OCHA Coordination Saves Lives

Project Proposal

Requesting Organization :	The Terre des hommes Foundation
Allocation Type :	1st Standard Allocation

Primary Cluster	Sub Cluster	Percentage
PROTECTION	Child Protection in Emergencies	65.00
HEALTH		35.00
		100

Project Title :	Community-based Child Protection and Mother and Child Health for vulnerable populations in Nangarhar and Laghman Provinces - Isthema project 3
Allocation Type Category :	

OPS Details

Project Code :		**Fund Project Code :**	AFG-17/3481/1SA/APC-H/INGO/4985
Cluster :		**Project Budget in US$:**	719,215.74
Planned project duration :	12 months	**Priority:**	
Planned Start Date :	01/06/2017	**Planned End Date :**	31/05/2018
Actual Start Date:	01/06/2017	**Actual End Date:**	31/05/2018

Project Summary :	Since Dec. 2015, Tdh has been implementing a project called Ishtema (meaning “community” in Dari and Pashto languages) through CHF funding in Nangarhar, then in Nangarhar and Kunar and now Tdh will scale up its activities with this third phase proposed in highly affected by return, of Nangarhar and Laghman provinces. The project intends to strengthen the resilience of the most vulnerable returnees, IDPs and host community/conflict affected population in isolated areas of Nangarhar and Laghman by the end of May 2018 : by reducing vulnerabilities through access to information on CP, non- formal MRE, and RMNCH (prevention), by addressing specific needs through community delivered life-saving psycho-social services, direct provision of RMNCH care and case management system (protection) and by strengthening community based protection mechanisms of Community Based Child Protection Committee (CBCPC) and volunteers. In the area of intervention selected by Tdh, is contaminated by UXO, especially in Nangarhar. According to DMAC, approximately 70 incidents occurred due to mines in the eastern provinces in 2016. DMAC and Tdh will continue to train CBCPC on non-formal MRE (DMAC) and CPiE (Tdh). The CBCPC will deliver the training within their community in order to raise awareness and mitigate the risk of casualties and child protection concern. Daily basis life-saving PSS activities in the villages will be delivered to improving copying mechanism of children and to detect the most vulnerable children in need of further assistance. Tdh will provide case management and direct assistance for the most vulnerable families identified. Tdh RMNCH activities proposed are based on the successful and long term experience acquired in outreach experience Kabul Informal settlements. In the proposed project, Tdh’s midwife will carry out home to home visits, to identify pregnant and lactating women, to provide perinatal care, postnatal care, to prepare birth preparedness plan, and newborn care. They will encourage women to have safe delivery, and convince husband and family about the importance of accessing to Health service provider. Tdh midwives will advocate and support vaccination especially during the health education sessions based on material developed by MoPH. The topics will cover hygiene and sanitation, danger signs of pregnancy, childbirth and newborn, nutrition during pregnancy, breastfeeding. Tdh’s actions will help reduce the risk of mortality by better identification of the poorest, most vulnerable and conservative population and by diminishing the risk of delivery without skilled attendant. Tdh will work in close collaboration with WHO, MoPH, and the entire Health cluster member to ensure a smooth and efficient collaboration and continue to improve RMNCH and combat child and maternal mortality of the region. This 12-month project (from 1st June 2017 to 30th May 2018) will be implemented in the eastern provinces as follows: - In Nangarhar: Sukhod (10 villages), Behsud (10 villages), Kama (10 villages), Rodat (10 villages), KuzKunar (8 villages). - In Laghman: Qaraghayi (10 villages) and Mihtarlam (6 villages) In Nangarhar and Laghman, around 370,102 Afghan refugees (documented and undocumented) have been registered after they return from Pakistan, where conflict induced 39,300 IDPs in 2016 and where high presence of prolonged IDP were reported by the REACH report. Tdh will continue to target the most vulnerable among the vulnerable individuals (IDP, returnee and host community). The data collected during Ishtema activities will be shared with cluster and OCHA regularly and when relevant will be shared with other partner for further support for the area where Tdh intervene. The sustainability and relevancy of the proposed project will be reinforced by integrating lessons learned of the evaluation realized in Dec. 2016 by ATR consulting, and by continuing working and empowering a network of volunteers

Direct beneficiaries :

Men	Women	Boys	Girls	Total
1,309	5,863	2,500	2,500	12,172

Other Beneficiaries :

Beneficiary name	Men	Women	Boys	Girls	Total
Refugees	524	2,345	1,000	1,000	4,869
Internally Displaced People	419	1,876	800	800	3,895
Host Communities	366	1,642	700	700	3,408

Indirect Beneficiaries :

As defined in the current phase of the project, any children willing to participate in PSS/recreational activities will be encouraged to do so and will be welcomed by community PSS volunteers. Any woman interested would be able to participate in the RMNCH group discussions. Not all of those persons will be considered as direct beneficiaries. Only the one fitting Tdh's criteria will be recorded in Tdh database.
The participation of people interested will contribute to reinforce social cohesion within the communities but will be counted as indirect beneficiaries and will be recorded in the attendance sheet of Tdh.
The CBCPC in charge of CPiE and non-formal MRE will reach out as much as possible people in their village and neighboring.

Catchment Population:

Population that benefits directly and indirectly from CHF funded humanitarian assistance.
Only in 2016, Laghman and Nangarhar had an extra 39,300 IDPs according to conflict induced displacement snapshot released by OCHA. As reported by UNHCR, in 2016, 370'102 individual returned from Pakistan, and 146'645 of them settled up in Laghman (7%) and in Nangarhar (32%). According to IOM, in 2016, 249'832 undocumented returnees from Pakistan came back to Afghanistan. Around 63% of the total of undocumented took refuge in the provinces of Laghman and Nangarhar, targeted by Tdh.
In the 64 villages targeted by the project, Tdh's assessment and data collected demonstrate that approximately the total population is 187'112 people (11% of returnees (documented and undocumented), 25% of IDPs) and around 70% of them are children.
With strong support of CBCPC members, the integration of IDPs, Returnees and host community/conflict affected population will be done and shared strictly based on Tdh's criteria in order to reduce potential tension among beneficiary involved in the project and population not assisted.

Link with allocation strategy :

In line with the first and second objective of the 2017 Humanitarian Response Plan– HRP (Immediate humanitarian needs of shock affected populations are met and lives are saved by ensuring access to emergency health and protective services and through advocacy for respect of International Law), Tdh Ishtema project will focus on vulnerable returnees, on host communities/conflict affected population, including IDP and host communities. The project will continue to address urgent and unmet humanitarian needs of returnees, IDPs and host communities in Nangarhar and Laghman. Tdh is the only CP service provider in the 64 selected villages. The direct involvement of the communities in all the activities of the project is a strategic decision to reinforce resilience whereby the community is empowered to use local capacity and resources to address distress and shock. Resilience of returnees, IDPs and local affected communities is supported through a comprehensive approach that includes prevention, response and sustainability dimensions fully into account.
By committing the community to promote non-formal MRE (in partnership with DMAC), CP and RMNCH, the project aims at focusing on more preventive measures through awareness and employing a community-based model in order to address the challenge of the vulnerable populations. This is reflected under the first and third outcomes. Displacements and degradation of the economic situation induce an increase of risk of GBV, risk of CP violations and exploitation such as involvement in worst forms of child labor, early marriage, physical or psychological abuses, enter in conflict with the Law... Furthermore, due to their playful curiosity, intendance to school mainly to work to support their family and unfamiliarity with the area and the overall threats posed by explosive hazards, children are more prone to landmine and ERW accidents.
In such conservative area, women have limited access out of their house and have limited knowledge on the importance of Health. The risk of home delivery or delivery without skilled attendant is likely. It could be prevented by increase the knowledge of danger of delivery without assistance of skilled attendant and the importance to go to the existing Health facilities. The outreach mobile midwives will screen the pregnant and lactating women identifying the risky pregnancy, delivering antenatal and postnatal care, refer to Health facilities or BPHS actors to get specialized services for the most pressing case and to promote vaccination for the babies. The Health education will also help to raise awareness among the community and to help especially the returnees, who recently arrived to be aware of existing services in a totally unknown new environment. It will reduce the risk of preventable disease and improve self-care of the community. By working directly with community based committees and local volunteers, Tdh ensures that psychosocial support is available at grass root level and that most at risk children and women can be referred to appropriate available services. Tdh will advocate with other potential partner to increase assistance of the villages assisted by Tdh.
The social cohesion will be reinforced with a smoother integration of IDP and returnees whom arrived in the community. Alongside to these awareness sessions, Ishtema team and CBCPC will identify and strengthen existing community coping mechanisms. Therefore Tdh will support the most vulnerable children and families with RMNCH care, case management support (mediation, social support, direct assistance) including referral to existing services (such as Health facilities, mobile clinic (BPHS) as well as other humanitarian actors with specialized services when available (shelter, organization supporting person with special needs, livelihood, NFI, legal assistance…)).

Sub-Grants to Implementing Partners :

Partner Name	Partner Type	Budget in US$

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

Other Funding Source	Other Funding Amount

Organization focal point :

Name	Title	Email	Phone
Celine Lefebvre	Middle East and North Africa (MENA) Regional Head	clf@tdh.ch	+ 41 21 654 66 75
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BACKGROUND

1. Humanitarian context analysis

Afghanistan has been subject to a protracted and complex crisis for over 35 years with a huge humanitarian distress as direct consequence. The number of people in need of humanitarian assistance in 2017 is estimated at 9.3 million by OCHA i.e. 32% of the total population of the country. Children account for 57% of the population in need and represent the most vulnerable group of the country.
The eastern region remain one of the most volatile and insecure province of Afghanistan, with numerous AOG groups, presence of ANSF and IMF, ongoing heavy clashes occurred in some districts since long time. Mobility, displacement, seeking refuge in neighboring areas is how communities deal when conflict reaches them. OCHA estimates that 1,500 persons are displaced from home every day.
The number of returnees from Pakistan has significantly increased in 2016, triggered by the decreased acceptance by hosting communities and local authorities, the loss of self-reliance opportunities and the risk of arrest and harassment. With the uncertainty of registration cards renewal (PoR) beyond December 2017, this trend is more than likely to continue. The provinces of Tdh intervention (Nangarhar and Laghman) have faced the arrival of thousands of Afghan refugees from Pakistan in 2016 and will certainly be challenged with additional arrivals in 2017, as OCHA expects at least 450,000 new IDPs with an estimation of 111,000 new vulnerable undocumented Afghan returnees.
Eastern region remains one of the areas with the highest cumulative density of new, prolonged and protracted displacement, compounded by thousands of newly arrived returning refugees and undocumented Afghans. According to IOM “socio-economic survey of undocumented returnees” released in February 2017, 86% of the returnees from Pakistan, interviewed in Tokham transit center, and declared willingness to settle in Nangarhar.
The long-term presence of Tdh in the region has allowed its teams to build a strong network in the area and acquire significant context knowledge. The challenges reported by communities through an evaluation of Tdh’s ongoing project, conducted by ATR Consulting in December 2016, were many including: lack of shelter, poor living conditions, and limited access to livelihood and employment opportunities. Early marriage, involvement with armed groups and worst form of child labor (WCFL) are some of the major risks enhanced by the situation of extreme vulnerability that returnees, IDPs and conflict affected/host families found themselves in.
One of the biggest challenges of the areas is access to Health and care for women and children. They are among the largest population of concern in the country. According to WHO and Afghan national survey, the rates of infant and maternal mortality remain among the highest in the world at 73/1000 live births and 327/100,000 live births respectively with reports of maternal mortality ratio (MMR) rates as high as 417/100,000 in rural parts of the country. The volatility of the region restricts access to health services but also perpetuates by social beliefs that women are vulnerable and therefore should not leave home, even if their life is endangered.
In addition, decades of conflict have left un-exploded remnants of war and landmines all over the country. Improvised explosive devices were the fourth leading cause of civilian casualties in Afghanistan in 2016. The continued presence of UXO is a major constraint within the targeted districts of this project especially for children who represent 84% of UXO victims.
Tdh can count on existing community networks and high acceptance in 5 districts of Nangarhar and will duplicate activities (non-formal MRE, PSS, CP) by identifying and train CBCPC in additional 2 new districts of Laghman.
RMNCH intervention will be launched in all the 64 villages welcoming big numbers of IDPs and returnees and having very few other organizations’ support.

2. Needs assessment

CP
An evaluation of the current project was realized in December 2016 by ATR consulting. The evaluation states the clear need to “tackle deep-rooted negative coping mechanisms which affect children, most noticeably when families in extreme poverty resort to income from child labor, enrollment in the conflict, or early marriage”. During an internal survey in December 2016, in 6 villages in KuzKunar district, an average of 9% of IDP families recognized having married their daughters before the legal marriage age. The main reason given was financial. The same survey reported that in 5% of IDP families with a child between 16 and 17 years old joined the Afghan Army. The taboo of discussing such sensitive issues has to be considered especially for child marriage which might be more prevalent that what was reported during this survey. IDPs and returning children represent 18% and 67% of the current Tdh beneficiaries, describe their distress in experiencing sudden displacement and the resulting loss of social networks and physical assets. According to a report made in collaboration with GRIFFITH university, the main sources of stress for children are fears related to physical violence, conflict and displacement. Anxiety resulting from displacement is a factor that impacts severely on the physical, mental and emotional health of children. Psycho-social distress (aggressiveness, sadness and low self-esteem,,,) has been continuously highlighted as a main concern by humanitarian actors.
Isthema project does reinforce positive coping mechanisms by improving community support and protective capabilities, develop external response through CPiE support (PSS activities, CP through case management system). The CPiE support including numerous meetings among host community, IDP and returnees community to build peace, to reinforce acceptance and support the most vulnerable in meeting their pressing and be better protected.
The PSS life-saving activities and CP support are contributing to reduce stress and the potential distress of individuals who went through difficult event (fighting, threatening family members and in the worst case the loss of the parents…) and to better cope with their new life. It empowered children by recreating connection with other children and by reducing the risk of enrollment of children in conflict or in illegal activities.
The awareness rising, as well as CP support will lessen, for instance, the risk to be victim of worst form of child labor for the boy, and the risk to be victim of early marriage for the girl, will promote the access to education and to Health.
RMNCH
In the villages where Tdh intervenes, only 4% benefit from direct access to a health facility. On average, the closest health center is at least 5 km away from a village. During their pregnancy, only 16% of women receive ANC. And when they receive ANC, it is only 2 visits (on average) which is not sufficient and creates a high level of risk (low weight, illness and even death of babies). According to a rapid assessment done by Tdh team in December 2016 Nangarhar provinces, only 10% of women give birth in health centers. This means that 90% of women deliver at home with no skilled birth attendance. Major concerns emphasized during the survey are that pregnant women continue heavy and hazardous work until delivery, do not have sufficient high quality food and are victims of domestic violence. All the surveyed heath centers confirmed that very few newborns and their mothers receive ANC and only a few newborns and their mothers receive PNC and a few children receive vaccination.
MRE
Due to their playful curiosity and unfamiliarity with the overall threats posed by explosive hazards, children are more prone to landmine and ERW accidents. Many children do not attend school, and supplement family income by working, which includes dangerous activities such as collecting scrap metal from ERW or agricultural work including digging with shovels.

3. Description Of Beneficiaries

The project will target specifically the most vulnerable children and their families, including pregnant and lactating women, from returnee, IDP and host communities in 64 localities of 7 districts in Nangarhar and Laghman provinces.
Vulnerability criteria are defined under Tdh Child Protection in humanitarian crises Policy and are in line with the Child Protection Minimum Standard (CPMS).
Tdh will use the CPMS as a basis for its intervention and will definitely mainstreaming the application of the standards within daily programming (for example standard 10 psychosocial distress and mental disorders, standard 15: case management, standard 17: child-friendly spaces and standard 16: community based-mechanism....)
Tdh's vulnerabilities criteria were defined in line with Tdh child protection in humanitarian crises thematic policy.
Tdh vulnerability criteria that will be used during the project will be cross-checked and cumulated, and will be related to:
- The child's personal situation: age (below 18 years old); children who were formerly engaged with extremist groups or at risk of recruitment by armed groups; child victim of exploitation or trafficking; children victim or prone to violence / SGBV (physical, verbal, early marriage, sexual , etc); children involved in labor and worst forms of child labor; children with disabilities or victim of discrimination; unaccompanied and at risk separated children; children with psychosocial disorders (at risk of self-injury, suicide, aggressiveness, sadness); children out of school; children at risk of danger and injuries.
- The family's situation: household with low or no resources; substandard household conditions; returning families not registered or not benefiting from UNHCR cash-assistance and other relief assistance; single parent family; women at risk of GBV; families with pregnant and lactating women and female-headed households.
In line with its mandate, Tdh will ensure equity for all vulnerable children and mothers in the access to services and does not seek a specific percentage in returnee, IDP or host communities/conflict affected population.
All the children who are interested will be integrated in the PSS activities.
The provision of the case management as well as the direct assistance will be provided to the most vulnerable children and families based on Tdh selection criteria defined.
The RMNCH support will be provided to all babies (less than 6 months), all the pregnant, lactating and postpartum of the villages. The Health education sessions will be open to all the women interested to participated (including youth).
All the activities will take place in the village and will be manage by people trained from the community the access to activities for the most vulnerable and the one with special needs will be easier. Tdh will backstop and supervise the activities to ensure the inclusion of everyone.
Most of the activities proposed are in house which will definitely contribute to the inclusion of the person with limited mobility or with movement restriction imposed. As part of Tdh's case management system, the action plan will be drawn according to the needs of the beneficiaries and his/her family in order to meet basic needs and address the needs identified.

4. Grant Request Justification

Since 2015, Tdh humanitarian interventions in the Eastern Region of Afghanistan have managed to provide much needed assistance for children and their caregivers and have highlighted the need to promote community based interventions for sustainability. In 2017, there will be pressing needs to integrate into the project more Afghan returnees from Pakistan, more displaced individuals affected by conflict and natural disasters, and more host communities destabilized by the crisis and the deterioration of their living conditions. Based on previous Isthema activities developed and lessons learned, the same approach in non-formal MRE, PSS and CPiE will be applied.
Since 10 years, Tdh contribute to improve RMNCH care in KIS and have gained extensive expertise and experience of working and supporting vulnerable population. The concept of mobile midwives developed by the Tdh Kabul delegation is positively recognized by the MoPH as well as supported by the AMA and there are numerous links established with other field actors (most recently MSF).
In eastern region, an evaluation of Tdh projects was realized by ATR consulting in Dec 2016. The recommendations suggest continuing the current activities and possibility to extend the scope of activities by integrating RMNCH. Based on Tdh's expertise gained in Kabul, as well as the current network built and the needs expressed by the community interviewed in eastern province were favorable to increase the support and addressed the needs.
Therefore, with the proposed project, Tdh decided to implement an integrated approach of non-formal MRE, CPiE and RMNCH. These 3 domains are complementary and will pave the way of better protection and respect of the basic rights of children and their mother. Tdh will be able to reach out babies, children, mother and their families and proposed a wide range of activities to improve their protection, PSS well-being, reduce the risk of Health issues and mortality and bring deep changes in the families and communities.
An internal referral will be developed in order to provide adapted assistance to beneficiaries. The trust gained with the community and the acceptance of Tdh will ease the process and allow Tdh to talk about sensitive issue for such conservative area.
The community resilience will be reinforcing by stronger understanding of their Rights, a better integration of them and better understanding of the danger of explosive device and what to do in case of finding an explosive device.
The proposed project and the new RMNCH activities will continue to help Tdh to reach out the isolated and inaccessible women (the one who could not get out of their home) with the outreach mobile approach developed. The midwives will be more easily accepted within home and the family, thanks to Tdh acceptance, and will create a trustful environment for women to speak out their problems. Tdh's midwives will then spent more time in trustful atmosphere within house, and will potentially be able to identify some hidden sensitive protection issues, which will be referred without any delay to social worker for protection support.
The integrated approach developed is complementary, unique in Afghanistan and will provide better support he community. Tdh will then be more capable to contribute by providing situational information to the clusters (Health, Protection). Tdh would continuously support clusters and OCHA to have better overview of the needs in RMNCH, Protection and PSS, help to develop better adapted activities, reinforcement collaboration with other actors in order to help better the community and the people in needs. Tdh and DMAC signed a letter of agreement (DMAC template). At Kabul and provincial level, close collaboration were built (started 1 year and half ago) and is very solid now. Tdh and DMAC will continue to guarantee no-overlapping by exchanging about the villages covered with DMAC and will continue to provide monthly report of activities

5. Complementarity

The proposed project (June 2017 – May 2018) is defined in the continuity of the 2 phases of Ishtema project presently supported by CHF and is based on the 2017 HRP. Since December 2015, Tdh and DMAC have successfully implemented non-formal MRE awareness sessions through a network of CBCPC Tot. DMAC will provide two, 2 days sessions of 3 days of non-formal MRE training for Tdh staff, and for the 128 ToT CBCPC members identified in the n
An additional CHF grant will enable Tdh not only to continue its activities, but also to scale up to additional beneficiaries in new areas of intervention and to cope with the predicted influx of new IDPs and returnees.
In the afghan context, in order to change dangerous behavior, one of the first pre-conditions to effective implementation is to increase the understanding of the importance of the access to Health facilities, especially for the pregnant mothers and their families. The current Afghanistan RMNCH programme helps to combat the lack of education of pregnant women and their families on the importance of using the primary Health care through awareness rising within the communities and a solid referral network resulting in the promotion of healthy behavior. The team of professional midwives provides complimentary outreach RMNCH care services, in order to reduce the overload in existing Health facilities and to ensure that the most critical patients are timely referred to say Health facilities, thus working in favor of effective coverage. For instance in Kabul, MSF has set up maternity wards for poor communities in Kabul and have been carrying out 1500 deliveries per month. In order to respond to this high demand, Tdh and MSF have developed a partnership to help to ensure smooth referral and reducing the work overload of MSF maternity. In this way, the availability of specialized wards is accessible for those in need and so that the quality of Reproductive, maternal, newborn and child health care remains to standard. Tdh's actions within the community aiming to deliver 'door to door' services and increase Health education is appreciated and deemed very useful by MSF and other Health partners of the area. In the proposed project, Tdh will use the same approach and complement the current Health intervention without overlapping or duplication.
According to the evaluation realized by ATR consulting in December 2016, the following needs were expressed in some villages covered by Tdh:
·Many respondents reported that health services were too far and/or expensive to access. RMNCH is a particular challenge; many pregnant women lack adequate care, and some respondents reported children being born at home.
·There is a disconnect between the perceptions of district health centres and community members in terms of the level of services available and existing demand. This is possibly because health workers in the district centre are unaware of health conditions in remote areas.
·Tdh's should draw on its past experience in providing RMNCH services and consider adding these services to its Isthema programming.
Tdh believes that this proposed intervention will benefit to the community and will ease the access to Health and better care, but also to the already existing Health actors of the area. Tdh will closely coordinate with PU-AMI or any other Health services provider of the area. A strong referral system and collaboration will be built in order to better served population. Tdh midwives will be regularly visiting Health facilities at the district level in order to reinforce referral. It will be important to build trust and ease the referral of beneficiaries, On the other hand, Tdh will work closely with Health cluster to improve better understanding of the needs on the ground and help to define potential advocacy message.
Tdh will multiply meetings in order to reinforce coordination, share results and find common ground of intervention to improve the current coverage and avoid overlapping

LOGICAL FRAMEWORK

Overall project objective

The project intends to strengthen the resilience of the most vulnerable returnees, IDPs and host communities/conflict affected population in isolated areas of Nangarhar and Laghman by the end of May 2018 by :
- reducing vulnerabilities through access to information on CP, non-formal MRE and RMNCH;
- addressing specific needs through community delivered life-saving psycho-social services, the direct provision of RMNCH care, case management support ;
- strengthening community based mechanisms by training and coaching volunteers on PSS, and CBCPC on CP, non-formal MRE and Health.

PROTECTION

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Objective 3: Support the creation of a protection-conducive environment to prevent and mitigate protection risks, as well as facilitate an effective response to protection violations	SO1: Immediate humanitarian needs of shock affected populations are met - including conflict and natural disaster affected and IDPs, refugees and returning Afghans from armed conflict	100

Contribution to Cluster/Sector Objectives : The project will address urgent and unmet humanitarian needs of the most vulnerable population (returnees, undocumented returnees, IDP, conflict affected population/host communities) of Nangarhar and Laghman. Target locations will be chosen based on needs and priority will be given to the places where no other child protection organizations are present. Tdh is the only service provider (RMNCH, CP, PSS) in the 64 villages targeted in 7 districts.

In line with the first and second objective of the 2017 Humanitarian Response Plan – HRP (Immediate humanitarian needs of shock affected populations are met and lives are saved by ensuring access to emergency health and protective services and through advocacy for respect of International Law),
Tdh will build on the existing intervention by integrating the know-how, the lessons learned and improve the efficient and quality of the intervention. The empowerment of the community (CPiE by Tdh and PSS training) will give the sufficient capabilities to the community to reinforce their resilience and to respond to their more pressing needs. For the most vulnerable families who needs specialized assistance or support, Tdh will provide direct specialized assistance.
Tdh will advocate among International community, NGO and authorities to provide enough assistance, feel the existing humanitarian gaps and better respect of international and national rights (especially for children and women).
The project will greatly contribute to create a protection-conducive environment to prevent and mitigate the protection risks, as well as facilitate an effective response to protection violation by involving the community, increasing their knowledge (in CPiE), by training community volunteers in delivering life-saving PSS activities and by the assisting the community on specialized support (case management and direct assistance).

Outcome 1

Outreach life-saving psychosocial support (PSS) are delivered for the most vulnerable children from the IDP, returnee and conflict affected population.

Output 1.1

Description

Establish community CFS with mobile Tdh service to provide supported to isolated villages in Nangarhar and Laghman

Assumptions & Risks

Those provinces are very volatile and activities could be cancelled because of security situation. Tdh selected the safest and more accessible district for the time being, but the situation could evolve very quickly and accessibility of certain area might not possible anymore. The link with the community will be very important, even though Tdh has a strong connection in the province, the accessibility and the involvement of the undocumented and new IDPs in some area will be a challenge.
Finally, the undocumented refugees and the new IDP could move if situation evolves in the area of intervention or if they want to find a more suitable place.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	PROTECTION	# of PSS volunteers trained					128
Means of Verification : database, field visit report							
Indicator 1.1.2	PROTECTION	% of villages where games or activities take place when Tdh is not present in the village.					100
Means of Verification : In the 64 villages targeted, 100% of the villages will have volunteers managing PSS activities on their own by the end of the project. database, field visit report							
Indicator 1.1.3	PROTECTION	% of children improving their behavioural status and their abilities to cope with their social environment. (SDQ questionnaire method).					70
Means of Verification : 70% of the children attended to the PSS activities (1750 girls and 1750 boys). database, pre and post SDQ (on sample population)							
Indicator 1.1.4	PROTECTION	SA1-Envelope Three: Number of affected individuals partaking in community-based prevention and mitigation initiatives, contributing to an environment enabling effective protection responses	0	0	2,500	2,500	5,000
Means of Verification : database, PSS forms, field visit report. The information related to the child registration, attendance and other information related to CFS and PSS will be shared with sub-cluster and protection cluster based on the requested reporting made by the cluster on unique and harmonized template available.							
Indicator 1.1.5	PROTECTION	Number of people who have raised awareness on CPiE					4,060
Means of Verification : database, attendance list, field visit report							

Activities

Activity 1.1.1

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

Volunteers from the community are identified, trained and mentored to deliver quality PSS activities

Activity 1.1.2

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

Deliver life-saving PSS activities with trained volunteers in each of the 64 villages identified

Activity 1.1.3

Standard Activity : Not Selected

As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly

Activity 1.1.4

Standard Activity : Not Selected

community have raised awareness on CPiE

Outcome 2

Pregnant and lactating women, babies and children at risk of/or victim of violence are supported through a case management system and RMNCH care.

Output 2.1

Description

GBV survivors and abused children are assisted by the case management system including direct support, effective referral system and NFI provision

Assumptions & Risks

The available Health services are available not too far from the villages targeted (especially mobile service).
Limited specialized services exist in such isolated villages.
Tdh will strongly advocate (among INGO, UN and A/NGO) to have broader range of services in the covered area.

The range of service provided by Tdh could contribute to reduce the protection risk faced by children and women.
By strengthening the resilience and the knowledge of the community, the project will be sustainable and have long term impact for women and child rights respect.

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 2.1.1	PROTECTION	% of case closed successfully within 6 months.					60
Means of Verification : 60% of the children identified and assisted with case management system will be better protected and assisted successfully within 6 month after identification. (60% = 480 children) database, case management forms							
Indicator 2.1.2	PROTECTION	# of NFI standardised kits (ES-NFI cluster guidelines) distributed to families affected by child protection concerns.					400
Means of Verification : database, case management forms							
Indicator 2.1.3	PROTECTION	SA1-Envelope Three: Number of affected individuals (GBV survivors and children abused or exploited by armed groups and armed forces) directly assisted with rights-based targeted assistance following the shock	0	0	200	200	400
Means of Verification : case management system forms, database							

Activities

Activity 2.1.1

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

Case management is provided to the most vulnerable children identified by CBCPC and Tdh

Activity 2.1.2

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

Providing direct assistance to the most vulnerable families in order to decrease the risk of abuse and exploitation of children

Outcome 3

Community is sensitized around non-foamal Mine Risk Education (MRE) to mitigate risks faced by children within their communities

Output 3.1

Description

CBCPC are established and trained to conduct community-based awareness on CP and non-formal MRE

Assumptions & Risks

The mobility of CBCPC members is an important component, male CBCPC will have to be able to come in Jalalabad to receive training from DMAC expert and Tdh staff (learning and development officer and Child Protection manager). If the security situation is not sufficient, the training could be reported, knowing that DMAC trainers will come from Kabul, the coordination and the organization could be difficult. The CBCPC members are gender balanced, as the 2 provinces are very conservative, the women CBCPC members will be trained directly in the villages by Tdh's staff already identified.
The key CBCPC members trained on ToT will have to replicate within their committee in order to raised the awareness within community.
The training, refreshment and follow up will be key element to insure quality of awareness raising.
In the current phase of the project, 64 CBCPC members have been trained in MRE Tot and will continue to be fully integrated and active in this project. In total, the project will benefit from 128 MRE tot and 128 CP Tot in 7 districts.

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 3.1.1	PROTECTION	SA1-Envelope Three: Number of prioritised mine/ERW impacted individuals provided with Mine Risk Education	64	64	0	0	128
Means of Verification : training attendance sheet, database, training report provided by DMAC							
Indicator 3.1.2	PROTECTION	# of CBCPC members trained on non formal MRE					128
Means of Verification : database, attendance sheet, training report DMAC							
Indicator 3.1.3	PROTECTION	% of CBCPC Tot who managed non formal MRE and CPiE session without direct support of Tdh					100
Means of Verification : database, field visit report. The entire team of CBCPC members trained (128 non formal MRE tot and 128 CPiE Tot) will deliver session on their own							

Activities

Activity 3.1.1

Standard Activity : Not Selected

Newly identified CBCPC members are trained by DMAC

Activity 3.1.2

Standard Activity : Not Selected

CBCPC members received refresher on non-formal MRE by DMAC

Output 3.2

Description

Individuals are better protected by having increased awareness on danger of explosive device and Child protection

Assumptions & Risks

The security situation will not jeopardize the access in the area of intervention.
The team will go regularly, one time per week in the 32 new villages, and one time per month in the 32 already served villages. It will give enough time to Tdh staff to follow up and realized the necessary backstopping to control that the CBCPC tot are capable to reach the target set.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 3.2.1	PROTECTION	SA1-Envelope Three: Number of prioritised mine/ERW impacted individuals provided with Mine Risk Education	2,030	2,030	2,500	2,500	9,060
Means of Verification : database, field visit report, attendance							
Indicator 3.2.2	PROTECTION	% of beneficiaries targeted by CBCPC show increased knowledge on key non formal MRE messages					70
Means of Verification : field visit report, interviews, database							

Activities

Activity 3.2.1

Standard Activity : Not Selected

Returnees, IDPs, conflict affected population at risk of ERW/EDO have raised awareness through sessions delivered by CBCPC members and Tdh staff

Additional Targets :

HEALTH

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Objective 2: Ensure access to essential basic and emergency health services for white conflict-affected areas and overburden services due to population movements	SO2: Lives are saved by ensuring access to emergency health and protective services and through advocacy for respect of International Humanitarian Law	100

Contribution to Cluster/Sector Objectives : The project will address urgent and unmet humanitarian needs of the most vulnerable population (returnees, undocumented returnees, IDP, conflict affected) of Nangarhar and Laghman. Target locations will be chosen based on needs and priority will be given to the places where no other child protection organizations are present.

The project will assist the not enough assisted villages with daily support on RMNCH care. The professional midwives will be on the ground on a daily basis, meet the families composed of lactating, pregnant and postpartum women as well as all babies. They will screen the women and babies and provide needed assistance and delivery of basic health assistance (vitamin and needed medicine) in order to limit the risk of disease and death.
The pregnant women will receive antenatal care to identify the complicated pregnancy in order to refer directly and urgently to the closest service provider of the area of mobile BPHS or Health facilities from the area.
The RMNCH outreach intervention will be a strong added value for the Health improvement in the regions, because Health education will be done and midwives will convince families to go to the closest Health facilities.
The project will target all babies (less than 6 months) as well as lactating and pregnant women from the villages without considering if they are IDP, refugees or Host community/conflict affected population.
The team will linked up with the Community Health Worker (CHW) from the area. The CHW will identify by the constant collaboration and coordination with WHO and the MoPH.

The project will perfectly fit with the Health cluster objective "Ensure access to essential basic and emergency health services for white conflict-affected areas and overburdened services due to population movements" and will address one of the top priority area defined by the HNO. The 64 villages targeted by Tdh are not covered by any other RMNCH specialist after assessment, evaluation and after checking with communities.

Outcome 1

Pregnant and lactating women, babies and children at risk of/or victim of violence are supported through a case management system and RMNCH care.

Output 1.1

Description

Pregnant and lactating women and their babies are supported with RMNCH care, Health education sessions and are referred to available Health services.

Assumptions & Risks

The distance between the villages and the Health facilities could be an issue for the complicated pregnancy.
The conservatism is really strong in this area and the RMNCH intervention could face some difficulties to be accepted by everyone.
The Health actors are often targeted by AOG and Tdh will have to be extremely careful.

Tdh has a strong link with Afghan Midwives Association and network within Nangarhar which will be helping to recruit experienced midwives. They will have to be capable to go in the area of intervention.
Tdh has an extensive experience and experimented staff in Kabul who will help in training, in supporting and in implementing quality intervention.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	HEALTH	SA1-Envelope One: Proportion of pregnant women in conflict 'white areas' receiving at least two antenatal care visits					51
Means of Verification : Tdh collected some information about the potential number of pregnant women in all the villages covered, this number is approximately 6'000 women. This is an approximation, and this is not including the lactating women. Tdh define this target of 3080 women assisted, means that around 48 women per village among the most vulnerable and the most at risk to have complicated will be selected and assisted during the entire project. Registration and identification forms will be used (based on the one used in Kabul), birth preparedness plan will be develop with all those pregnant women in order to ensure a delivery assisted by a skilled attendant, in the hospital or any other Health actors present in the area. Tdh midwives will follow up with the public hospital and Health actors present to guarantee a good RMNCH care, and the collaboration will be reinforced as soon as the delivery date will be close. Every single women and babies will be registered in Tdh's database.							
Indicator 1.1.10	HEALTH	Number of women benefiting from Health education session					4,620
Means of Verification : field visit report, database, attendance list							
Indicator 1.1.2	HEALTH	% of deliveries supervised by birth skilled attendant					50
Means of Verification : database, field visit report, data collection. All the pregnant women will be identified and supported by the midwives. The midwives will ensure a referral to Health facilities to prepare and facilitate the delivery. A birth preparedness plan will be made with the pregnant and her family in order to have assisted delivery and avoid complication. A close follow up and collaboration will be set with the other Health facilities to ensure delivery supervised by birth skilled attendant. The national level is around 32.9% of delivery take place in Health facilities, the target set is above the national level but it will be a challenge as the conservatism of the area is very high and it will be a challenge to convince the family to go the delivery outside of home. The database registration will be used to monitor closely the target set.							
Indicator 1.1.3	HEALTH	% of new-born babies (within 6 months) referred for vaccination					100
Means of Verification : data collection, field visit report, referral forms, database. The trust relation will be built during the different regular visit made by midwives, they should have the time to discuss with mother and her family, as well as the neighbor especially during the Health education session. Tdh midwives will be a visit in the first following day after the delivery in order to advocate one more time for breastfeeding and for vaccination if it was not already done. Tdh won't do the vaccination but will refer all the babies for vaccination to public hospital or Health partner (PU-AMI for instance or AADA).							
Indicator 1.1.4	HEALTH	Number of midwives (12) and team leader (1) recruited					13
Means of Verification : HR files, recruitment process, interview report, contract							
Indicator 1.1.5	HEALTH	Number of midwives and team leader trained on Tdh's outreach approach and RMNCH care					13
Means of Verification : Tdh's database, attendance list, field visit report							
Indicator 1.1.6	HEALTH	Participating in Health cluster meeting in Jalalabad and Kabul					10
Means of Verification : Health cluster meeting minutes, Tdh database							
Indicator 1.1.7	HEALTH	Number of face to face meetings with Health actors attended in Jalalabad					10
Means of Verification : Tdh database, meeting report, RMNCH coordinator field visit report							
Indicator 1.1.8	HEALTH	Number of visit made to the Health facilities of the area					40
Means of Verification : field visit report, Tdh's database							

Indicator 1.1.9	HEALTH	Number of monthly report done to WHO (expand the current monthly report made in the new area of intervention)					10

Means of Verification : WHO database

Activities

Activity 1.1.1

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

Deliver RMNCH care (antenatal and postnatal care, referral, promotion of immunization,…) to pregnant and lactating women and babies

Activity 1.1.2

Standard Activity : Not Selected

Build coordination, facilitate referral and collaboration with Health actors of the region

Activity 1.1.3

Standard Activity : Not Selected

As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly

Activity 1.1.4

Standard Activity : Not Selected

Recruit and trained the midwives and the team leader

Activity 1.1.5

Standard Activity : Not Selected

Realize ANC and PNC

Activity 1.1.6

Standard Activity : Not Selected

Refer pregnant women for delivery assisted by skilled attendant

Activity 1.1.7

Standard Activity : Not Selected

Refer all babies to Public hospital or Health partners

Activity 1.1.8

Standard Activity : Not Selected

Raise awareness on importance of Health witin the women community

Additional Targets :

M & R

Monitoring & Reporting plan

The operational follow up of activities is ensured by emergency program coordinator (expat) assisted by the regional program manager (based in Jalalabad).
A dedicated M&E Officer is also in place to support the overall M&E activities as well as the development of M&E tools (e.g. database, questionnaires, referral and registration forms, rapid assessments, focus group discussions, etc.) and capacity building of relevant staff. He will managed the data clerk recruited in Jalalabad in order to print all the form, ensure a good implementation of the tool developed and will do the data entry in the databases developed for the proposed intervention. The M&E officer will have to go to Jalalabad at least one every 2 months to monitor the quality of the monitoring implemented. The M&E will be involved in the different reporting (internal monthly reporting, cluster, OCHA...) and will report any discrepancies without any delay.
With regards to CPiE:
Based on Tdh Project Cycle Management handbook, internal monitoring will be integrated throughout the project in order to closely follow up and report progress of activities in accordance to planned objectives, indicators and time frame. Data and information collected by Tdh mobile teams will be recorded in CPiE databases and will be used to follow the quantitative and qualitative achievements of the project. In addition, monthly review meetings are organized to understand the progress of the project, to take corrective actions when necessary, and capitalize on lessons learned. Technical support will be provided by Child Protection manager based in Kabul and who will go regularly (monthly basis) in Jalalabad and who are directly reporting to the Tdh's Country Representative.
With regards to non-formal MRE:
The data will be collected on daily basis by the team and will be entered in the database. The same M&E methods explained for the CPiE will apply. Tdh will send a monthly reporting with DMAC and organized regular meetings in Kabul to ensure good partnership and adjust the program according to the potential needs identified on the field.

With regards to RMNCH:
Based on Tdh Project Cycle Management handbook, internal monitoring will be integrated throughout the project in order to closely follow up and report progress of activities in accordance to planned objectives, indicators and time frame. Data and information collected by Tdh midwives will be recorded in RMNCH databases and will be used to follow the quantitative and qualitative achievements of the project. In addition, monthly review meetings are organized to understand the progress of the project, to take corrective actions when necessary, and capitalize on lessons learned. Technical support will be provided by RMNCH Coordinator based in Kabul and who will go regularly (monthly basis) in Jalalabad and who are directly reporting to the Tdh's Country Representative. The RMNCH team leader will supervise the activities of the midwives, define the action plan, identify the potential gaps and will be the one participating in every single meeting in Jalalabad (Health cluster, face to face partner meetings, government or authorities meeting).
Finance, administration, human resources and logistics are also framed by procedures, monitored on a monthly basis, and closely controlled by Tdh headquarters.
Tdh will report to OCHA as per contract requirement, Tdh will continue to report on monthly basis to WHO and will include the new activities implemented. With regard to CPiE, Tdh will contribute as the last 5 years in the Protection cluster (regional and cenral one) as well as the CPiE sub-cluster in Kabul. In addition, Tdh will ensure a smooth reporting with the government authorities at regional and central level as per NGO Law.

Workplan

Activitydescription	Year	1	2	3	4	5	6	7	8	9	10	11	12
Activity 1.1.1: Deliver RMNCH care (antenatal and postnatal care, referral, promotion of immunization,…) to pregnant and lactating women and babies	2017								X	X	X	X	X
	2018	X	X	X	X	X							
Activity 1.1.1: Volunteers from the community are identified, trained and mentored to deliver quality PSS activities	2017						X	X	X	X	X	X	X
	2018	X	X	X	X	X							
Activity 1.1.2: Build coordination, facilitate referral and collaboration with Health actors of the region	2017						X	X	X	X	X	X	X
	2018	X	X	X	X	X							
Activity 1.1.2: Deliver life-saving PSS activities with trained volunteers in each of the 64 villages identified	2017						X	X	X	X	X	X	X
	2018	X	X	X	X	X							
Activity 1.1.3: As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly	2017											X	
	2018					X							
	2017											X	
	2018					X							
Activity 1.1.4: community have raised awareness on CPiE	2017						X	X	X	X	X	X	X
	2018	X	X	X	X	X							
Activity 1.1.4: Recruit and trained the midwives and the team leader	2017						X	X			X		
	2018	X			X								
Activity 1.1.5: Realize ANC and PNC	2017								X	X	X	X	X
	2018	X	X	X	X	X							
Activity 1.1.6: Refer pregnant women for delivery assisted by skilled attendant	2017								X	X	X	X	X
	2018	X	X	X	X	X							

Activity 1.1.7: Refer all babies to Public hospital or Health partners	2017								X	X	X	X	X
	2018	X	X	X	X	X							
Activity 1.1.8: Raise awareness on importance of Health witin the women community	2017								X	X	X	X	X
	2018	X	X	X	X	X							
Activity 2.1.1: Case management is provided to the most vulnerable children identified by CBCPC and Tdh	2017						X	X	X	X	X	X	X
	2018	X	X	X	X	X							
Activity 2.1.2: Providing direct assistance to the most vulnerable families in order to decrease the risk of abuse and exploitation of children	2017						X	X	X	X	X	X	X
	2018	X	X	X	X								
Activity 3.1.1: Newly identified CBCPC members are trained by DMAC	2017						X	X	X				
	2018												
Activity 3.1.2: CBCPC members received refresher on non-formal MRE by DMAC	2017												X
	2018	X	X										
Activity 3.2.1: Returnees, IDPs, conflict affected population at risk of ERW/EDO have raised awareness through sessions delivered by CBCPC members and Tdh staff	2017						X	X	X	X	X	X	X
	2018	X	X	X	X	X							

OTHER INFO

Accountability to Affected Populations

Tdh has been dedicated to improve beneficiaries' participation to the project since its first phase in December 2015. Tdh is in the process of becoming a signatory member of the Humanitarian Accountability Partnership – International (HAP-I), which seeks to empower communities and hold humanitarian service providers accountable to their beneficiaries for their activities.
Through the establishment, training and follow-up of CBCPC and PSS volunteers Tdh ensures that local communities participate fully in and engage with project planning, design, implementation and M&E practices. Indeed, the community volunteers jointly work with Tdh to define vulnerability criteria, design local games, deliver messages, identify vulnerable children and families, and follow case management and share data with Tdh mobile teams.
The PSS volunteers and the CBCPC tot are receiving regular training and benefiting from mentoring of the Tdh staff on regular basis. In total, a network of 256 CPBPC Tot and 256 PSS volunteers will be totally trained and autonomous by the end of the project. They will be able to organize PSS activities for children in the 64 villages covered and the CBCPC Tot will be able to continue CPiE and non-formal MRE awareness sessions beyond the end of project. During the project, Tdh staff will deliver the technical support and care and try to build a sustainable referral system in all the districts covered.
As Tdh mobile teams visit each village regularly (every week for the new villages and on a monthly basis for the already served villages), communities have access to timely, relevant and clear information about the organization and its values. This information can also include an update on project plans and outcomes, staff roles and responsibilities, contact information but also complaints procedures. Indeed, believing that affected populations have the right to "have a say" and that aid providers have the duty to consider and respond, Tdh has developed a complaint handling mechanism through its Child Safeguarding Policy (CSP). In each area of intervention, a Tdh CSP focal point will be selected, trained and known by the community. Those CSP FP will support the complaint mechanism and will have several ways to report to Tdh management any complain. All the volunteers of the project, and the entire Tdh staff are trained on Tdh's CSP and know the complaint mechanism (deployed through poster, leaflet and complain mechanism visibility) displayed in all Tdh premises.
The community will be regularly informed verbally about the complaint mechanism system implemented (Tdh's CSP) in order to strengthen the system. The community will be able to report verbally to any Tdh's staff (team of 7 peoples) or to the CSP FP trained in each community or to call the senior management of Tdh, thanks to the awareness raising.
Finally they would be able to report to the management who will do monitoring visit to ensure the quality of the activities implemented and the good acceptance of the project by the community.
A community-based monitoring mechanism is in place with regular focus group discussions at village level between Tdh teams, CBCPC members and communities, enabling beneficiaries' participation and seeking feedback on the project. Community Focus Group Discussions organized with ATR Consulting during the evaluation of the first phase of the project at the end of 2016 has allowed Tdh to continue the same activities (CPiE, PSS and non-formal MRE) and include implementing RMNCH care.

Implementation Plan

Tdh will deploy 4 mobile teams, composed by 1 community mobilizer, 2 social workers, 2 animators and 3 midwives in order to provide PSS service (delivered by the volunteers from the community), CPiE and non-formal MRE awareness rising, child protection support through case management system and RMNCH care to the most vulnerable children, mother and babies identified.
In addition to the initial orientation, more than 256 CBCPC members will be directly supported by Tdh mobile teams that will meet with the groups on a weekly basis to ensure follow up, monitoring and additional technical support. The CBCPC members will focus on delivering CPiE and non-formal MRE promotion based on training delivered by Tdh training and development officer (for CPiE and based on Tdh PSS training curricula) and DMAC (for non-formal MRE). The CBCPC will be backstopped by Tdh staffs and by DMAC (part of the refresher sessions on non-formal MRE).
Animators will be in charge of PSS activities and training the 256 PSS volunteers while social workers will be in charge of follow-up with children and families with special needs and referrals as well as follow up on training from realized by CBCPC key members about CPiE.
The PSS activities will consist in organizing specific activities (boys and girls separated) with clear objective to empower children, developed their skills, reinforce children social cohesion and released their tension and potential bad behavior. The PSS activities could be sport, numeracy, drawing, local games, puzzling… Each session will be organized and structured based on Tdh internal guidelines.
The case management system (by following the international guidelines of case management) implemented will consist to identify the most vulnerable children though CBCPC members, community referral, observation during PSS activities. The Social worker will then visit house of the children, discuss with the parent and assess the situation. Based on the assessment (and Tdh vulnerability criteria), a case will be open (or not) and an action plan will be defined by the social worker, the children and the parent. Some supporting actions will be directly done by the social worker; some will require referral to specialized agency. For the poorest and the most vulnerable families, specific NFI kits will be provided by Tdh (based on NFI cluster kit contents). As soon as the objective defined will be achieved the case will be closed.
Tdh midwives will minimize the RMNCH knowledge gap (in close collaboration of the CHW) through awareness rising on the importance of timely and proper RMNCH care and Health. The material used for the Health education will be adapted from the one developed by WHO and MoPH. A close collaboration will be done with the BPHS implementers, CHW, MoPH, WHO to ensure adequate awareness and integrated the key message and services available. These actions will help to convince the families and women who are not willing, informed or capable to available Health support. The midwives will provide complementary health care services such as baby screening and ante/postnatal care to pregnant and lactating women. Health services will be always promoted and advised by the Tdh midwives, and the access to Health will be facilitated by our action.
Tdh midwives will identify their beneficiaries through door to door introductions, with the support of CBCPC. Some key members of CBCPC (female), as well as CHW will be trained on Health education by Tdh RMNCH Kabul team (Doctor who is working with Tdh since 20 years). CBCPC Health facilitator will be able to do basic sensitization on Health importance and to refer the beneficiaries to the closest Heath facilities and to the Community Health worker in the area.
Tdh team will be supervised by a Program Coordinator based 50% in Kabul and 50% in Jalalabad with the assistance of the regional manager (PSS/Protection) and the support of the Kabul technical team support

Coordination with other Organizations in project area

Name of the organization	Areas/activities of collaboration and rationale
WHO	WHO is the Health cluster coordinator (in Jalalabad and in Kabul, Tdh will report all the activities, the achievement and the progress of the project. Tdh will seek information, advice and guidelines to WHO in order to implement the project efficiently
UNHCR - UNICEF	UNICEF- UNHCR are Protection cluster coordinator and CPiE sub cluster coordinator (in Jalalabad and in Kabul), Tdh will report all the activities, the achievement and the progress of the project. Tdh will seek information, advice and guidelines to UNHCR in order to implement the project efficiently
Government of Islamic Republic of Afghanistan	Tdh will registered the project through MoEC, report and coordinate closely with the technical line minister (Health, RR and LSAMD)
BPHS implementers and Health actors	Tdh will coordinate closely with the BPHS implementers in order to work together to cover more area, to faciliate the referral (to know better the type of services provided by BPHS implementers, their ressources....) and refer all the cases requiring specialized assistance (delivery, complicated pregnancy, illness, vaccination, provision of medicine, injuries of children....) - PU-AMI, AADA, SCA...
Specialized agencies	Tdh will refer all the children and family members with specific needs to specailized agencies (to have more details please refer to annex related to existing referral mapping)
INSO	Tdh will closely communicate and get information from INSO in order to get the daily basis securiy clearance in order for the team to move on the field location.
IOM	Tdh will closely work with IOM to refer the case of undocumented refugees, and in order to obtain specific assistance and/or message to improve the life of the most vulnerable families.
PU-AMI	Tdh and PU-AMI will closely collaborating in Nangarhar in order to avoid overlapping and to ensure a good referral in order to maximize the assistance provided to beneficiaries.
DMAC	Deliver the training of trainers for the CBCPC members and collect information on MRE sessions delivered. DMAC provides the MRE material to be printed. letter of agreement is signed between DMAC and Tdh. This letter of agreement is still valid (one year validity) and will be renew when needed. REgular meeting for coordination will be done at regional level with the sub-office of DMAC
APC, CPiE	APC is the Protection and CPiE cluster and sub cluster coordinator (in Jalalabad and in Kabul, Tdh will report on activities, achievement and findings. Tdh will see information, advice and support of APC, CPiE.

OCHA	Tdh will report regularly to UNOCHA at Kabul and Jalalabad level. Tdh will facilitate the spot check visit from OCHA/HFU every time it will be requested. Tdh will continue to participate to any meeting organized by OCHA/HFU and in line with our project at Kabul and Jalalabad level

Environment Marker Of The Project

A: Neutral Impact on environment with No mitigation

Gender Marker Of The Project

2a-The project is designed to contribute significantly to gender equality

Justify Chosen Gender Marker Code

Based on Tdh's global approach towards gender mainstreaming, women's as well as men's concerns and experiences are integral to the design, implementation, monitoring, and evaluation of the program.
The proposed project gives specific attention to gender with a global 50/50 ratio of boy to girl beneficiaries in CFS. This means that boys and girls are given the same opportunities of participation. The same applies for the male-female ratio among Tdh mobile teams, CBCPC members and PSS volunteers.
Taking into account that Tdh intervenes in very conservative areas –women and girls cannot leave their homes to participate in activities– awareness sessions on CP, as well as RMNCH care will be conducted at home. To allow women to attend training, sessions will be organized at the village level by Tdh female staff. Due to nature of the activities, women and girls will represent 72% of the targeted beneficiaries.

Despite the support provided directly on CPiE, the CBCPC received Tot on CPiE and non-formal MRE. The CBCPC are gender balanced (2 men and 2 females), the main message around child protection and the risk of explosive devices. The child rights are integrated in order for example for the people to understand the importance of education or the access of Health (with a special attention on mother through MCH component). The message are also done in order to reduce the violence against children (girl are more vulnerable to be victim within house and boys when they are in school or in their place of work). Finally, child labor, early marriage and child marriage are important part of the awareness rising and are completely integrated in all Tdh intervention in Afghanistan. For the non-formal MRE, child friendly have been developed with DMAC and will be continuously used as the previous intervention. The material was realized and adapted to completely integrate vulnerable person (illiterate) and the one with specific needs (disability). The material used image and little text in order to really make it understandable by everyone.

The community elders are automatically integrated at the first stage of the project implementation in order to get their approbation to do the activities. Then CBCPC are selected from the community and they will have to cover as much as possible members from their villages. For instance, in the current project, some CBCPC members (female) are using the marriage gathering in their village to deliver message on CPiE and non-formal MRE to other women because it's big gathering of women. Thus, they understand the importance of those messages on CPiE (including early marriage) and MRE and they are willing to make as much as possible other women aware of this.

Protection Mainstreaming

Tdh develops all its projects in accordance with the principles of humanitarian aid. In addition to this, the Tdh Child Safeguarding Policy is disseminated, applied and monitored among all the parties involved in project activities. As per rules of Tdh, all the staff and volunteers receive a first training on CP policy followed by refreshment training. The Child Protection Minimum Standards (CPMS) are also a fundamental guide for Tdh intervention. Training on CPMS may be extended to external actors to increase awareness on CP issues.
The "Do No Harm" principles will be applied for the intervention together with the protection principles of the Sphere guidelines to avoid exposing people to further harm as a result of Tdh actions. Steps will be taken to avoid or minimize any adverse effects of Tdh intervention, in particular the risk of exposing people to increased danger or abuse of their rights. The assistance and protection efforts will not undermine the affected population's capacity for self-protection. Sensitive information will be managed in a way that does not jeopardize the security of the informants or those who may be identifiable from the information. The confidentiality of the information collected on the children and their families will be guarded. Cultural and religious sensitivities will be taken into account in each phase of the project. Tdh will maintain positive and fruitful relationships with all the concerned communities to mitigate tensions and secure social cohesion, especially through CBCPC.
Tdh will continue adopting a participatory approach to ensure that all the actors on the ground have their voice on the project for adjustments, discussions and information sharing. Regular joint meetings with the beneficiaries, CBCPC, PSS volunteers, local health centers and authorities will be organized for this purpose.
Tdh will contribute to different cluster and sub cluster in order to advocate for child protection and Mother and Child Health, as well as joining the effort of WHO, UNHCR, UNICEF and OCHA to get efficient response and clear picture of the situation on the ground. The participation in the cluster at Kabul and Jalalabad level is crucial for providing the best assistance and protection to the most vulnerable population. The effort and the specialization of each agency are required and sharing information, collaborating and delivering will be either by participating to those meeting. Finally, Tdh will report progress and information related to the project (database, progress report) as requested per CHF agreement and guidelines. Tdh will share information in order to contribute to advocate having better funding and more project on child protection.
The integrated approach of child protection and RMNCH will definitely participate in the global effort designed by the HRP, the project will support the community in being more resilient, more aware of the importance of child protection and access to Health and the project will assist the most vulnerable population affected by consequences related to crisis, conflict, return, displacement without forgetting the host community.

Country Specific Information

Safety and Security

The volatility of the security context in Afghanistan's Eastern Region has the potential to significantly hinder Tdh staff access to the areas of intervention. The security situation is constantly monitored by the Tdh Security Manager and Tdh's response activities will be based on Tdh Security Plan. In a context where tensions and insecurity are increasing Tdh will ensure maintenance of a close collaboration with community elders/leaders and work towards a strong acceptance by the communities. Close links will also be maintained at central and local level with GoA, other NGOs, INSO, and UN bodies to facilitate implementation. At field level, social cohesion activities will be promoted while ensuring equitable access to all affected populations regardless of their origins.

Access

Access will be based on the relationship with communities and local authorities, on a strict security analysis, on good coordination with INSO and other humanitarian partners and on effective and transparent assistance to the populations. This strategy has been fruitful in Nangarhar where Tdh has gained strong acceptance from the communities and has been granted continued access over the first two project phases. Tdh's intervention and the cordial collaboration with community leaders, Maliks and religious leaders have enabled Tdh to be identified as a neutral and reliable organization. Moreover, Tdh has a transparent selection process of beneficiaries that does not create any division but reinforces the social cohesion between IDP, returnee and host communities.
Tdh has a long standing experience in the area and in the work in the community. The program implementation integrates an induction phase to make sure that the community elders and the key people of the community know about Tdh, about the implementation of the activities planned. So far, Tdh did not face any problem and the activities were always well accepted by the community, even the one which could be considered as sensitive (CPiE, early marriage...). The rights of the children are well accepted by the community and the work done on awareness rising by CBCPC is really helpful for changing the mentally and easily integrate the main message even if sensitive. In addition, Tdh's is reinforcing the message and delivering assistance in order to tackle the child protection concerns.
Through the establishment, training and follow-up of CBCPC and PSS volunteers Tdh ensures that local communities participate fully in and engage with project planning, design, implementation and M&E practices. Indeed, the community volunteers jointly work with Tdh to define vulnerability criteria, design local games, deliver messages, identify vulnerable children and families, and follow case management and share data with Tdh mobile teams.
The PSS volunteers and the CBCPC tot are receiving regular training and benefiting from mentoring of the Tdh staff on regular basis. As they are completely integrated in the activities, delivery of messages (even the most sensitive) is more easily accepted as the person delivering the message is from the village. The activities are taken in house or in location chosen by the community elders and CBCPC and are within the village. This ensures safety, facilitate the participation and trust for parent to let their children participate in PSS activities for example.
Access to areas of intervention is monitored every day by Tdh Security Officer and by the regional manager. The network developed in the Nangarhar and Laghman ease the checking before movement on daily basis and also in case of incident to take the appropriate decision. Some additional measures are taken as first aid training for Tdh staff, GPS tracker, regular refreshing on security management for team. Tdh mobile teams are not allowed to move without prior security clearance. In case of security deterioration and if Tdh mobile teams have no access to an area, the activities will continue to be implemented through CBCPC and PSS volunteers. A remote mentoring system will be set up to allow Tdh mobile team to follow and monitor the activities.
As Tdh project is developed on mobility and accessing the unserved and isolated population, the mobile team are going where none or very few other actors are presents. The project is definitely contributing to have increased coverage of those "white area" and will definitely be helpful in advocating having further support in those areas. If more organization assists, Tdh team will be able to reach other unserved area. The backstopping of CBCPC and PSS volunteers will be done periodically in the already assisted villages. Most of activities proposed are draw to support the inclusion of vulnerable person including children with disability.

BUDGET

Code	Budget Line Description	D / S	Quantity	Unit cost	Duration Recurrance	% charged to CHF	Total Cost
1. Staff and Other Personnel Costs							
1.1	Outreach Social workers (CPiE)	D	8	663.00	12	100.00	63,648.00
	2 social workers are part of each 4 mobile team. They are in Tdh salary scale 2A step 1 - including 2% annual increase						
1.2	Tdh country director (SHARED)	S	1	7,500.00	12	12.00	10,800.00
	Overview of the project, direct supervision of the program coordinator, revision of reporting, part of the Project Accountability Group which ensure the monitoring, the vision and the quality of the intervention (meeting on monthly basis) and field visits planned.						
1.3	CBCPC Mobiliser (CPiE)	D	1	663.00	12	100.00	7,956.00
	In charge to organise the training (CPiE) in Jalalabad for the new CBCPC Tot (as well as the refresher which will take place), organizing the female CBCPC Tot training in the villages. He/she will follow up the training replication done by the CBCPC tot already trained and go on the field to collect the training attendance form filled by CBCPC tot in each villages.						
1.4	Learning and development officer (CPiE)	D	1	1,140.00	12	60.00	8,208.00
	In charge of training social workers and animators on life saving PSS, sharing knowledge and common PSS methods , Tdh Salary scale 4						
1.5	PSS/Protection Project officer (CPiE)	D	1	1,720.00	12	100.00	20,640.00
	He is the guarantor of the good project implementation, do the link with the DoPH, he is the team leader. He will do the security clearance and represent Tdh in external meeting related to his specialty. He will ensure the strict following of CP and PSS thematic policies and be in charge of monitoring and evaluation of the full project. *He will participate in the regional cluster Protection, sub cluster CPiE and will be do the reporting for the different government bodies at the regional level.*						
1.6	Admin/ Finance officer (Jalalabad) (SHARED)	S	1	1,100.00	12	25.00	3,300.00

	Will support the financial monitoring of the project at field level, prepare cash books ,monitor bank transfers and cash flow. Tdh salary scale 3						
1.7	RMNCH Coordinator(Kabul) (RMNCH)	D	1	3,130.00	12	25.00	9,390.00
	The RMNCH coordinator based in Kabul will be the technical support and will guaranty of quality RMNCH activities and link with WHO and MoPH guidelines. She will be part of the recruitment, she will go to train the midwives recruited and visit the project location time to time to ensure the quality of the care provided. She will be in charge to update the guidelines, the tools to make sure that the care provided is up to date according to Government and WHO guidelines. She will do the reporting requirement for the Health cluster and for the different line ministries.						
1.8	Project Manager (Expat) (SHARED)	D	1	6,950.00	12	84.00	70,056.00
	The expat project coordinator supervise the entire project, monitoring and evaluation, training, reporting and representation of Tdh in different cluster and meetings with authorities. She/He will be based in Kabul with 50% (minimum) of his/her time in Nangarhar.						
1.9	Team Leader RMNCH - (RMNCH)	D	1	750.00	12	91.70	8,253.00
	The RMNCH team leader is the supervisor of the full team of midwives. She will identify the needs of training, she will ensure the link with the DoPH in Jalalabad. She will supervise and guarantee the quality of the RMNCH and will be in technical line with the RMNCH coordinator in Kabul.						
1.10	Midwives - (RMNCH)	D	12	650.00	12	87.00	81,432.00
	Each of the 4 mobile team will be composed of 3 midwives. The midwives are in charge of the RMNCH care (screening, providing Antenatal care, postnatal care, and identification of complicated pregnancy…) they will advocate for delivery in health facilities, for vaccination and breastfeeding. They will be in charge to deliver Health education based on WHO, MoPH guidelines and under the supervision of RMNCH coordinator based in Kabul.						
1.11	Admin/Logistics Clerk (SHARED)	S	1	510.00	12	100.00	6,120.00
	Based in Jalalalab, for overall Logistics follow up for the project (kits purchase/ distribution) and all other logistics related tasks. He will coordinate the van movement and manage the rental contract, as well as do the quotation process for all the purchase to be done during the project implementation. He will in charge to ensure the delivery of the kit in each of the 96 villages of intervention in the 3 provinces.						
1.12	Guards - (SHARED)	S	5	510.00	12	90.00	27,540.00
	4 full time guards to ensure the security of the office, one part time contract (50%) to cover the leave time of the guards. Therefore the number of guards will be 5: In total 4 guards full time (100%) and one guard at part time (50%).						
1.13	Monitoring/ Evaluation officer - (SHARED)	S	1	1,132.00	12	42.00	5,705.28
	The monitoring and evaluation officer will be based in Kabul and will develop all the forms needed for the good implementation of the project. He will go to Jalalabad to train the team and the data entry person on the use of them. He will go on the field to ensure that the quality of the intervention is in equitation with the logframe and results expected. Finally the M&E will do a monthly follow up report on the indicators that will be checked by project manager.						
1.14	PSS Junior Animators - CPiE	D	8	663.00	12	100.00	63,648.00
	Two in each van. In charge of life saving PSS, CPiE awareness sessions for children, Tdh salary scale 2 A.						
1.15	Security officer - (SHARED)	S	1	1,504.00	12	32.00	5,775.36
	He will ensure that the security plan is strictly followed up, he will control that security clearance is done every morning and supervise movement from Kabul to Jal. He will do regular field visits (travel expenses covered by Tdh office). Tdh salary scale , Tdh Salary scale 5						
1.16	Driver (Kabul) - (SHARED)	S	1	560.00	12	30.00	2,016.00
	Around 3 movements per month (via road) will have to be done to monitor and evaluate the project and ensure the quality of the project. 1 driver from Kabul will dedicated for these movements.						
1.17	HR Manager Kabul - (SHARED)	S	1	1,616.00	12	8.00	1,551.36
	He will support the recruitment of the staff in the beginning, he will manage the payrolls for all the staff on monthly basis, he will ensure that Tdh HR guidelines are implemented and respected.Tdh Salary scale 5						
1.18	Finance Coordinator Kabul - (SHARED)	S	1	3,149.00	12	32.00	12,092.16
	He will check and have the financial and admin overview of the project. He will be in daily link with the admin and finance manager based in Jalalabad. He will do internal control by visiting office and villages on regular basis. He will supervise the payment of the tax to the government, ensure that the bi-annual financial reporting for the MoEC at Kabul and in Jalalabad is done on time and guarantee.						
1.19	Data Clerk - (SHARED)	D	1	510.00	12	100.00	6,120.00
	The data clerk will enter all the data related to the project in the databases developed by the M&E. It will include, CBCPC Tot CP, PSS and RMNCH.						

1.20	Project Manager Child protection (Kabul) - (SHARED)	D	1	1,583.00	12	43.00	8,168.28
	CP manager Kabul will provide technical support to the project and will regularly visit the project activities to ensure proper follow up and quality of services delivered to the beneficiaries. The Project Manager will be in charge of the reporting to the line ministry, will do the link with DMAC, will participate in Protection cluster and GBV, CPiE sub cluster as well as Ref & Ret chapter.						
1.21	Community Mobilizer (MRE)	D	4	663.00	12	100.00	31,824.00
	The community mobilizer will be part of the mobile team, they will focus mainly on the 32 new villages to organize and train the CBCPC members. In the mean time, they will also rotate and going time to time in all the other 64 villages. They will follow up CBCPC training especially on MRE.						
	Section Total						**454,243.44**
2. Supplies, Commodities, Materials							
2.1	Material for PSS activities - (CPiE)	D	4	150.00	12	100.00	7,200.00
	The PSS material are defined in CFS minimum standard define by Tdh and in Annex. The material will have to be renewed on monthly basis and some of the material will be given to the community volunteers in order to continue the PSS support even when Tdh won't be present in the villages (it's including toys, books, charts, pencils and paper, paints, items for games (rope, balls, etc.). Each of the 7 vans will have 150 USD per month in average.						
2.2	Refreshment for children (during PSS Sessions) - (CPiE)	D	5000	1.00	12	95.00	57,000.00
	The small snacks are estimated to 1 USD for each piece. Each children registered and who participated in the session will received one snacks.						
2.3	Production of Communication Materials - (CPiE)	D	1	50.00	12	100.00	600.00
	It will be used for all the awareness sessions materials used during the different training organised.						
2.4	Cost of the organisation and cost of the Tot for CBCPC - (CPiE)	D	128	12.50	2	100.00	3,200.00
	this includes training material and refreshment for 128 members for Jalalabad ToT and PSS/CP, total 2 sessions will be organized in 12 months (PSS, CPiE) One ToT and one refresher , each event will be for a maximum of 3 days						
2.5	Staff training / Self care - (SHARED)	D	5	300.00	2	100.00	3,000.00
	It will be specific sessions organized with the support of external consultant (psychotherapist, psychologist, or any other needs) in order for the staff to release their stress, bad stories heard during their working time, bad thoughts. *It will limit the impact of difficult situation the staff are dealing with on daily basis, be more efficient in their work and the support to beneficiaries.*						
2.6	PSS volunteers communication and transport fee - (CPiE)	D	256	5.00	12	100.00	15,360.00
	Monthly fees provided to PSS volunteers in order to organise the PSS sessions with the children, to communicate with Tdh and to move around in the area.(5 USD for 256 PSS volunteers).						
2.7	CBCPC ToT communication and transportation fees - (CPiE)	D	128	5.00	12	100.00	7,680.00
	128 CBCPC Tot - Monthly allowance provided provided to move around						
2.8	Direct assistance for the most vunerable families(Hygiene+ Winter kits) - (CPiE)	D	400	40.00	1	100.00	16,000.00
	40 USD per kit based on the ERM Standards and ES NFI cluster. (BoQ attached.)						
2.9	RMNCH Health Assitance(medicine, delivery kits /other assitance). - (RMNCH)	D	3080	6.00	1	100.00	18,480.00
	The medecins could be iron or any other basic medicine to combat the anemia of the mother and the babies in order to reduce the risk of disease and mortality.The clean delivery kit is a powerrful tool used to convince the mother to deliver to Health facilities or to have at least the basic kit to deliver home if the family is not allowing the hospital visit. (BoQ attached)						
2.10	Standard Midwivery Kits - (RMNCH)	D	7	300.00	1	100.00	2,100.00
	This kit will be useful for eah ot the 7 team of midwives to provide adapted assistance to mother and babies(BoQ attached)						
2.11	Health Education Kits - (RMNCH)	D	7	100.00	1	100.00	700.00
	Each of the couple team of midwives will need a Health education kit to do the Health education properly. *The kit will include the printing of the already developed IEC material.*						
2.12	Production of material for the MRE activities	D	1	305.00	12	100.00	3,660.00
	It will be used for all the MRE awareness sessions materials used during the different training organized. The material will be adapted to illiterate people.						
2.13	Cost of the organisation and cost of the Tot for CBCPC - (MRE)	D	128	12.50	2	100.00	3,200.00
	this includes training material and refreshment for 128 members for Jalalabad ToT and PSS/CP, total 2 sessions will be organized in 12 months (PSS, CPiE) One ToT and one refresher , each event will be for a maximum of 3 days						

2.14	Cost of the accomodation for the DMAC trainers . (MRE)	D	8	60.00	2	100.00	960.00
	cost of the accommodation of the DMAC trainers who will come in Jalalabad to deliver the Tot for the CBCPC members. It will be 3 days of training for 2 persons from DMAC, twice.						
2.15	CBCPC ToT communication and transportation fees - (MRE)	D	128	5.00	12	100.00	7,680.00
	128 CBCPC Tot - Monthly allowance provided provided to move around to deliver MRE training						
	Section Total						**146,820.00**
3. Equipment							
3.1	Furniture / Equipment - (SHARED)	S	1	1,500.00	1	100.00	1,500.00
	Purchase of small equipment for the office during the duration of the project - renewal of computer, printers, table…(BoQ attached)						
	Section Total						**1,500.00**
4. Contractual Services							
4.1	Rental Cars (Mini Vans) - (SHARED)	D	4	650.00	12	100.00	31,200.00
	rental of 4 mini vans (including fuel, maintenance and salary of driver)						
4.2	Rental cars for monitoring and quality insurance - (SHARED)	D	1	400.00	12	89.00	4,272.00
	This car will be used for the management team to do monitoring field visit, to visit authorities. The car will be used by CBCPC mobiliser, team leader RMNCH and the data clerk/M&E to visit the field and collect the missing data, delivery notes... finally, this car will be used within Jalalabad to attend to the different clusters, progress meetings and meeting with authorities.						
	Section Total						**35,472.00**
5. Travel							
5.1	Transportation Cost Kabul-Jalalabad - (SHARED)	D	1	480.00	12	83.00	4,780.80
	one flight ticket per month, and the rest will the cover the movement needed by road. The car is provided by Tdh, but the cost of maintenance, the driver salary, the gas is calculated based on the average cost of the current movement. *According to UNHAS price list one round trip from Kabul to Jalalabad is 280 USD for one person, the rest will be used to cover the cost of at least 1 movement per car from Kabul to Jalalabad (around 302 km).*						
	Section Total						**4,780.80**
6. Transfers and Grants to Counterparts							
NA	NA	NA	0	0.00	0	0	0.00
	NA						
	Section Total						**0.00**
7. General Operating and Other Direct Costs							
7.1	Rent of Jalalabad Office - (SHARED)	S	1	635.00	12	100.00	7,620.00
	This Line will cover the rent of the office.						
7.2	Office Running costs Jalalabad office - (SHARED)	S	1	350.00	12	100.00	4,200.00
	Office running costs (electricity, heating, office supplies etc) will be covered under this budget line						
7.3	Kabul office rent and running costs - (SHARED)	S	1	2,700.00	12	32.00	10,368.00
	Partial cost of Kabul office rent and running costs (electricity, heating, water, office supplies , internet etc).						
7.4	Communication costs for the staff, internet in the office + Thuraya cards - (SHARED)	S	1	300.00	12	100.00	3,600.00
	Monthly mobile top up cards and office internet fee.						
7.5	Financial Services - (SHARED)	S	1	180.00	12	100.00	2,160.00
	Bank charges, monthly salary transfers chargers, FTT charges for bank to bank transfers.						

7.6	Office Security improvement and maintenance - (SHARED)	S	1	1,400.00	1	100.00	1,400.00
	GPS tracker annual fees and reinforcement of office building or to purchase additional equipment for security will be charged under this budget line.						
	Section Total						**29,348.00**
SubTotal			9,347.00				**672,164.24**
Direct							566,416.08
Support							105,748.16
PSC Cost							
PSC Cost Percent							7.00
PSC Amount							47,051.50
Total Cost							**719,215.74**

Project Locations

Location	Estimated percentage of budget for each location	Estimated number of beneficiaries for each location					Activity Name
		Men	Women	Boys	Girls	Total	
Nangarhar -> Behsud	14	183	821	350	350	1,704	Activity 1.1.1 : Volunteers from the community are identified, trained and mentored to deliver quality PSS activities Activity 1.1.1 : Deliver RMNCH care (antenatal and postnatal care, referral, promotion of immunization,…) to pregnant and lactating women and babies Activity 1.1.2 : Deliver life-saving PSS activities with trained volunteers in each of the 64 villages identified Activity 1.1.2 : Build coordination, facilitate referral and collaboration with Health actors of the region Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.4 : community have raised awareness on CPiE Activity 1.1.4 : Recruit and trained the midwives and the team leader Activity 1.1.5 : Realize ANC and PNC Activity 1.1.6 : Refer pregnant women for delivery assisted by skilled attendant Activity 1.1.7 : Refer all babies to Public hospital or Health partners Activity 1.1.8 : Raise awareness on importance of Health witin the women community Activity 2.1.1 : Case management is provided to the most vulnerable children identified by CBCPC and Tdh Activity 2.1.2 : Providing direct assistance to the most vulnerable families in order to decrease the risk of abuse and exploitation of children Activity 3.1.1 : Newly identified CBCPC members are trained by DMAC Activity 3.1.2 : CBCPC members received refresher on non-formal MRE by DMAC Activity 3.2.1 : Returnees, IDPs, conflict affected population at risk of ERW/EDO have raised awareness through sessions delivered by CBCPC members and Tdh staff

Nangarhar -> Surkhrod	14	183	821	350	350	1,704	Activity 1.1.1 : Volunteers from the community are identified, trained and mentored to deliver quality PSS activities Activity 1.1.1 : Deliver RMNCH care (antenatal and postnatal care, referral, promotion of immunization,…) to pregnant and lactating women and babies Activity 1.1.2 : Deliver life-saving PSS activities with trained volunteers in each of the 64 villages identified Activity 1.1.2 : Build coordination, facilitate referral and collaboration with Health actors of the region Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.4 : community have raised awareness on CPiE Activity 1.1.4 : Recruit and trained the midwives and the team leader Activity 1.1.5 : Realize ANC and PNC Activity 1.1.6 : Refer pregnant women for delivery assisted by skilled attendant Activity 1.1.7 : Refer all babies to Public hospital or Health partners Activity 1.1.8 : Raise awareness on importance of Health witin the women community Activity 2.1.1 : Case management is provided to the most vulnerable children identified by CBCPC and Tdh Activity 2.1.2 : Providing direct assistance to the most vulnerable families in order to decrease the risk of abuse and exploitation of children Activity 3.1.1 : Newly identified CBCPC members are trained by DMAC Activity 3.1.2 : CBCPC members received refresher on non-formal MRE by DMAC Activity 3.2.1 : Returnees, IDPs, conflict affected population at risk of ERW/EDO have raised awareness through sessions delivered by CBCPC members and Tdh staff

Nangarhar -> Rodat	10	131	586	250	250	1,217	Activity 1.1.1 : Volunteers from the community are identified, trained and mentored to deliver quality PSS activities Activity 1.1.1 : Deliver RMNCH care (antenatal and postnatal care, referral, promotion of immunization,...) to pregnant and lactating women and babies Activity 1.1.2 : Deliver life-saving PSS activities with trained volunteers in each of the 64 villages identified Activity 1.1.2 : Build coordination, facilitate referral and collaboration with Health actors of the region Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.4 : community have raised awareness on CPiE Activity 1.1.4 : Recruit and trained the midwives and the team leader Activity 1.1.5 : Realize ANC and PNC Activity 1.1.6 : Refer pregnant women for delivery assisted by skilled attendant Activity 1.1.7 : Refer all babies to Public hospital or Health partners Activity 1.1.8 : Raise awareness on importance of Health witin the women community Activity 2.1.1 : Case management is provided to the most vulnerable children identified by CBCPC and Tdh Activity 2.1.2 : Providing direct assistance to the most vulnerable families in order to decrease the risk of abuse and exploitation of children Activity 3.1.1 : Newly identified CBCPC members are trained by DMAC Activity 3.1.2 : CBCPC members received refresher on non-formal MRE by DMAC Activity 3.2.1 : Returnees, IDPs, conflict affected population at risk of ERW/EDO have raised awareness through sessions delivered by CBCPC members and Tdh staff

Nangarhar -> Kama	11	144	645	275	275	1,339	Activity 1.1.1 : Volunteers from the community are identified, trained and mentored to deliver quality PSS activities Activity 1.1.1 : Deliver RMNCH care (antenatal and postnatal care, referral, promotion of immunization,…) to pregnant and lactating women and babies Activity 1.1.2 : Deliver life-saving PSS activities with trained volunteers in each of the 64 villages identified Activity 1.1.2 : Build coordination, facilitate referral and collaboration with Health actors of the region Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.4 : community have raised awareness on CPiE Activity 1.1.4 : Recruit and trained the midwives and the team leader Activity 1.1.5 : Realize ANC and PNC Activity 1.1.6 : Refer pregnant women for delivery assisted by skilled attendant Activity 1.1.7 : Refer all babies to Public hospital or Health partners Activity 1.1.8 : Raise awareness on importance of Health witin the women community Activity 2.1.1 : Case management is provided to the most vulnerable children identified by CBCPC and Tdh Activity 2.1.2 : Providing direct assistance to the most vulnerable families in order to decrease the risk of abuse and exploitation of children Activity 3.1.1 : Newly identified CBCPC members are trained by DMAC Activity 3.1.2 : CBCPC members received refresher on non-formal MRE by DMAC Activity 3.2.1 : Returnees, IDPs, conflict affected population at risk of ERW/EDO have raised awareness through sessions delivered by CBCPC members and Tdh staff

Nangarhar -> Kuzkunar	16	209	938	400	400	1,947	Activity 1.1.1 : Volunteers from the community are identified, trained and mentored to deliver quality PSS activities Activity 1.1.1 : Deliver RMNCH care (antenatal and postnatal care, referral, promotion of immunization,...) to pregnant and lactating women and babies Activity 1.1.2 : Deliver life-saving PSS activities with trained volunteers in each of the 64 villages identified Activity 1.1.2 : Build coordination, facilitate referral and collaboration with Health actors of the region Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.4 : community have raised awareness on CPiE Activity 1.1.4 : Recruit and trained the midwives and the team leader Activity 1.1.5 : Realize ANC and PNC Activity 1.1.6 : Refer pregnant women for delivery assisted by skilled attendant Activity 1.1.7 : Refer all babies to Public hospital or Health partners Activity 1.1.8 : Raise awareness on importance of Health witin the women community Activity 2.1.1 : Case management is provided to the most vulnerable children identified by CBCPC and Tdh Activity 2.1.2 : Providing direct assistance to the most vulnerable families in order to decrease the risk of abuse and exploitation of children Activity 3.1.1 : Newly identified CBCPC members are trained by DMAC Activity 3.1.2 : CBCPC members received refresher on non-formal MRE by DMAC Activity 3.2.1 : Returnees, IDPs, conflict affected population at risk of ERW/EDO have raised awareness through sessions delivered by CBCPC members and Tdh staff

Laghman -> Mehtarlam	21	275	1,231	525	525	2,556	Activity 1.1.1 : Volunteers from the community are identified, trained and mentored to deliver quality PSS activities Activity 1.1.1 : Deliver RMNCH care (antenatal and postnatal care, referral, promotion of immunization,…) to pregnant and lactating women and babies Activity 1.1.2 : Deliver life-saving PSS activities with trained volunteers in each of the 64 villages identified Activity 1.1.2 : Build coordination, facilitate referral and collaboration with Health actors of the region Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.4 : community have raised awareness on CPiE Activity 1.1.4 : Recruit and trained the midwives and the team leader Activity 1.1.5 : Realize ANC and PNC Activity 1.1.6 : Refer pregnant women for delivery assisted by skilled attendant Activity 1.1.7 : Refer all babies to Public hospital or Health partners Activity 1.1.8 : Raise awareness on importance of Health witin the women community Activity 2.1.1 : Case management is provided to the most vulnerable children identified by CBCPC and Tdh Activity 2.1.2 : Providing direct assistance to the most vulnerable families in order to decrease the risk of abuse and exploitation of children Activity 3.1.1 : Newly identified CBCPC members are trained by DMAC Activity 3.1.2 : CBCPC members received refresher on non-formal MRE by DMAC Activity 3.2.1 : Returnees, IDPs, conflict affected population at risk of ERW/EDO have raised awareness through sessions delivered by CBCPC members and Tdh staff

Laghman -> Qarghayi	14	184	821	350	350	1,705	Activity 1.1.1 : Volunteers from the community are identified, trained and mentored to deliver quality PSS activities Activity 1.1.1 : Deliver RMNCH care (antenatal and postnatal care, referral, promotion of immunization,...) to pregnant and lactating women and babies Activity 1.1.2 : Deliver life-saving PSS activities with trained volunteers in each of the 64 villages identified Activity 1.1.2 : Build coordination, facilitate referral and collaboration with Health actors of the region Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.3 : As per agreement, progress report as well as complaint mechanism to OCHA will be done regularly Activity 1.1.4 : community have raised awareness on CPiE Activity 1.1.4 : Recruit and trained the midwives and the team leader Activity 1.1.5 : Realize ANC and PNC Activity 1.1.6 : Refer pregnant women for delivery assisted by skilled attendant Activity 1.1.7 : Refer all babies to Public hospital or Health partners Activity 1.1.8 : Raise awareness on importance of Health witin the women community Activity 2.1.1 : Case management is provided to the most vulnerable children identified by CBCPC and Tdh Activity 2.1.2 : Providing direct assistance to the most vulnerable families in order to decrease the risk of abuse and exploitation of children Activity 3.1.1 : Newly identified CBCPC members are trained by DMAC Activity 3.1.2 : CBCPC members received refresher on non-formal MRE by DMAC Activity 3.2.1 : Returnees, IDPs, conflict affected population at risk of ERW/EDO have raised awareness through sessions delivered by CBCPC members and Tdh staff

Documents

Category Name	Document Description
Project Supporting Documents	Nang_Kunar_TdH_EvaluationReport_07.03.17.pdf
Project Supporting Documents	Griffith research_executive summary_Tdh December 2015.pdf
Project Supporting Documents	Map of Intervention.jpg
Project Supporting Documents	Update Resource Coordination Mapping Ishteme 2017 .xlsx
Project Supporting Documents	village population for Ishtema 3.xlsx
Project Supporting Documents	coordination and partners.docx
Project Supporting Documents	Ishtema selection criteria for CMS Cases .docx
Project Supporting Documents	Ishtema selection criteria for Kitchen Items .docx
Project Supporting Documents	Ishtema selection criteria for MCH .docx
Project Supporting Documents	Ishtema selection criteria for Winterization Kit.docx
Project Supporting Documents	MCH information in Isthema 3 areas of intervention Jan 2017.docx
Project Supporting Documents	preparation work for Ishtema3.docx
Project Supporting Documents	Annex 6 - Kit content.xls
Project Supporting Documents	APC CHF Support letter_12032017 - Tdh.pdf
Project Supporting Documents	Endorsment_Letter_Health_Cluster_CHF_Tdh.pdf
Project Supporting Documents	.breakdowns_Beneficiary_ CBCPC_Volunteer_3Ishtema3.xlsx

Project Supporting Documents	Beneficiaries and activities(1).docx
Budget Documents	BoQ 7.2 office running cost .xlsx
Budget Documents	Refreshment for children Line 2.2..xlsx
Budget Documents	Budget line 2.8 NFI+ winter kits .xls
Budget Documents	BoQ 2.1 -2.9.xlsx
Budget Documents	BoQ 2.4 - 2.12 -2.13.xlsx
Budget Documents	BoQ Furniture 3.1 .xlsx
Grant Agreement	TDH - Grant Agreement signed by HC.pdf
Grant Agreement	TDH - Grant Agreement signed by HC & IP.pdf