces while remaining will be under ECHO and USAID . hence the unit is visit						
	Section Total						20,310.00

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
6.1	Sub-contract SHRDO to provide health services in KIS for 9 months	D	1	35555	9	100.00%	319,995.00
	SHRDO will provide health services in KIS through 7 Mobile Health Teams servicing 28 locations total pop 30393 the unit cost for Mobile health team per month is 5800 USD ; this includes health staff, referral services, and the running cost of the clinic. CHF will support the services for 9 months only. The remaining 3 months will be funded using other donors funding. Please see the SHRDO budget and concept note attached.						
6.2	Undertake 5 Community awareness campaigns	D	5	25000	1	81.00%	101,250.00
	Including printing and distribution of health education material targeting vulnerable population affected by natural disasters and public health outbreaks (5 high risk provinces for floods and earthquakes and measles outbreaks) this activity is cost shared with USAID which will cover the remaining costs. the campaign will focus on ARI, measles and Diarrhea . Key messages will be transmitted targeting different needs men/women and children. Under CHF we will target; Kandahar, Ghazni, Nangarhar, Paktika and Herat. Unit cost per campaign is approx. $25000 * 5 campaigns (recurrence) * 0.81 (share of CHF for 5 campaigns) BoQ attached.						
	Section Total						421,245.00

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	Operational cost for EPR team investigating assessing emergencies and public Health outbreaks	D	50	1000	1	100.00%	50,000.00
	EPR teams in all provinces have been trained (and will receive refresher training) on how to conduct assessment during emergencies especially those of public health risks.						
7.2	Transportation cost for drugs and supplies for kits and supplies procured under this project	D	1	90000	1	100.00%	90,000.00
	Transport to south, southeast, north and western regions which is usually 10% of the cost of the drugs for international and internal transportation cost plus Operational cost (clearance, handling, temporary storage and in-country distribution)						
7.3	WHO field operatoional cost	S	1	2000000	1	8.00%	160,000.00
	15% of the 8% is for operations, 15% of the 8% logistics, 30% of the 8% security cost, 30% of the 8% rental of offices in UNOCA and regions, 10% of the 8% communication the total amount needed is around 2.000,000 and we are covering 8% of the needs through this proposal: 24,000.00 = 15% of the 8% is for operations 24,000.00 = 15% of the 8% logistics 48,000.00 = 30% of the 8% security cost 48,000.00 = 30% of the 8% rental of offices in UNOCA and regions 16,000.00 = 10% of the 8% communication 160,000.00 = 8% of 2.000,000 requirements						
7.4	Implement 5 simulation excercises to test MCM plans	D	17	10000	1	30.00%	51,000.00
	Undertake simulation exercises in Herat, Faryab, Laghman, Khost, Kabul. these are provinces that the MCM plans are in place and they should be tested. by the end of May we will have 17 MCM plans ready. the cost includes the travel of WHO staff and operational cost in the field and its based on the cost spent in Jalalabad simulation exercise conducted in March 2015						
	Section Total						351,000.00

Sub Total Direct Cost	2,644,529.50
Indirect Programme Support Cost *PSC rate (insert percentage, not to exceed 7 per cent)*	7%
Audit Cost *(For NGO, in percent)*	
PSC Amount	185,117.07

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	2,829,646.57

Project Locations

Location	Estimated percentage of budget for each location	Beneficiary Men	Women	Boy	Girl	Total	Activity
Kabul	15	116841	121611	29210	30403	298065	
Kapisa	3	10206	10612	2547	2651	26016	
Parwan	1	6278	6525	1566	1630	15999	
Wardak	2	10195	10608	2547	2651	26001	
Logar	4	10247	10654	2557	2662	26120	
Nangarhar	5	18059	18780	4508	4692	46039	
Laghman	4	12777	13297	3194	3324	32592	
Panjsher	1	6278	6525	1566	1630	15999	
Baghlan	1	6279	6525	1566	1630	16000	
Bamyan	1	6281	6526	1566	1630	16003	
Ghazni	4	18055	18779	4508	4692	46034	
Paktya	3	10237	10650	2557	2662	26106	
Kunar	3	10198	10609	2547	2651	26005	
Nuristan	3	6264	6519	1566	1630	15979	
Badakhshan	3	6267	6520	1566	1630	15983	
Takhar	1	6279	6525	1566	1630	16000	
Kunduz	1	6279	6525	1566	1630	16000	
Balkh	1	6279	6525	1566	1630	16000	
Samangan	1	6278	6525	1566	1630	15999	
Sar-e-Pul	1	6278	6525	1566	1630	15999	
Ghor	1	6267	6520	1566	1630	15983	
Daykundi	1	6280	6526	1566	1630	16002	

Uruzgan	2	10235	10649	2557	2662	26103	
Zabul	1	6267	6520	1566	1630	15983	
Paktika	4	18041	18773	4508	4692	46014	
Khost	3	10196	10609	2547	2651	26003	
Jawzjan	1	6278	6525	1566	1630	15999	
Faryab	4	15134	15738	3778	3932	38582	
Badghis	3	6267	6520	1566	1630	15983	
Hirat	3	15715	16345	3924	4084	40068	
Farah	3	10235	10649	2557	2662	26103	
Hilmand	5	10235	10649	2557	2662	26103	
Kandahar	10	66249	68944	16558	17234	168985	
Nimroz	1	6279	6525	1566	1630	16000	

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

Admin Location1	Percentage
Kabul	15
Kapisa	3
Parwan	1
Wardak	2
Logar	4
Nangarhar	5
Laghman	4
Panjsher	1
Baghlan	1
Bamyan	1
Ghazni	4
Paktya	3
Kunar	3
Nuristan	3
Badakhshan	3
Takhar	1
Kunduz	1
Balkh	1
Samangan	1
Sar-e-Pul	1
Ghor	1
Daykundi	1
Uruzgan	2
Zabul	1
Paktika	4
Khost	3
Jawzjan	1
Faryab	4
Badghis	3
Hirat	3
Farah	3
Hilmand	5
Kandahar	10
Nimroz	1

DOCUMENTS

Document Description
1. Annex 1 activities distributed among donors.xlsx
2. Annex 2 Blood Bank Standards checklist.xls
3. Annex 3 CHC trainings 100 fcailities.xlsx
4. Annex 4 beneficiaries.xlsx
5. Annex 5 BB monitoring plan.xlsx
6. Annex 6 List of items in standard WHO kits.xls
7. Annex 7 Misc Loose Medicine.xlsx

8. Annex 8 HFR facilities 15-16.xlsx
9. Annex 3 CHC trainings 100 facilities.xlsx
10. Annex 4 beneficiaries new.xlsx
11. Annex 9 SHRDO BB new.xlsx
12. Annex 10 HFR CN new.docx
13. Annex 4 beneficiaries new v2.xlsx
14. Annex 11 9 Months Emergency Health Services in 28 DIP camps in Kabul June 2015 to 29 Feb 2016.doc
15. annex 12 BOQ community awarness.xls
16. Annex 4 beneficiaries and locations v3.xlsx
17. Annex 4 beneficiaries and locations v4.xlsx
18. Annex 4 beneficiaries and locations v 5.xlsx
19. BL 7 1 WHO ERP invest-Team cost Breakdown.xlsx