OCHA Coordination Saves Lives

Project Proposal

Requesting Organization :	PREMIERE-URGENCE-AIDE-MEDICALE-INTERNATIONALE
Allocation Type :	2017 2nd Standard Allocation

Primary Cluster	Sub Cluster	Percentage
HEALTH		60.00
NUTRITION		20.00
PROTECTION	PROTECTION	20.00
		100

Project Title :	Emergency Medical, Nutrition and Protection assistance to hard to reach populations of Kunar province
Allocation Type Category :	

OPS Details

Project Code :		**Fund Project Code :**	AFG-17/3481/SA2/H-N-APC/INGO/6860
Cluster :		**Project Budget in US$:**	722,150.00
Planned project duration :	12 months	**Priority:**	
Planned Start Date :	20/10/2017	**Planned End Date :**	19/10/2018
Actual Start Date:	20/10/2017	**Actual End Date:**	19/10/2018

Project Summary :

The intervention proposed by PU-AMI intends to provide an integrated approach to address comprehensive needs identified in Kunar province, in the eastern region of Afghanistan. With over ten years of experience in the area, in the implementation of health, nutrition and PFA activities, PU-AMI has acquired a sound knowledge of the needs of the populations. Strong of its historic and diverse presence on several regions of the country, PU-AMI has built a strong knowledge and understanding of the conflict dynamics as well as a comprehensive network with different stakeholders from communities to central government authorities.

In a mountainous and rural area where multiple AOGs affect the everyday life of the populations, access to essential healthcare is severely impacted. Numerous IDPs have left their area of origin to flee from conflict, which has dire consequences on their well-being, both at physical and psychological level. The Protection Community Assessment in Nangarhar, carried out by a variety of NGOs, including PU-AMI, and coordinated by UNHCR collected data in late 2016. This assessment highlighted some of the numerous protection concerns among IDPs, returnees and host communities. Given Kunar and Nangarhar are neighboring provinces with similar challenges (mountainous and rural terrain, bordering Pakistan, presence of AOGs, displacements), conclusions drawn for Nangarhar can be considered to also be applicable for Kunar province.
Furthermore, poverty and displacement also lead to a high malnutrition rate: with a 16.2% global acute malnutrition rate (Nutrition cluster data), the situation in Kunar province breaches the emergency threshold.

PU-AMI is a well-known and recognized humanitarian actor in the area and therefore benefits of access to hard to reach areas, where humanitarian needs are the highest.
PU-AMI has extensive experience and expertise in health, and will thus create, equip and maintain four FATPs (First aid trauma posts) to address emergency trauma needs in 4 existing HF while also establishing four SHC (Sub Health Centers) and one MHT (Mobile Health Team) through which primary healthcare, mother and childcare and immunization services will be provided.

The SHC and MHT will act as an entry point for the provision of nutrition and protection services. Indeed, the provision of protection services is still negatively perceived, therefore, the use of health as a motivation to gather beneficiaries is an ideal method especially since the need for psychological first aid or psychosocial services will most often not be identified by the beneficiary himself.

Special attention will be given to women, though the hiring of female staff in each team, dedicated PFA and PSS services, as well as to children U5, through the provision of nutrition services.

Direct beneficiaries :

Men	Women	Boys	Girls	Total
8,034	7,546	2,238	2,082	19,900

Other Beneficiaries :

Beneficiary name	Men	Women	Boys	Girls	Total
Host Communities	6,258	5,686	1,644	1,532	15,120
Internally Displaced People	888	930	297	275	2,390
Other	888	930	297	275	2,390

Indirect Beneficiaries :

Health services have an extensive impact to improve the health status of the entire population living in the catchment area of the health facilities. In addition, health facilities can welcome and treat people from outside of their catchment area. This remains challenging to quantify. For example, as direct beneficiaries of the health facilities, the current calculation only includes the population of the village in which the HF will be established, however neighboring villages might also come seeking healthcare. It is estimated that an additional 9960 individuals may visit SHCs to benefit of healthcare services.

Catchment Population:

Seven hard to reach districts of Kunar province: Bar Kunar, Dar I Pech, Ghaziabad, Khas Kunar, Marawara, Shigal and Watapur

Link with allocation strategy :

The proposed project aligns with the second standard allocation strategy and the Humanitarian Response Plan 2017 by providing lifesaving assistance for people in hard to reach and underserved areas.
In line with HRP and the Health Cluster, PU-AMI's proposed intervention aims to meet the immediate humanitarian needs of shock affected populations through essential basic and emergency health and protective services. PU-AMI will focus on hard to reach districts of Kunar province and support both emergency trauma care as well as primary healthcare.

In this project, PU-AMI meets the Nutrition cluster objectives, which aim to contribute to the reduction of the risk of excessive mortality and morbidity by improving the nutritional status of vulnerable groups, especially among boys, girls and pregnant and lactating women, through treatment and prevention of acute malnutrition and micronutrient.

PU-AMI proposed project aligns with the Protection Cluster Strategy, through the implementation of PSS activities and PFA services. Furthermore, PU-AMI is offering a package of integrated activities with health service as an entry point, which is one of the main requirements for this second allocation

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
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BACKGROUND

1. Humanitarian context analysis

According to the Humanitarian Information Unit (US Department of State), four of Afghanistan's eastern province - Kabul, Kunar, Laghman and Nangarhar host over 1.7 million vulnerable people, including 1.04 million returnees. During a surge in returns from Pakistan in late 2016, the majority entered in Nangarhar province, which hosts the largest number of last year's returnees despite many claiming a different province of origin.
According to IOM report, nearly 80 000 undocumented returnees arrived from Pakistan and 206 318 from Iran since January 2017. Further, UNHCR registered 44 579 returnees.
As the rate of returns is influenced by several political, security and other related factors both in Afghanistan and the neighboring countries, another surge in returns could occur at any time.
According to Humanitarian Needs Overview, the volatile security situation in many parts of the country, especially in Kunar province has also limited the access to basic health services. Indeed, the eastern provinces represent a relatively small geographical area with a high presence of various AOGs, where a proportionately high number of clashes have occurred between the ANSF, Taliban and ISIS.
The largest concentration of needs result from constrained or complete lack of access to essential basic and emergency services, including health care system, nutrition, protection and WASH. Indeed, the insecurity in Afghanistan has had a debilitating impact on the ability and the willingness of humanitarian agencies to ensure reactive presence, which is responsive to meet the needs of people most impacted by the crisis, which results in an unequal coverage of needs.
The challenges posed by an increasingly insecure environment have inevitably impacted the provision of response but also severely limits understanding of humanitarian needs in the more insecure and harder to access areas.

The security situation in Kunar remains very fragile and continues to take heavy casualties on the civilian population. Furthermore, Kunar, which is a mountainous province, is amongst the less developed province in the country. According to PU-AMI data, about 20% of the population had poor access to health services. Due to decades of war, the health care system was completely destroyed and the population didn't have access to health care services.

2. Needs assessment

PU-AMI offers a response to the different needs identified in seven hard to reach districts of Kunar province: Bar Kunar, Dar I Pech, Ghaziabad, Khas Kunar, Marawara, Shigal and Watapur

In Kunar in 2016, according to PU-AMI ECHO database, 25,264 trauma cases of which 2,249 due to conflict, have been reported. FATPs will be established in four existing health facilities which receive high numbers of trauma cases: Asmar CHC (Bar Kunar district), Khas Kunar CHC (Khas Kunar district), Marawara BHC (Marawara district), and Quro BHC (Watapur district), with an average of 900 trauma cases reported from these 4 health facilities during 2016 and an increase of 46% in the first 6 months of 2017 (821 cases) (HMIS reports).

Four areas in four hard to reach districts of Kunar (Mountainous, small and scattered villages) have been identified as the most vulnerable to provide health, nutrition and protection services. The list includes Wardish tangi (Dar I Pech district),Sooki (Ghaziabad district), Bar Galayee (Shigal district), Dargo (Watapur district). These proposed health facilities are at a distance of at least 6 kilometers from the nearest existing health facilities and would serve a total population of 16 600 individuals. These health facilities will provide health, nutrition and protection services to the population of these hard to reach areas due to its geographic condition and restriction of movements due to conflicts and presence of AOGs. - The four proposed SHCs lie in districts with important AOG presence (three of them are in areas totally under control of AOGs). Thus, the area of operation of the MHT is defined in collaboration with the PPHD, and will reach both IDPs sites as well as hard to reach villages that don't benefit of access to a HF.

Otherwise, in all the country, mortality rate for mothers and children is considerably high (According to the Afghanistan Health Indicators, Maternal Mortality Ratio is 327 per 100,000 live births and Infant Mortality Rate is 77 per 1000 live births) and access is the big challenge. The lack of health care professional, especially of women, is one of the key obstacles for health care delivery. In this proposed project, PU-AMI aims to increase essential health services to population in Kunar, especially to Women and children.
Under-nutrition of children under five years old (CU5) and pregnant and lactating women (PLW) is an ongoing critical public health issue in Afghanistan. According to the last National Nutrition Survey, the national GAM rate is 9.5% and SAM 4%, though in Kunar province the GAM rate is 16.2%; MAM 9.7 %; and SAM 6.5%; with a critical result for underweight of >15%; and very high stunting of >40%. Nationally, 9.2% of women of reproductive age were thin or undernourished. The survey revealed that CU5 and women of reproductive age were the most affected by micronutrient deficiencies, with 43% of children and 40% of women suffering from anemia.
As we already mentioned, nutrition activities are part of PU-AMI integrated approach, MAM and SAM screening and detection will be conducted in the five health facilities (4 SHC and 1 MHT).

Concerning the Protection activities, based on PU-AMI experience implementing PFA services, and the decades of protracted conflict show that the population is in dire need of psychological support. In such a context, PU-AMI will provide Psychological First Aid (PFA) and Psychosocial support (PSS) in the five above mentioned health facilities. Besides, the prevalence of GBV particularly remains high in Afghanistan, with most GBV cases concealed and driven by socio-cultural beliefs, values and practices. PU-AMI teams will be trained on case identification for GBV so as to be able to provide adequate response if cases should be identified.

3. Description Of Beneficiaries

PU-AMI will target different needs with different responses, providing an adapted Health Facility to the challenges of the populations.

First of all, four FATPs will target 1300 trauma cases and will be established in :
District Khas Kunar, Khas Kunar CHC
District Marawara, Marawara BHC
District Bar Kunar, Asmar CHC
District Watapur, Quro BHC
Breakdown of FATP beneficiaries is expected to be as follows
Women 200, Men 800, Girls 130, Boys 170

18 600 beneficiaries in need of primary health care will be targeted through the four SHCs and one MHT. These beneficiaries are the communities living in the catchment areas of the four Sub-Health Centers, in otherwise very isolated areas. The target population is composed of IDPs, returnees, and host communities of the hard to reach and conflict affected districts of Kunar.
The total catchment populations is 18 600 which is disaggregated as follows;
- 4 SHCs:
Wardish Tangi: Women 1442; Men 1518; Girls 360, Boys 380 - Total 3700
Sooki: Women 1364; Men 1436; Girls 341, Boys 359 - Total 3500
Bar Galayee: Women 1637, Men 1723; Girls 409, Boys 431 - Total 4200
Dargo: Women 2027, Men 2133; Girls 506; Boys 534 - Total 5200
Total: Women 6471 (38.98%), Men 6809 (41.02%); Girls 1617 (9.74%), Boys 1703 (10.26%)
- MHT:
Men; 425, Women; 875, Boys; 365, Girls; 335, Total; 2000 ¬¬¬¬¬¬¬
Health facility staff will be trained on HMIS, infection prevention, EPI refresher training, Drug management, and Basic Life support.

Additionally 4 SHC and 1 MHT will be staffed with 1 skilled birth attendant,
Number of pregnant women receiving at least 2 antenatal care visits: 372

Beneficiaries for Nutrition
This proposed project aims to bring nutrition services to the population who is not covered by BPHS and EPHS. Complementary with BPHS was taken into consideration to avoid duplication.
PU-AMI is already an active respondant when it comes to nutrition needs in Kunar province, and intervenes through 27 OPD SAM, 3 IPD SAM and 25 OPD MAM sites.
Number of children 0-59 months screened for malnutrition: 3 120 (1,778 Girls, 1,342 Boys)
Number of SAM children 0-59 months admitted for treatment: 780 (445 Girls, 335 Boys),
Number of MAM children 0-59 months admitted for treatment 2 340 (1,334 Girls, 1,006 Boys),
Number of SAM children 0-59 months discharged cured: 702 (400 Girls, 302 Boys),
Number of MAM children 0-59 months discharged cured 2 028 (1,156 Girls, 872 Boys),
Number of Acute malnourished PLW women treated: 1 560.

Beneficiaries for Protection
Number of beneficiaries receiving Psychosocial support: 2000 people (450 girls, 450 boys; 550 women, 550 men

4. Grant Request Justification

Through the proposed project, PU-AMI will implement an integrated approach intervention, targeting different areas with beneficiaries in common for different sectors.

High insecurity in Kunar prevents people to access to Health Facilities. In such a context, bringing emergency and primary health services such as: First Aid Trauma Post, SHC and MHT are paramount to increase and to create access to quality and standard essential health, nutrition and protection services for hard to reach populations in Kunar Province.

PU-AMI is an international NGO with extensive experience in Afghanistan including in the most conflict affected areas and has implemented health programs in Afghanistan for 35 years across several provinces and contexts spanning emergency interventions to development actions. PU-AMI has a unique access throughout Kunar province, due to its long presence in the region through the implementation of BPHS. Recognized as key health actor, PU-AMI established clinics in the most isolated areas of the province. There are 59 health facilities run by PU-AMI under SEHAT (BPHS)contracts including 1 provincial hospital, two district hospitals, 9 CHCs, 17 BHCs, 28 SHCs, 1 MHT and one prison health clinic. This proposed project aims to bring health services to the population who is not covered by BPHS and EPHS.

The Nutrition sector will be a complementary part of PU-AMI integrated approach, through MAM and SAM activities. As previously mentioned, the SHC and MHT will act as an entry point for the provision of nutrition services.
PU-AMI has been implementing WFP-funded projects since 2010 and thus has acquired significant experience in nutrition activities.
Through the proposed project, PU-AMI aims to reduce mortality and morbidity associated with malnutrition of children under five and PLW and improves their health status in hard to reach areas of Kunar Province.
Furthermore, PU-AMI currently works in partnership with the DG ECHO, CHF (UNOCHA) and WFP to provide life-saving assistance to vulnerable population affected by conflict through Health services, Nutrition and Protection interventions. PU-AMI has implemented PFA services in close coordination with WHO and the mental health department of MoPH in Kunar and Nangarhar Province.

In addition, despite the natural mountainous barrier to health care facilities for populations of Kunar, PU-AMI has a unique access overall in the province, due to its long presence in the region through the implementation of BPHS and the establishment of clinics in the most isolated areas of the province. Indeed, PU-AMI has currently two field bases in Jalalabad (regional office) and Asadabad (Kunar). Thanks to a constant respect of humanitarian principles and community approach, PU-AMI has secured access to remote communities and their successful involvement in project implementation. Furthermore, PU-AMI experience in BPHS enables advocacy and planning for integration of the proposed MHT into Kunar.

5. Complementarity

PU-AMI has maintained a consistent presence in Kunar province since 1994 and has developed excellent relationships with communities, local officials, and the Ministry of Public Health (MoPH). Since the beginning of the population wave of return in mid-2016 and in coordination with Clusters and stakeholders, PU-AMI increased its intervention to ensure the provision of multi sector emergency response/assistance to returnees and conflict induced IDPs in Nangarhar and Kunar provinces.
Indeed, PU-AMI has scaled up its intervention in Nangarhar and Kunar to respond to the returnees' crisis from Pakistan in the Eastern region, thanks to ECHO and CHF support. PU-AMI was able to broaden its response with Health, NFI and WASH activities. Furthermore, as we already mentioned, PU-AMI is a BPHS implementer in Kunar, and the proposed project is a complementary of BPHS, as it will meet the gap of BPHS health services.

With those projects, PU-AMI has developed a strong analysis and understanding of the returns and displacements dynamics. The proposed intervention in Kunar intends to complement the decades-long effort in the strengthening of the health system, while providing an immediate response in the short term to the needs of returnees.

LOGICAL FRAMEWORK

Overall project objective

To increase and to create access to quality and standard essential health, nutrition and protection services for hard to reach populations in Kunar Province.

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 :

Outcome 1

Conflict affected IDPs and host communities in hard to reach areas have access to basic and emergency healthcare services

Output 1.1

Description

First Aid Trauma Posts are set up to provide emergency trauma cares for conflict affected IDPs and host communities seeking lifesaving intervention

Assumptions & Risks

Assumptions & Risks:
- The security situation is permissive and humanitarian access is maintained in the areas of intervention
- All needed qualified staff are recruited
- Funding commitment is secured by donor
- Coordination with local health authorities and partners is effective

Mitigation strategies
- Ensure both the National and Provincial Safety & Security Plans are up-to-date and relevant.
- Ensure planning reviews are completed on time.
- Ensure all staffs are briefed on the security situation, standard operating procedures, and all safety and security measures.
- Ensure a proper and efficient communication about the FATPs with health facility directors and PPHD
- Discussion with influential leaders and Elders/ Shuras is sustained.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	HEALTH	SA2- Number of high risk conflict-affected districts with at least one first aid trauma post	4				4
Means of Verification : HMIS reports Construction report							
Indicator 1.1.2	HEALTH	SA2- Number of individuals receiving trauma care services	800	200	170	130	1,300
Means of Verification : HMIS report							

Activities

Activity 1.1.1

Standard Activity : Not Selected

Four integrated first aid trauma posts (FATP) are established in conflict affected areas of Kunar Province

BPHS and EPHS packages remains unable to respond to emergency situations, such as those frequently witnessed in Kunar as a result of ongoing protracted conflicts. The nature of the conflict is bringing inflow of weapon-related trauma cases requiring sustained emergency life-saving medical support. In Kunar in 2016 alone, according to PU-AMI ECHO database, 25,264 trauma cases of which 2,249 due to conflict, have been reported.

First aid trauma posts will be established to increase the capacity of local health facilities to deal with the upsurge of trauma cases due to conflict in their vicinity.
Data of 2015, 2016 and first 7 months of 2017 was reviewed to identify the existing health facilities receiving the highest number of trauma cases (conflict induced or not). Following health facilities were chosen for integration of a FATP.
- District Khas Kunar, Khas Kunar CHC
- District Marawara, Marawara BHC
- District Bar Kunar, Asmar CHC
- District Watapur, Quro BHC

In accordance with PPHD and Health Cluster Coordinator, decision was made to have FATPs integrated in existing BHC/CHC to leave the possibility of integration in the BPHS once the emergency intervention is over, thus keeping in mind the exit strategy after the emergency intervention. The goals to prevent death and disability in injured patients can be categorized into three broad sets of needs:
1. Life-threatening injuries are appropriately treated, promptly and in accordance with appropriate priorities, so as to maximize the likelihood of survival.
2. Potentially disabling injuries are treated appropriately, so as to minimize functional impairment and to maximize the return to independence and to participation in community life.
3. Pain and psychological suffering are minimized.

The set-up of these FATPs will be achievable through all different aspects of trauma cares resources that would be necessary to assure such care. These include human resources (staffing and training) and physical resources (infrastructure, equipment and supplies) that should be in place to assure optimal care of the injured patient at the range of health facilities.
In working towards decreasing the burden of death and disability from injury, a spectrum of activities will be considered, ranging from surveillance and basic prevention programs, to trauma management/stabilization and referral.

The drawing of the FATP was done by the PU-AMI engineer based on the constraints linked to each location (availability of terrain, etc) and on recommendations of PPHD and director of the health facility to ensure its acceptance and integration in the functioning of the facility. Essential notions such as access and hygiene standards (ease to clean) were obviously taken into consideration. (Drawings and BOQ attached, respectively in Annexes 06 and 05)

Together, the Engineer with the Project Manager will regularly monitor the construction progress and will ensure that FATPs are established according the calendar and standards.

Activity 1.1.2

Standard Activity : Not Selected

Procurement and distribution of essential medical supplies and equipment to four FATPs

For all facilities treating emergency trauma cases, equipment will be provided by PU-AMI, following ICRC standards. (BOQ attached in Annex 07)
In order to ensure the quality of trauma cares services, PU-AMI will ensure the FATPs are provided with all adequate medical equipment, consumables and drugs. This will be done through international procurement of drugs and local purchase for supplies that will follow PU-AMI own and donor's procurement rules for pharmaceuticals respecting Afghanistan Ministry of Health approved medical items.
PU-AMI medical procurement is led by the Health Department, consisting of a health coordinator and a pharmacist at mission level with technical support from HQ Pharmacist and HQ Health Advisor.
Drugs and medical supplies will be stored in the PU-AMI pharmacy in Jalalabad before being dispatched to the FATPs. Stock and consumption will be monitored by the pharmacist using software and checked by the health coordinator.

PU-AMI pharmacy department will monitor the process of procurement and distribution of essential medical supplies and equipments using PU-AMI and ICRC standards. Stock cards, pharmacy checklists, receive notes will be used to monitor the adequate amount of supplies to FATPs.

Activity 1.1.3

Standard Activity : Not Selected

Provision of essential trauma care services

Emergency trauma kits (including medical equipment, drugs and consumables, BOQ attached, Annex 07) will be delivered to those four health facilities. Both doctors and nurses are obviously important for a smooth running of the FATP. One provides assessment and diagnosis while the other offers aid, physical and psychological treatment. In short, they are both complementary factors to what makes the FATP operate efficiently.
The most important function of the doctor will be to identify and treat life-threatening conditions and then to assess the patient carefully for other complaints or findings that may require referral. The nurse will be in charge of providing first essential trauma care to patients. Since the FATPs are attached to an existing health facility, the doctor of the adjacent health facility (CHC or BHC) will also be operational in the FATP. Under CHF funding, PU-AMI will provide an additional nurse which will be dedicated full time to the FATP. The nurses will receive refresher training on Basic Life Saving.

The minimum package of First Aid Care/ trauma care at the FATP comprises early detection, initial medical care for severe injury or sudden illness using a certain amount of drugs and equipment to perform primary intervention and assessment to fulfill the basic principles of trauma care, which are to preserve life, to prevent further harm and to keep the patient condition's stable. This may include applying first aid techniques, airway and/or shock management, fluid resuscitation, caring burns, injury and wounds management, stabilization and promote recovery including dispensing of medication.

Strict protocols will be applied, according to national guidelines to always reach the highest quality of services. Patient records will be kept through a registration system (administrative registration and medical details taken by the doctor respecting confidential management of sensitive data).
Diagnostic and treatment protocols will be based on MoPH national guidelines.

Establishment of a referral system to secondary health facility level: The teams will be in continuous coordination with surrounding Hospital in case of referral needed. The referral will be done through an ambulance.

Security allowing, monthly supervision visits will be carried out by CHF programject manager to monitor the delivery of essential trauma care services. Supervision checklists will be used during supervision visits. Trauma registers will be checked for verifying the delivery of trauma services. Monthly reporting formats will be developed for each site to report their monthly achievement and will be stored in trauma database.

Output 1.2

Description

SHC and MHT provide essential package of primary health care services including mother and child health, immunization and trauma care for 18 600 people in Kunar province.

Assumptions & Risks

Assumptions & Risks:
- The security situation is permissive and humanitarian access is maintained in the areas of intervention
- All needed qualified staff are recruited, including female staff
- Funding commitment is secured by donor
- Coordination with local health authorities and partners is effective
-Communities are willing to provide a building for the establishment of the clinics
- Vaccine are provided by provincial health authorities
- Immunization services are accepted by returnees and IDPs

Mitigation strategies:
- Ensure both the National and Provincial Safety & Security Plans are up-to-date and relevant.
- Ensure planning reviews are completed on time.
- Ensure all staffs are briefed on the security situation, standard operating procedures, and all safety and security measures.
- Ensure a proper and efficient communication about immunization services to the beneficiaries.
- Discussion with influential leaders and Elders/ Shuras is sustained.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.2.1	HEALTH	SA2- Number of conflict affected people in underserved areas served by emergency PHC and mobile services	7,346	7,234	1,952	2,068	18,600
Means of Verification : HMIS reports							
Indicator 1.2.2	HEALTH	SA2- Number of health facilities in priority districts staffed by Skilled Birth Attendant	5				5
Means of Verification :							
Indicator 1.2.3	HEALTH	SA2- Number of pregnant women in conflict affected and underserved areas receiving at least two antenatal care visits		346		26	372
Means of Verification : HMIS report							

Activities

Activity 1.2.1

Standard Activity : Not Selected

Four sub health centers are established in hard to reach districts of Kunar Province

4 locations in need of a sub health center have been identified with the support of PPHD and based on data on populations and current white areas
District Dar I Pech, Wardish Tangi village
District Ghazadabad, Sooki village
District Shygal, Bar Galayee village
District Watapur, Dargo village

All locations are more than 2 hours walk from the closest health facility

In each village, PU-AMI teams will reach out to local representatives, community elders and shuras, will present and explain the project and thus will ask that a building should be lent to PU-AMI for the duration of the project in each of the four locations. PU-AMI teams will ensure that communities understand the reasons behind the opening of the health facility as well as the scope and limitation of the funding, including the project end date. The communities will be consulted regarding the recruitment of staff to gain their support, though PU-AMI will always seek the best qualified and experienced persons for the role.
Engagement with the community Shura and Health Shura will continue throughout the project on a regular basis, through monthly meetings (and extra ad hoc meetings depending on needs)

Once the agreement with local representatives for the use of the building is signed, PU-AMI engineer will proceed with leading its renovation. Indeed, the building will have to be adapted to meet the requirements of a health facility, in terms of access (wheelchair or stretcher), layout and hygiene requirements (tiling of the delivery room for example)

Each SHC will be staffed with one doctor, one midwife, two vaccinators (1 male and 1 female) and a cleaner/guard. The female vaccinator will operate within the SHC while the male vaccinator can conduct outreach vaccinations. A majority of the patients will be female (for TT vaccination) who do not accept to be vaccinated by men for cultural reasons, or children in need of OPV, as Kunar is the province which is most affected by polio (4 of the 6 cases recorded in 2016 were recorded in Kunar province)

PU-AMI will announce the vacancies with ACBAR and locally in Asadabad as well as in the nearest health facilities. Special attention will be given to hiring female staff including midwives and fixed vaccinators if possible, as PU-AMI is already aware this will be challenging. Salaries and other benefits will conform to the MoPH salary scale in order to prepare the staff for a potential integration into the BPHS system at a later date.

As BPHS implementer, PUAMI will collaborate with MoPH to support the integration of the SHC in the BPHS.

Project team will supervise the Health facilities and will ensure that the health facilities are established according the standards for the health services provision. Supervision and monitoring checklists will be used during supervision visits. PU-AMI team will assess the buildings provided by the communities to arrange it according the MoPH standards.

Activity 1.2.2

Standard Activity : Not Selected

One Mobile Health Teams is established and provides mobile services in hard to reach districts

Currently only 3 MHTs are active in all of Kunar province: one is run by ARCS, one has been recently set up by AADA and PU-AMI also has a mobile health clinic as a part of the BPHS activities implemented in Kunar. In a province with a high number of IDPs (over 8700 IDPs according to most recent OCHA data available) and returnees, where displacements are regular due to conflict between various AOGs, this remains insufficient to cover the needs.
PU-AMI will provide an additional MHT under the CHF, to ensure a better coverage of the needs of IDPs, returnees and host populations in hard to reach areas.
The area of operation of the MHT is defined in collaboration with the PPHD, who coordinates the action of the various implementers of health services in the province.

Each MHT will be staffed by 1 Medical Doctor (MD), 1 nurse, 1 vaccinator, 1 midwife and 1 health promoter The doctor will be dedicated to patient consultations, establishing diagnosis, writing prescriptions and treating the occasional emergency case
The vaccinator will be fully dedicated to vaccination (TT and OPV and measles vaccination in case of an outbreak)
The midwife is in charge of ANC and PNC, family planning and attending emergency deliveries in the home of beneficiaries.
The health promoter will be in charge of health education, sensitization, community awareness, and explaining to patients how to properly use drugs. He will conduct health education to the patients based on IEC material approved by MoPH.

All staff will receive a 3 days refresher training on RUD (Rational Usage of Drugs) and 3 days refresher training on HMIS (Health Management Information System) based on lesson learnt of previous CHF experience. Follow up training might be provided as per need.
Waste management will also be part of the refresher training plan to ensure the MHT intervention will have no negative impact on the environment. Cooperation with BPHS health facilities is already in place and medical waste will be brought to the closest health facility for adequate waste management

Regular supervision and monitoring visits will be carried out to the MHT, applying supervision checklists. Activity plan for MHT will be developed in coordination with PPHD and DoRR to reach IDPs and provide them with essential primary health services

Activity 1.2.3

Standard Activity : Not Selected

Procurement and distribution of essential medical supplies and equipment to five health facilities:

For all previous mentioned health facilities (4 SHC and 1 MHT) PU-AMI considers the MHT as a health facility, as the provided services reflect those of a static health facility, but have the advantage of reaching more remote and disseminated beneficiaries. PU-AMI will use the MoPH standard list of drugs and supplies in order to provision the health facilities with items which would also be provided if the facilities were part of the BPHS. As there is currently no BPHS support or overlap, CHF would provide the financial support for all supplies

Procurement for the health facilities will be arranged by the Project Manager according to consumption rates of comparable health facilities and based on data on the most common diseases in Afghanistan.

In order to ensure the quality of health services, PU-AMI will ensure the health facilities and the MHT are provided with all adequate medical consumables and drugs. This will be done through international procurement of drugs and local purchase for supplies that will follow PU-AMI own and donor's procurement rules for pharmaceuticals respecting Afghanistan Ministry of Health approved medical items.
PU-AMI medical procurement is led by the Health Department, consisting of a health coordinator and a pharmacist at mission level with technical support from HQ Pharmacist and HQ Health Advisor.
Drugs and medical supplies will be stored in the PU-AMI pharmacy in Jalalabad before being dispatched to the Health facilities and MHT. Stock and consumption will be monitored by the pharmacist using software and checked by the health coordinator.

PU-AMI will receive the standard vaccines from the provincial cold chain which is managed by the Provincial EPI Management Team (PEMT). This Provincial EPI Management Team is represented by an EPI Officer of the Directorate of Public Health. They will provide the vaccines requested by PU-AMI for the supported health facilities. PU-AMI will be in charge of the transport from PEMT to the said health facility, ensuring that the cold chain is respected and the vaccines maintained in the appropriate conditions during their transportation.

Though PEMT should also provide RCW50 refrigerators for vaccine vials conservation, so far challenges have been observed in neighboring regions and the unreliable supply of the RCW50 refrigerators have impacted the immunization services in remote and hard to reach areas. Therefore PU-AMI will keep the option of procuring them. Should the RCW50 refrigerators finally be made available by the PEMT, the funds will be used to procure supplementary equipment or drugs for the HF

Pharmacy stock cards and checklists will be used to ensure the adequate distribution and availability of all essential drugs in the health facilities. PU-AMI pharmacy team will regularly analyze pharmacy data and provide feedback to the health staff about the utilization of services and consumption of drugs. During supervision visits, the pharmacy stock will be observed and supervised for the rational use of drugs.

Activity 1.2.4

Standard Activity : Not Selected

Delivery of essential primary health care, mother and child health care services and immunization in five health facilities (4SHC and 1 MHT)

Services offered will conform to the MoPH standard guidelines and practices in order to maintain a consistent approach throughout the province. Services include a wide range of health services (preventive and curative consultations, including acute, chronic, injuries, health and hygiene promotion and referrals to secondary care facilities;

Amongst the delivery of the primary healthcare package, a specific attention will be given to the most vulnerable beneficiaries. In that regard, huge needs have been confirmed for pregnant and lactating women; PU-AMI Midwives reported that a dedicated service is very much appreciated, also for cultural reasons: without much community networks or protection, women tend to avoid going to health facilities; once PU-AMI midwives share their phone numbers, they regularly receive calls asking for guidance and orientation. As such, MNCH services provision will be ensured by one midwife per HF. This allows women in hard to reach areas to benefit from ANC, PNC, and FP services. Midwives will also ensure the timely referral of full-term pregnant women to deliver in closest HFs or hospital or, if not possible, try to ensure assisted home delivery, as this happened on exceptional cases. To that purpose, midwives will provide consultation and orientation taking into account the availability of services in the HFs and hospitals
Based on total catchment population of the 5 HF (4 SHC and 1 MHT), providing services to a total of 18 600 beneficiaries, and on pregnancy rate data from PU AMI HMIS in Kunar, it is estimated that approximately 4% of the catchment population will be pregnant women.
Though through these services, PU-AMI hopes to serve all pregnant women, the target has been established at 50% of the latter, i.e a total of 372 pregnant individuals.
Based on HMIS data from Kunar, it is estimated that 8% of the individuals consulting for antenatal care visits are under 18 years old and therefore fall under the category of "girls"

All routine immunization including OPV and Tetanus Toxoid vaccinations will be provided to children under one year old and women (pregnant and non pregnant). In addition, medical staff and health promoter will raise awareness on benefits of vaccine, risk of vaccine preventable diseases, awareness on polio virus and its prevention by polio drops. Awareness messages will increase sensitization of communities regarding vaccine preventable disease.
Considering the specificity of Kunar context, PU-AMI aims is repeating successful past experience by adding a vaccinator to each newly opened SHC. One female vaccinator will perform fixed vaccination services in the health facility, motivating mothers to come to the clinic in a way to increase coverage of ANC services as well, while a male vaccinator will provide outreach immunization services in the more remote corners of each catchment area.

PU-AMI being the BPHS implementer, this will facilitate the organization of staff training for the following topics:
- HMIS Practical Training;
- Infection Prevention;
- Management of Drug Supplies and rational prescriptions
- Practical immunization training (for nurses only)

Other trainings may be organized depending on needs

Supervision checklists will be used during supervision visits and the findings will be shared with the PM and the Emergency Coordinator, for the necessary improvements and follow ups. Data of monthly reports will be crosschecked with health facility registers to ensure the consistency and accuracy of data. Standard treatment guidelines and treatment protocols will be used to provide quality services

Activity 1.2.5

Standard Activity : Not Selected

Participation in DEWS and outbreak management and response:

Through its MHT PU-AMI will be regularly accessing IDP sites as well as host communities who remain hard to reach and underserved. PU-AMI will participate in the DEWS response
 MHT team can be contacted by previously visited communities if a disease outbreak is suspected. In this case, PU-AMI will inform PPHD about the change of field activity for the day and keep PPHD informed about the status of the outbreak (confirmed or not, number of cases, need for follow up, etc)
 MHT team may also be called upon by the PPHD if they hear of a suspected outbreak. The process will then be the same, MHT team going to the location of suspected outbreak and keeping PPHD informed about the outcome of the visit.

Good collaboration with the PPHD DEWS Officer will be essential, and will be maintained through regular coordination meetings.

PU-AMI MHT may also join an outbreak response team in case of a larger outbreak.

Outbreak reports will systematically be shared with PPHD HMIS officer, PPHD DEWS officer as well as WHO focal point

Additional Targets :

NUTRITION

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Objective 2: The incidence of acute malnutrition is reduced through Integrated Management of Acute Malnutrition among boys, girls, and pregnant and lactating women	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 :

Outcome 1

Reduce mortality and morbidity associated with malnutrition of children under five and Pregnant and Lactating Women and improve their health status in hard to reach areas of Kunar province

Output 1.1

Description

Essential IMAM services are provided in four SHC and through one MHT in Kunar province

Assumptions & Risks

Assumptions & Risks:
- The security situation is permissive and humanitarian access is maintained in the areas of intervention
- All needed qualified staff are recruited, including female staff
- Funding commitment is secured by donor
- Coordination with local health authorities and partners is effective
- Delay of food commodities deliveries from WFP and UNICEF.
- Changes in operational commitment from WFP partners

Mitigation strategies:
- Ensure both the National and Provincial Safety & Security Plans are up-to-date and relevant.
- Ensure planning reviews are completed on time.
- Ensure all staffs are briefed on the security situation, standard operating procedures, and all safety and security measures.
- Discussion with influential leaders and Elders/ Shuras is sustained.
- Develop a clear delivery plan with UNICEF and WFP and keep them regularly updated of consumption to avoid any shortage.
- Specific MoU is concluded with WFP as the beginning of the project to clarify each partner's responsibility.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	NUTRITION	SA2- Number of children 6-59 months screened for acute malnutrition at community and facility level and referred for treatment as needed in priority districts			1,342	1,778	3,120
Means of Verification : Monthly statistic report, HMIS Report, Register							
Indicator 1.1.2	NUTRITION	SA2- Number and proportion of severely acutely malnourished boys and girls 6-59 months admitted for treatment			335	445	780
Means of Verification : Monthly statistic report, HMIS Report, Register							
Indicator 1.1.3	NUTRITION	SA2- Number and proportion of moderately acutely malnourished boys and girls 6-59 months admitted for treatment			1,006	1,334	2,340
Means of Verification : Monthly statistic report, HMIS Report, Register							
Indicator 1.1.4	NUTRITION	SA2- Number of boys and girls aged 0-59 months discharged cured from management of severe acute malnutrition programmes			302	400	702
Means of Verification : Monthly statistic report, HMIS Report, Register							

Indicator 1.1.5	NUTRITION	SA2- Number of boys and girls aged 6-59 months discharged cured from management of moderate acute malnutrition programmes			872	1,156	2,028
Means of Verification : Monthly statistic report, HMIS Report, Register							
Indicator 1.1.6	NUTRITION	SA2- Number of acutely malnourished pregnant and lactating women admitted for treatment		1,435		125	1,560
Means of Verification : Monthly statistic report, HMIS Report, Register							
Indicator 1.1.7	NUTRITION	Number of PLW and caregivers attending IYCF awareness and/or receiving breastfeeding counseling					2,080
Means of Verification : Nutrition Database, HMIS							

Activities

Activity 1.1.1

Standard Activity : Not Selected

Screening for MAM and SAM

In the seven priority districts considered under this allocation, there are important gaps in coverage for both SAM and MAM. According to Nutrition Cluster data, the best coverage for SAM is in Shygal with a 90% coverage, while it ranges between 16 to 38 % in all other districts. MAM coverage rates go from 13% and 37%: these alarmingly low rates emphasis the relevance of nutrition programs.

Nutrition activities are fully and complementary part of the integrated approach of PU-AMI, and will benefit of the quality health services providing for vulnerable population as an entry point for screening of children aged 0-59 months as well as PLW.

MAM and SAM screening and detection will be conducted in the five health facilities operated by PU-AMI in the frame of this CHF allocation, in hard to reach areas of Kunar province, i.e
• Four sub health centers located in
District Dar I Pech, Wardish Tangi village
District Ghazadabad, Sooki village
District Shygal, Bar Galayee village
District Watapur, Dargo village
• One mobile health team that will be visiting underserved host communities as well as locations with high concentrations of IDPs and returnees in the seven priority districts of Kunar province.

MAM and SAM screening will be done by the midwife in all above mentioned locations, especially when it comes to screening of PLW, which can only be done by a woman for cultural reasons. Depending on workload, she might be assisted by the doctor.

Screening will be done using MUAC as well as checking for oedema and weight for height.
The material for screening will be partly provided by the Nutrition partners (UNICEF and WFP) and complementary items will be purchased by PU-AMI

At the health facility level monitoring of this activity will be conducted by the head of the health facility , He or she will observe daily children screening and the proper filling of screening registration by the midwife/nurse The nutrition officer will also participate in the monitoring by crosschecking the adequate screening and registration procedures.

Activity 1.1.2

Standard Activity : Not Selected

SAM and MAM case management

Children with SAM without complications will be admitted in the OPD SAM Program and will be provided with Ready-to-Use Therapeutic Food (RUTF), that will be provided by UNICEF. According to the estimated caseload, PU-AMI expects to need 858 boxes (or 128,700 sachets) of RUTF.
Children with MAM will be admitted in the OPD MAM program and will be provided with Ready-to-Use Supplementary Food (RUSF), provided by WFP. Estimated caseload brings the need to 231,660 sachets.
Cases of SAM with medical complications can't be treated within the SHC or MHTs, as they require a comprehensive treatment that can only be provided through appropriate structures in IPD. They will therefore be referred to the nearest stabilization center in Kunar province. PU-AMI teams will follow up on the referral with the IPD SAM.

Based on PU-AMI 2016 nutrition database for Kunar, the admission rates are about 43% for boys and 57% for girls, beneficiaries have therefore been calculated accordingly.
The PLWs detected with acute malnutrition will all receive SuperCereals as well as multiple micronutrients, with estimated needs mounting up to 12,870 kg of supercereal and 478,764 tablets of micronutrients.
The treatment provided will be based on the national IMAM protocol, and includes the provision of systematic medical treatment and nutritional support. RUTF and RUSF is expected to be provided by WFP and UNICEF depending on the cases and needs of the patients., but PU-AMI will also constitute a buffer stock to cope with possible supply breakdown (Estimated Supplementary Feeding requirements are detailed in Annex 12)
The quantities required have been estimated based on caseloads in similar structures currently managed by PU-AMI, however the above mentioned figures might vary over the course of the project implementation. PU-AMI will regularly coordinate with both WFP and UNICEF to keep both organizations informed about the actual consumption and forecasted needs.

A food distributor will distribute the necessary supplementary feeding rations according to IMAM protocol.

Part of the follow up will be conducted by community mobilizers, who will actively search for the absent or defaulter cases in order to find out about the causes and solve it as possible to get them back to the programs and follow ups. The aim will be to decrease the number of default cases.

The Community mobilizers will be trained on screening, defaulter tracing, and referral for malnutrition at community level and nutrition education. They will be supervised by the doctor. Overall technical supervision of the nutrition activities, and ensuring IMAM protocol is respected will be done by the Nutrition Program Manager and the Health Coordinator

At the health facility level, monitoring of this activity will be conducted by the head of the health facility. He or she will observe daily admission of children in the program and also proper filling of OPD SAM/MAM cards and registration by the nutrition nurse. The nutrition officer will crosscheck the cards and registrations and will also randomly verify SAM and MAM cases accordingly to IMAM guidelines. Based on PU-AMI experience, verification committees will be established for verification of acutely malnourished PLWs to avoid miss use of food rations

Activity 1.1.3

Standard Activity : Not Selected

IYCF promotion and counseling

IYCF promotion will be used for prevention of malnutrition as well as part of the recovery process.
This key strategy represents an opportunity to increase awareness by providing relevant information to communities with healthcare access difficulties, and making a final impact on the wellbeing of the infant, young child, and also among the female population.
The dissemination of key nutrition messages will be the responsibility of the whole team, i.e. doctor, midwife, community mobilizer and food distributor.
Information sessions will be supported by IEC material.

PU-AMI will set up a range of IYCF prevention of malnutrition awareness sessions and training including:
 Increase knowledge and sensitize care givers and community members on health and nutrition (IYCF) key messages, through IYCF training to female nurses, midwives, doctors and health promoters
 Deliver IYCF certified training and nutrition education messages through group discussions, sensitization campaigns for key community members and opinion leaders, specially the one that are located far away
 Use already existing relevant and adapted IYCF IEC/BCC materials through participatory methods with the communities
 Pre-test and post-test will be applied in a didactic practical way, as evidence of participation, and acquired and applied knowledge among the community participants
 The midwives will conduct counseling during the PNC visit and also regular education on early initiation of breast feeding, exclusive breast feeding, and complementary feeding. They will also conduct breast feeding counseling to lactating women who has breast feeding problems
 Ensure better surveillance among communities and health workers to respond to cases of acute malnutrition
 Periodic report of IYCF activities. At HFs level there will be registrations and monthly reports which will be collected by the supervisor and entered into the nutrition data base, for the respective analysis at the provincial and central level and final submission to the PND and the Nutrition Cluster.

Monitoring of this activity will be conducted by the head of the health facility , He or she will observe daily education sessions and breast feeding counseling performed by the nurse or midwife. The Nutrition Officer will crosscheck the HF's IYCF report with nutrition data base

Activity 1.1.4

Standard Activity : Not Selected

Capacity building of Health and Nutrition staff

The program will enhance capacity of Health and Nutrition staff in diagnosis and management of SAM and MAM affected children and PLW through trainings, workshops and regular coaching to improve knowledge and skills in order to improve nutrition services delivery to the beneficiaries and promote project sustainability. PU-AMI aims to:
 Train medical staffs on IMAM that will be involved in managing moderate and severe acute malnutrition (m/f)
 Participate in the trainings conducted by other stakeholders to carry out community based nutrition screening (MUAC and oedema detection) and referral of malnourished children, defaulter tracing, conduction of nutrition and health education in the intervention areas (m/f)
 Ensure effective reporting and information sharing with other partners at the governorate and national levels including MoH, Nutrition Cluster in a timely manner
 Ensure better data collection mechanisms at OTPs and SFP sites
 Participate actively in Nutrition Cluster and sector coordination meetings both at National and province level to discuss nutrition and health related activities to improve outcomes in targeted districts

The following subjects will be included in the trainings:
 Breastfeeding counseling, highlighting the importance of breastfeeding, common difficulties and related recommendations
 Education about recommendations of nutrition during pregnancy and breastfeeding periods
 Hygienic preparation of food
 Complementary feeding

Regular monitoring of the activities by the Programject Manager and the Nutrition Officer could reveal need for additional training: on the job training may be provided on the spot. Should the identified need be broader, a formal training session might also be organized. The output of the training will be monitored by pre and post tests.

Additional Targets :

PROTECTION

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Objective 2: Evolving protection concerns, needs and violations are monitored, analysed, and responded to upholding fundamental rights and restoring the dignity and well-being of vulnerable shock affected populations	SO3: The impact of shock induced acute vulnerability is mitigated in the medium term	100

Contribution to Cluster/Sector Objectives :

Outcome 1

Vulnerable and conflict affected populations of Kunar province have access to protection services

Output 1.1

Description

PFA and PSS are provided through four SHC and one MHT in Kunar province

Assumptions & Risks

Assumptions & Risks:
- The security situation is permissive and humanitarian access is maintained in the areas of intervention
- All needed qualified staff are recruited, including female staff
- Funding commitment is secured by donor
- Coordination with local health authorities and partners is effective
-Communities maintain acceptance to PSS and PFA activities

Mitigation strategies:
- Ensure both the National and Provincial Safety & Security Plans are up-to-date and relevant.
- Ensure planning reviews are completed on time.
- Ensure all staffs are briefed on the security situation, standard operating procedures, and all safety and security measures.
- Ensure a proper and smooth communication about PSS and PFA services to the beneficiaries.
- Discussion with influential leaders and Elders/ Shuras is sustained.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	PROTECTION	SA2- Number of boys, girls, men and women receiving psychosocial support	550	550	450	450	2,000

Means of Verification : Beneficiary Database

Activities

Activity 1.1.1

Standard Activity : Not Selected

Provide Psychological first aid to conflict affected IDPs and returnees and host communities:

PU-AMI has implemented PFA services in close coordination with WHO and the mental health department of MoPH in Kunar and Nangarhar provinces, progressively scaling up since 2014 and conducting trainings in PFA for other NGOs and service providers'

Significant psychological harm remains one of the dramatically underreported consequences of insecure contexts. The implementation in the past 3 years of PFA services shows how, following decades of protracted conflict, the population is in dire need of psychosocial support. PFA services provided in Kunar through health workers and in Nangarhar through mobile clinics confirm the needs for such services in addition to more traditional primary health care. The MoPH, PU-AMI, and other implementing partners reaffirmed throughout 2016 the need to strengthen and expand PFA services for populations affected by the conflict that are regularly exposed to suffering and violence. Mainstreaming psychological support and improving the inclusion of such activities in the MoPH priorities is a long-term structural undertaking which requires slow but constant steps.

A PFA provider will be operational in each of the five health facilities (four sub health centers and one mobile health team) operated by PUAMI in Kunar province under this allocation. Health is an ideal entry point for the acceptance and therefore provision of PFA services.Since mental health is not a common medical area, well-understood and accepted by the population in Afghanistan, the targeted beneficiary will be informed of the purpose, goals and advantages of the PFA interventions. Community elders and shuras will also be sensitized to the need for mental health services.
The PFA provider will ensure the screenings, counseling, and referrals of traumatized persons to the AADA counselor in the district hospital. This method to ensure mental health services to traumatized persons has proved its value and necessity, notably for people affected by displacement.
S/He will provide initial PFA response with individuals or groups to help them cope with stress symptoms and prevent the development of trauma and related psychological disorders.

Supportive supervision and refresher/follow-up working sessions will be organized regularly by expatriate Psychologist Adviser (with extensive experience in clinical psychology) to develop the quality of the services provided.

Activity 1.1.2

Standard Activity : Not Selected

Provide psychosocial support to conflict affected IDPs, returnees and host communities

For those beneficiaries who have long lasting trauma and couldn't access PFA in due time (PFA needs to be provided within 1 month after the trauma) as well as for victims of protracted traumas (such as domestic violence), the only current counselor available is in the District Hospital, and therefore inaccessible to the most vulnerable due to the travel cost.

Psychosocial support will help individuals and communities heal psychological wounds and rebuild social structures. Adequate psychosocial support activities will
- Prevent distress and suffering from evolving into something more severe
- Help people cope better and become reconciliated to everyday life
- Help beneficiaries resume a normal life
- Meet community identified needs

PSS activities will be implemented at the SHC and MHT level, and will be implemented according to WHO IADC Guidelines on Mental Health and Psychosocial Support in Emergency Settings
At MHT level, a PSS counselor will provide blanket PSS services to women and girls while the health promoter will engage with males on advocacy/awareness raising about issues.
At the SHC level, both individual and collective sessions will be organized to provide adapted services to the range of needs of patients, with a special focus on needs of women.
Children will participate in group sessions, which will be coordinated by the PSS worker and facilitated through activities encouraging them to express themselves in a creative way, as well as to interact with another.

The prevalence of GBV particularly remains high in Afghanistan, with most GBV cases concealed and driven by socio-cultural beliefs, values and practices. The latest Afghanistan Demographic Health Survey indicates that half (53%) of the ever-married women age 15-49 have experienced physical violence at least once. Though PU-AMI will not actively seek GBV cases, PSS patients will include GBV survivors.
PU-AMI teams will be trained on basic PSS, clinical management of rape (CMR) and referral to specialized services. PU-AMI will coordinate with family protection centers (one stop GBV service delivery points in Asadabad provincial, Kama district and Jalalabad regional hospitals, all of which are funded by UNFPA funds and managed by AADA and IMC) as well as with other stakeholders as necessary. UNFPA dignity kits (designed for women and girls) will be provided as part of the GBV response.

From previous projects in Kunar province, PU-AMI has recorded that most of the people seeking protection services are adults (91%) , with many more men (59%) than women (32%)seeking these services.
While the focus so far was on PFA, through the introduction of PSS, PU-AMI intends to increase the catchment of women and children. With the lack of experience and data on group sessions of PSS, the targets have been set at 50% for each gender.

Furthermore, to promote PFA and PSS activities , training on PFA and PSS will be provided to Protection Cluster partners to strengthen the overall protection response throughout the country.

Identity of beneficiaries will remain confidential, through the use of a coding system.

Additional Targets :

M & R

Monitoring & Reporting plan

Over the years, PU-AMI has developed an effective department for the monitoring and evaluation of its own project implementation. The monitoring will be integrated in the core of the project implementation.

PU-AMI implementation teams will keep daily and weekly reports of their achievements, that will be regularly shared with the PM (Project Manager) and Deputy PM.
The PM will have the overall responsibility to supervise and monitor the implementation of the M&E plan. His role is to follow up on both the progress towards indicators but also on the quality of the healthcare services provided. Supervision includes regular field visits on project activities. Based on the observations of the PM or Deputy PM, more ad hoc trainings can be organized if deemed necessary.
The PM will be supported by the M&E officer who will be responsible for the data management and ensuring all the program data is safely stored.

The implementation team in Kunar province will be supervised by the country office staff, based in Kabul, who is in charge of the overall monitoring of the project, both in terms of technical quality as in terms of progress against workplan.
National technical managers from PU-AMI country office will periodically visit project sites to monitor the quality of service delivery and ensure the achievements of indicators.
All field activity reports are consolidated in a monthly report called the Project Monitoring Tool (PMT – internal monitoring tool of PU-AMI on project progress and achievements). The PMT allows an overview of the project implementation, progress and challenges. It is the main follow-up tool between the project manager and the grants and reporting officer (Kabul coordination team). Each month also, the project manager will gather his team to discuss project implementation, next month planning and challenges.

Additionally, several project-specific tools will be developed and implemented throughout the project cycle:
A reporting format will be developed to collect the data of trauma care services.
A data base will be developed for storing and analyzing the data of trauma care services.
For Primary Health Care and Nutrition (both at SHC and MHT level) reporting the existing monthly reporting formats of BPHS will be used.
An excel data base will be developed for psychosocial support data, and monthly data will be stored and analyzed using the database.
Monthly reporting formats will also be developed

Monthly statistical reports will be shared with MoPH, UNICEF and WFP.
Reports and assessments will be submitted timely to the Health, Nutrition and Protection clusters, OCHA and on Report Hub.
Interim report and final report to will be shared with OCHA based on agreed reporting calendar.

PU-AMI will submit monthly statistical report to MOPH, Nutrition cluster, UNICEF and WFP and will also submit the progress activity report.
Activities will be reported on ReportHub

Workplan	

Activitydescription	Year	1	2	3	4	5	6	7	8	9	10	11	12
Activity 1.1.1: Four integrated first aid trauma posts (FATP) are established in conflict affected areas of Kunar Province BPHS and EPHS packages remains unable to respond to emergency situations, such as those frequently witnessed in Kunar as a result of ongoing protracted conflicts. The nature of the conflict is bringing inflow of weapon-related trauma cases requiring sustained emergency life-saving medical support. In Kunar in 2016 alone, according to PU-AMI ECHO database, 25,264 trauma cases of which 2,249 due to conflict, have been reported. First aid trauma posts will be established to increase the capacity of local health facilities to deal with the upsurge of trauma cases due to conflict in their vicinity. Data of 2015, 2016 and first 7 months of 2017 was reviewed to identify the existing health facilities receiving the highest number of trauma cases (conflict induced or not). Following health facilities were chosen for integration of a FATP. □ District Khas Kunar, Khas Kunar CHC □ District Marawara, Marawara BHC □ District Bar Kunar, Asmar CHC □ District Watapur, Quro BHC In accordance with PPHD and Health Cluster Coordinator, decision was made to have FATPs integrated in existing BHC/CHC to leave the possibility of integration in the BPHS once the emergency intervention is over, thus keeping in mind the exit strategy after the emergency intervention. The goals to prevent death and disability in injured patients can be categorized into three broad sets of needs: 1. Life-threatening injuries are appropriately treated, promptly and in accordance with appropriate priorities, so as to maximize the likelihood of survival. 2. Potentially disabling injuries are treated appropriately, so as to minimize functional impairment and to maximize the return to independence and to participation in community life. 3. Pain and psychological suffering are minimized. The set-up of these FATPs will be achievable through all different aspects of trauma cares resources that would be necessary to assure such care. These include human resources (staffing and training) and physical resources (infrastructure, equipment and supplies) that should be in place to assure optimal care of the injured patient at the range of health facilities. In working towards decreasing the burden of death and disability from injury, a spectrum of activities will be considered, ranging from surveillance and basic prevention programs, to trauma management/stabilization and referral. The drawing of the FATP was done by the PU-AMI engineer based on the constraints linked to each location (availability of terrain, etc) and on recommendations of PPHD and director of the health facility to ensure its acceptance and integration in the functioning of the facility. Essential notions such as access and hygiene standards (ease to clean) were obviously taken into consideration. (Drawings and BOQ attached, respectively in Annexes 06 and 05) Together, the Engineer with the Project Manager will regularly monitor the construction progress and will ensure that FATPs are established according the calendar and standards.	2017										X	X	X
	2018												

Activity 1.1.1: Provide Psychological first aid to conflict affected IDPs and returnees and host communities: PU-AMI has implemented PFA services in close coordination with WHO and the mental health department of MoPH in Kunar and Nangarhar provinces, progressively scaling up since 2014 and conducting trainings in PFA for other NGOs and service providers' Significant psychological harm remains one of the dramatically underreported consequences of insecure contexts. The implementation in the past 3 years of PFA services shows how, following decades of protracted conflict, the population is in dire need of psychosocial support. PFA services provided in Kunar through health workers and in Nangarhar through mobile clinics confirm the needs for such services in addition to more traditional primary health care. The MoPH, PU-AMI, and other implementing partners reaffirmed throughout 2016 the need to strengthen and expand PFA services for populations affected by the conflict that are regularly exposed to suffering and violence. Mainstreaming psychological support and improving the inclusion of such activities in the MoPH priorities is a long-term structural undertaking which requires slow but constant steps. A PFA provider will be operational in each of the five health facilities (four sub health centers and one mobile health team) operated by PUAMI in Kunar province under this allocation. Health is an ideal entry point for the acceptance and therefore provision of PFA services.Since mental health is not a common medical area, well-understood and accepted by the population in Afghanistan, the targeted beneficiary will be informed of the purpose, goals and advantages of the PFA interventions. Community elders and shuras will also be sensitized to the need for mental health services. The PFA provider will ensure the screenings, counseling, and referrals of traumatized persons to the AADA counselor in the district hospital. This method to ensure mental health services to traumatized persons has proved its value and necessity, notably for people affected by displacement. S/He will provide initial PFA response with individuals or groups to help them cope with stress symptoms and prevent the development of trauma and related psychological disorders. Supportive supervision and refresher/follow-up working sessions will be organized regularly by expatriate Psychologist Adviser (with extensive experience in clinical psychology) to develop the quality of the services provided.	2017										X	X	X
	2018	X	X	X	X	X	X	X	X	X	X		
Activity 1.1.1: Screening for MAM and SAM In the seven priority districts considered under this allocation, there are important gaps in coverage for both SAM and MAM. According to Nutrition Cluster data, the best coverage for SAM is in Shygal with a 90% coverage, while it ranges between 16 to 38 % in all other districts. MAM coverage rates go from 13% and 37%: these alarmingly low rates emphasis the relevance of nutrition programs. Nutrition activities are fully and complementary part of the integrated approach of PU-AMI, and will benefit of the quality health services providing for vulnerable population as an entry point for screening of children aged 0-59 months as well as PLW. MAM and SAM screening and detection will be conducted in the five health facilities operated by PU-AMI in the frame of this CHF allocation, in hard to reach areas of Kunar province, i.e • Four sub health centers located in District Dar I Pech, Wardish Tangi village District Ghazadabad, Sooki village District Shygal, Bar Galayee village District Watapur, Dargo village • One mobile health team that will be visiting underserved host communities as well as locations with high concentrations of IDPs and returnees in the seven priority districts of Kunar province. MAM and SAM screening will be done by the midwife in all above mentioned locations, especially when it comes to screening of PLW, which can only be done by a woman for cultural reasons. Depending on workload, she might be assisted by the doctor. Screening will be done using MUAC as well as checking for oedema and weight for height. The material for screening will be partly provided by the Nutrition partners (UNICEF and WFP) and complementary items will be purchased by PU-AMI At the health facility level monitoring of this activity will be conducted by the head of the health facility , He or she will observe daily children screening and the proper filling of screening registration by the midwife/nurse The nutrition officer will also participate in the monitoring by crosschecking the adequate screening and registration procedures.	2017										X	X	X
	2018	X	X	X	X	X	X	X	X	X	X		

Activity 1.1.2: Procurement and distribution of essential medical supplies and equipment to four FATPs For all facilities treating emergency trauma cases, equipment will be provided by PU-AMI, following ICRC standards. (BOQ attached in Annex 07) In order to ensure the quality of trauma cares services, PU-AMI will ensure the FATPs are provided with all adequate medical equipment, consumables and drugs. This will be done through international procurement of drugs and local purchase for supplies that will follow PU-AMI own and donor's procurement rules for pharmaceuticals respecting Afghanistan Ministry of Health approved medical items. PU-AMI medical procurement is led by the Health Department, consisting of a health coordinator and a pharmacist at mission level with technical support from HQ Pharmacist and HQ Health Advisor. Drugs and medical supplies will be stored in the PU-AMI pharmacy in Jalalabad before being dispatched to the FATPs. Stock and consumption will be monitored by the pharmacist using software and checked by the health coordinator. PU-AMI pharmacy department will monitor the process of procurement and distribution of essential medical supplies and equipments using PU-AMI and ICRC standards. Stock cards, pharmacy checklists, receive notes will be used to monitor the adequate amount of supplies to FATPs.	2017										X	X	X
	2018	X	X										
Activity 1.1.2: Provide psychosocial support to conflict affected IDPs, returnees and host communities For those beneficiaries who have long lasting trauma and couldn't access PFA in due time (PFA needs to be provided within 1 month after the trauma) as well as for victims of protracted traumas (such as domestic violence), the only current counselor available is in the District Hospital, and therefore inaccessible to the most vulnerable due to the travel cost. Psychosocial support will help individuals and communities heal psychological wounds and rebuild social structures. Adequate psychosocial support activities will □ Prevent distress and suffering from evolving into something more severe □ Help people cope better and become reconciliated to everyday life □ Help beneficiaries resume a normal life □ Meet community identified needs PSS activities will be implemented at the SHC and MHT level, and will be implemented according to WHO IADC Guidelines on Mental Health and Psychosocial Support in Emergency Settings At MHT level, a PSS counselor will provide blanket PSS services to women and girls while the health promoter will engage with males on advocacy/awareness raising about issues. At the SHC level, both individual and collective sessions will be organized to provide adapted services to the range of needs of patients, with a special focus on needs of women. Children will participate in group sessions, which will be coordinated by the PSS worker and facilitated through activities encouraging them to express themselves in a creative way, as well as to interact with another. The prevalence of GBV particularly remains high in Afghanistan, with most GBV cases concealed and driven by socio-cultural beliefs, values and practices. The latest Afghanistan Demographic Health Survey indicates that half (53%) of the ever-married women age 15-49 have experienced physical violence at least once. Though PU-AMI will not actively seek GBV cases, PSS patients will include GBV survivors. PU-AMI teams will be trained on basic PSS, clinical management of rape (CMR) and referral to specialized services. PU-AMI will coordinate with family protection centers (one stop GBV service delivery points in Asadabad provincial, Kama district and Jalalabad regional hospitals, all of which are funded by UNFPA funds and managed by AADA and IMC) as well as with other stakeholders as necessary. UNFPA dignity kits (designed for women and girls) will be provided as part of the GBV response. From previous projects in Kunar province, PU-AMI has recorded that most of the people seeking protection services are adults (91%) , with many more men (59%) than women (32%)seeking these services. While the focus so far was on PFA, through the introduction of PSS, PU-AMI intends to increase the catchment of women and children. With the lack of experience and data on group sessions of PSS, the targets have been set at 50% for each gender. Furthermore, to promote PFA and PSS activities , training on PFA and PSS will be provided to Protection Cluster partners to strengthen the overall protection response throughout the country. Identity of beneficiaries will remain confidential, through the use of a coding system.	2017										X	X	X
	2018	X	X	X	X	X	X	X	X	X	X		

Activity 1.1.2: SAM and MAM case management	2017										X	X	X
Children with SAM without complications will be admitted in the OPD SAM Program and will be provided with Ready-to-Use Therapeutic Food (RUTF), that will be provided by UNICEF. According to the estimated caseload, PU-AMI expects to need 858 boxes (or 128,700 sachets) of RUTF. Children with MAM will be admitted in the OPD MAM program and will be provided with Ready-to-Use Supplementary Food (RUSF), provided by WFP. Estimated caseload brings the need to 231,660 sachets. Cases of SAM with medical complications can't be treated within the SHC or MHTs, as they require a comprehensive treatment that can only be provided through appropriate structures in IPD. They will therefore be referred to the nearest stabilization center in Kunar province. PU-AMI teams will follow up on the referral with the IPD SAM. Based on PU-AMI 2016 nutrition database for Kunar, the admission rates are about 43% for boys and 57% for girls, beneficiaries have therefore been calculated accordingly. The PLWs detected with acute malnutrition will all receive SuperCereals as well as multiple micronutrients, with estimated needs mounting up to 12,870 kg of supercereal and 478,764 tablets of micronutrients. The treatment provided will be based on the national IMAM protocol, and includes the provision of systematic medical treatment and nutritional support. RUTF and RUSF is expected to be provided by WFP and UNICEF depending on the cases and needs of the patients., but PU-AMI will also constitute a buffer stock to cope with possible supply breakdown (Estimated Supplementary Feeding requirements are detailed in Annex 12) The quantities required have been estimated based on caseloads in similar structures currently managed by PU-AMI, however the above mentioned figures might vary over the course of the project implementation. PU-AMI will regularly coordinate with both WFP and UNICEF to keep both organizations informed about the actual consumption and forecasted needs. A food distributor will distribute the necessary supplementary feeding rations according to IMAM protocol. Part of the follow up will be conducted by community mobilizers, who will actively search for the absent or defaulter cases in order to find out about the causes and solve it as possible to get them back to the programs and follow ups. The aim will be to decrease the number of default cases. The Community mobilizers will be trained on screening, defaulter tracing, and referral for malnutrition at community level and nutrition education. They will be supervised by the doctor. Overall technical supervision of the nutrition activities, and ensuring IMAM protocol is respected will be done by the Nutrition Program Manager and the Health Coordinator At the health facility level, monitoring of this activity will be conducted by the head of the health facility. He or she will observe daily admission of children in the program and also proper filling of OPD SAM/MAM cards and registration by the nutrition nurse. The nutrition officer will crosscheck the cards and registrations and will also randomly verify SAM and MAM cases accordingly to IMAM guidelines. Based on PU-AMI experience, verification committees will be established for verification of acutely malnourished PLWs to avoid miss use of food rations	2018	X	X	X	X	X	X	X	X	X	X		

Activity 1.1.3: IYCF promotion and counseling	2017										X	X	X
IYCF promotion will be used for prevention of malnutrition as well as part of the recovery process. This key strategy represents an opportunity to increase awareness by providing relevant information to communities with healthcare access difficulties, and making a final impact on the wellbeing of the infant, young child, and also among the female population. The dissemination of key nutrition messages will be the responsibility of the whole team, i.e. doctor, midwife, community mobilizer and food distributor. Information sessions will be supported by IEC material. PU-AMI will set up a range of IYCF prevention of malnutrition awareness sessions and training including: Increase knowledge and sensitize care givers and community members on health and nutrition (IYCF) key messages, through IYCF training to female nurses, midwives, doctors and health promoters Deliver IYCF certified training and nutrition education messages through group discussions, sensitization campaigns for key community members and opinion leaders, specially the one that are located far away Use already existing relevant and adapted IYCF IEC/BCC materials through participatory methods with the communities Pre-test and post-test will be applied in a didactic practical way, as evidence of participation, and acquired and applied knowledge among the community participants The midwives will conduct counseling during the PNC visit and also regular education on early initiation of breast feeding, exclusive breast feeding, and complementary feeding. They will also conduct breast feeding counseling to lactating women who has breast feeding problems Ensure better surveillance among communities and health workers to respond to cases of acute malnutrition Periodic report of IYCF activities. At HFs level there will be registrations and monthly reports which will be collected by the supervisor and entered into the nutrition data base, for the respective analysis at the provincial and central level and final submission to the PND and the Nutrition Cluster. Monitoring of this activity will be conducted by the head of the health facility , He or she will observe daily education sessions and breast feeding counseling performed by the nurse or midwife. The Nutrition Officer will crosscheck the HF's IYCF report with nutrition data base	2018	X	X	X	X	X	X	X	X	X	X		
Activity 1.1.3: Provision of essential trauma care services	2017										X	X	X
Emergency trauma kits (including medical equipment, drugs and consumables, BOQ attached, Annex 07) will be delivered to those four health facilities. Both doctors and nurses are obviously important for a smooth running of the FATP. One provides assessment and diagnosis while the other offers aid, physical and psychological treatment. In short, they are both complementary factors to what makes the FATP operate efficiently. The most important function of the doctor will be to identify and treat life-threatening conditions and then to assess the patient carefully for other complaints or findings that may require referral. The nurse will be in charge of providing first essential trauma care to patients. Since the FATPs are attached to an existing health facility, the doctor of the adjacent health facility (CHC or BHC) will also be operational in the FATP. Under CHF funding, PU-AMI will provide an additional nurse which will be dedicated full time to the FATP. The nurses will receive refresher training on Basic Life Saving. The minimum package of First Aid Care/ trauma care at the FATP comprises early detection, initial medical care for severe injury or sudden illness using a certain amount of drugs and equipment to perform primary intervention and assessment to fulfill the basic principles of trauma care, which are to preserve life, to prevent further harm and to keep the patient condition's stable. This may include applying first aid techniques, airway and/or shock management, fluid resuscitation, caring burns, injury and wounds management, stabilization and promote recovery including dispensing of medication. Strict protocols will be applied, according to national guidelines to always reach the highest quality of services. Patient records will be kept through a registration system (administrative registration and medical details taken by the doctor respecting confidential management of sensitive data). Diagnostic and treatment protocols will be based on MoPH national guidelines. Establishment of a referral system to secondary health facility level: The teams will be in continuous coordination with surrounding Hospital in case of referral needed. The referral will be done through an ambulance. Security allowing, monthly supervision visits will be carried out by CHF programject manager to monitor the delivery of essential trauma care services. Supervision checklists will be used during supervision visits. Trauma registers will be checked for verifying the delivery of trauma services. Monthly reporting formats will be developed for each site to report their monthly achievement and will be stored in trauma database.	2018	X	X	X	X	X	X	X	X	X	X		

Activity 1.1.4: Capacity building of Health and Nutrition staff	2017											X	X
The program will enhance capacity of Health and Nutrition staff in diagnosis and management of SAM and MAM affected children and PLW through trainings, workshops and regular coaching to improve knowledge and skills in order to improve nutrition services delivery to the beneficiaries and promote project sustainability. PU-AMI aims to: Train medical staffs on IMAM that will be involved in managing moderate and severe acute malnutrition (m/f) Participate in the trainings conducted by other stakeholders to carry out community based nutrition screening (MUAC and oedema detection) and referral of malnourished children, defaulter tracing, conduction of nutrition and health education in the intervention areas (m/f) Ensure effective reporting and information sharing with other partners at the governorate and national levels including MoH, Nutrition Cluster in a timely manner Ensure better data collection mechanisms at OTPs and SFP sites Participate actively in Nutrition Cluster and sector coordination meetings both at National and province level to discuss nutrition and health related activities to improve outcomes in targeted districts The following subjects will be included in the trainings: Breastfeeding counseling, highlighting the importance of breastfeeding, common difficulties and related recommendations Education about recommendations of nutrition during pregnancy and breastfeeding periods Hygienic preparation of food Complementary feeding Regular monitoring of the activities by the Programject Manager and the Nutrition Officer could reveal need for additional training: on the job training may be provided on the spot. Should the identified need be broader, a formal training session might also be organized. The output of the training will be monitored by pre and post tests.	2018			X	X								

Activity 1.2.1: Four sub health centers are established in hard to reach districts of Kunar Province 4 locations in need of a sub health center have been identified with the support of PPHD and based on data on populations and current white areas District Dar I Pech, Wardish Tangi village District Ghazadabad, Sooki village District Shygal, Bar Galayee village District Watapur, Dargo village All locations are more than 2 hours walk from the closest health facility In each village, PU-AMI teams will reach out to local representatives, community elders and shuras, will present and explain the project and thus will ask that a building should be lent to PU-AMI for the duration of the project in each of the four locations. PU-AMI teams will ensure that communities understand the reasons behind the opening of the health facility as well as the scope and limitation of the funding, including the project end date. The communities will be consulted regarding the recruitment of staff to gain their support, though PU-AMI will always seek the best qualified and experienced persons for the role. Engagement with the community Shura and Health Shura will continue throughout the project on a regular basis, through monthly meetings (and extra ad hoc meetings depending on needs) Once the agreement with local representatives for the use of the building is signed, PU-AMI engineer will proceed with leading its renovation. Indeed, the building will have to be adapted to meet the requirements of a health facility, in terms of access (wheelchair or stretcher), layout and hygiene requirements (tiling of the delivery room for example) Each SHC will be staffed with one doctor, one midwife, two vaccinators (1 male and 1 female) and a cleaner/guard. The female vaccinator will operate within the SHC while the male vaccinator can conduct outreach vaccinations. A majority of the patients will be female (for TT vaccination) who do not accept to be vaccinated by men for cultural reasons, or children in need of OPV, as Kunar is the province which is most affected by polio (4 of the 6 cases recorded in 2016 were recorded in Kunar province) PU-AMI will announce the vacancies with ACBAR and locally in Asadabad as well as in the nearest health facilities. Special attention will be given to hiring female staff including midwives and fixed vaccinators if possible, as PU-AMI is already aware this will be challenging. Salaries and other benefits will conform to the MoPH salary scale in order to prepare the staff for a potential integration into the BPHS system at a later date. As BPHS implementer, PUAMI will collaborate with MoPH to support the integration of the SHC in the BPHS. Project team will supervise the Health facilities and will ensure that the health facilities are established according the standards for the health services provision. Supervision and monitoring checklists will be used during supervision visits. PU-AMI team will assess the buildings provided by the communities to arrange it according the MoPH standards.	2017										X	X	X
	2018												

Activity 1.2.2: One Mobile Health Teams is established and provides mobile services in hard to reach districts Currently only 3 MHTs are active in all of Kunar province: one is run by ARCS, one has been recently set up by AADA and PU-AMI also has a mobile health clinic as a part of the BPHS activities implemented in Kunar. In a province with a high number of IDPs (over 8700 IDPs according to most recent OCHA data available) and returnees, where displacements are regular due to conflict between various AOGs, this remains insufficient to cover the needs. PU-AMI will provide an additional MHT under the CHF, to ensure a better coverage of the needs of IDPs, returnees and host populations in hard to reach areas. The area of operation of the MHT is defined in collaboration with the PPHD, who coordinates the action of the various implementers of health services in the province. Each MHT will be staffed by 1 Medical Doctor (MD), 1 nurse, 1 vaccinator, 1 midwife and 1 health promoter The doctor will be dedicated to patient consultations, establishing diagnosis, writing prescriptions and treating the occasional emergency case The vaccinator will be fully dedicated to vaccination (TT and OPV and measles vaccination in case of an outbreak) The midwife is in charge of ANC and PNC, family planning and attending emergency deliveries in the home of beneficiaries. The health promoter will be in charge of health education, sensitization, community awareness, and explaining to patients how to properly use drugs. He will conduct health education to the patients based on IEC material approved by MoPH. All staff will receive a 3 days refresher training on RUD (Rational Usage of Drugs) and 3 days refresher training on HMIS (Health Management Information System) based on lesson learnt of previous CHF experience. Follow up training might be provided as per need. Waste management will also be part of the refresher training plan to ensure the MHT intervention will have no negative impact on the environment. Cooperation with BPHS health facilities is already in place and medical waste will be brought to the closest health facility for adequate waste management Regular supervision and monitoring visits will be carried out to the MHT, applying supervision checklists. Activity plan for MHT will be developed in coordination with PPHD and DoRR to reach IDPs and provide them with essential primary health services	2017										X	X	X
	2018	X	X	X	X	X	X	X	X	X			

Activity 1.2.3: Procurement and distribution of essential medical supplies and equipment to five health facilities: For all previous mentioned health facilities (4 SHC and 1 MHT) PU-AMI considers the MHT as a health facility, as the provided services reflect those of a static health facility, but have the advantage of reaching more remote and disseminated beneficiaries. PU-AMI will use the MoPH standard list of drugs and supplies in order to provision the health facilities with items which would also be provided if the facilities were part of the BPHS. As there is currently no BPHS support or overlap, CHF would provide the financial support for all supplies Procurement for the health facilities will be arranged by the Project Manager according to consumption rates of comparable health facilities and based on data on the most common diseases in Afghanistan. In order to ensure the quality of health services, PU-AMI will ensure the health facilities and the MHT are provided with all adequate medical consumables and drugs. This will be done through international procurement of drugs and local purchase for supplies that will follow PU-AMI own and donor's procurement rules for pharmaceuticals respecting Afghanistan Ministry of Health approved medical items. PU-AMI medical procurement is led by the Health Department, consisting of a health coordinator and a pharmacist at mission level with technical support from HQ Pharmacist and HQ Health Advisor. Drugs and medical supplies will be stored in the PU-AMI pharmacy in Jalalabad before being dispatched to the Health facilities and MHT. Stock and consumption will be monitored by the pharmacist using software and checked by the health coordinator. PU-AMI will receive the standard vaccines from the provincial cold chain which is managed by the Provincial EPI Management Team (PEMT). This Provincial EPI Management Team is represented by an EPI Officer of the Directorate of Public Health. They will provide the vaccines requested by PU-AMI for the supported health facilities. PU-AMI will be in charge of the transport from PEMT to the said health facility, ensuring that the cold chain is respected and the vaccines maintained in the appropriate conditions during their transportation. Though PEMT should also provide RCW50 refrigerators for vaccine vials conservation, so far challenges have been observed in neighboring regions and the unreliable supply of the RCW50 refrigerators have impacted the immunization services in remote and hard to reach areas. Therefore PU-AMI will keep the option of procuring them. Should the RCW50 refrigerators finally be made available by the PEMT, the funds will be used to procure supplementary equipment or drugs for the HF Pharmacy stock cards and checklists will be used to ensure the adequate distribution and availability of all essential drugs in the health facilities. PU-AMI pharmacy team will regularly analyze pharmacy data and provide feedback to the health staff about the utilization of services and consumption of drugs. During supervision visits, the pharmacy stock will be observed and supervised for the rational use of drugs.	2017										X	X	X
	2018	X	X										

Activity 1.2.4: Delivery of essential primary health care, mother and child health care services and immunization in five health facilities (4SHC and 1 MHT) Services offered will conform to the MoPH standard guidelines and practices in order to maintain a consistent approach throughout the province. Services include a wide range of health services (preventive and curative consultations, including acute, chronic, injuries, health and hygiene promotion and referrals to secondary care facilities; Amongst the delivery of the primary healthcare package, a specific attention will be given to the most vulnerable beneficiaries. In that regard, huge needs have been confirmed for pregnant and lactating women; PU-AMI Midwives reported that a dedicated service is very much appreciated, also for cultural reasons: without much community networks or protection, women tend to avoid going to health facilities; once PU-AMI midwives share their phone numbers, they regularly receive calls asking for guidance and orientation. As such, MNCH services provision will be ensured by one midwife per HF. This allows women in hard to reach areas to benefit from ANC, PNC, and FP services. Midwives will also ensure the timely referral of full-term pregnant women to deliver in closest HFs or hospital or, if not possible, try to ensure assisted home delivery, as this happened on exceptional cases. To that purpose, midwives will provide consultation and orientation taking into account the availability of services in the HFs and hospitals Based on total catchment population of the 5 HF (4 SHC and 1 MHT), providing services to a total of 18 600 beneficiaries, and on pregnancy rate data from PU AMI HMIS in Kunar, it is estimated that approximately 4% of the catchment population will be pregnant women. Though through these services, PU-AMI hopes to serve all pregnant women, the target has been established at 50% of the latter, i.e a total of 372 pregnant individuals. Based on HMIS data from Kunar, it is estimated that 8% of the individuals consulting for antenatal care visits are under 18 years old and therefore fall under the category of “girls” All routine immunization including OPV and Tetanus Toxoid vaccinations will be provided to children under one year old and women (pregnant and non pregnant). In addition, medical staff and health promoter will raise awareness on benefits of vaccine, risk of vaccine preventable diseases, awareness on polio virus and its prevention by polio drops. Awareness messages will increase sensitization of communities regarding vaccine preventable disease. Considering the specificity of Kunar context, PU-AMI aims is repeating successful past experience by adding a vaccinator to each newly opened SHC. One female vaccinator will perform fixed vaccination services in the health facility, motivating mothers to come to the clinic in a way to increase coverage of ANC services as well, while a male vaccinator will provide outreach immunization services in the more remote corners of each catchment area. PU-AMI being the BPHS implementer, this will facilitate the organization of staff training for the following topics: HMIS Practical Training; Infection Prevention; Management of Drug Supplies and rational prescriptions Practical immunization training (for nurses only) Other trainings may be organized depending on needs Supervision checklists will be used during supervision visits and the findings will be shared with the PM and the Emergency Coordinator, for the necessary improvements and follow ups. Data of monthly reports will be crosschecked with health facility registers to ensure the consistency and accuracy of data. Standard treatment guidelines and treatment protocols will be used to provide quality services	2017										X	X	X
	2018	X	X	X	X	X	X	X	X	X	X		

Activity 1.2.5: Participation in DEWS and outbreak management and response: Through its MHT PU-AMI will be regularly accessing IDP sites as well as host communities who remain hard to reach and underserved. PU-AMI will participate in the DEWS response MHT team can be contacted by previously visited communities if a disease outbreak is suspected. In this case, PU-AMI will inform PPHD about the change of field activity for the day and keep PPHD informed about the status of the outbreak (confirmed or not, number of cases, need for follow up, etc) MHT team may also be called upon by the PPHD if they hear of a suspected outbreak. The process will then be the same, MHT team going to the location of suspected outbreak and keeping PPHD informed about the outcome of the visit. Good collaboration with the PPHD DEWS Officer will be essential, and will be maintained through regular coordination meetings. PU-AMI MHT may also join an outbreak response team in case of a larger outbreak. Outbreak reports will systematically be shared with PPHD HMIS officer, PPHD DEWS officer as well as WHO focal point	2017										X	X	X
	2018	X	X	X	X	X	X	X	X	X	X		

OTHER INFO

Accountability to Affected Populations

As an active actor of the health sector in the Eastern Region, PU-AMI has established accountability mechanisms at several levels. Considering the large volume of people in need of assistance, and the importance to ensure smooth integration with host communities and the existing services delivered, PU-AMI adopted specific focus on community mobilization and awareness.

Interventions are constantly monitored with visits on project sites where beneficiaries are directly assisted and have space for remarks or requests through a complaint/suggestion box.

Additionally, regular exchanges with health Shuras and local leaders are allowing PU-AMI to have a constant feedback on the relief delivered and on fresh needs or gaps. HF staff and PU-AMI's CHF project manager will be in contact with the Community Shuras and leaders on a regular basis.
PU-AMI will work closely with local communities for the choice of the building to be used for SHC, or with the health facility directors for the construction of the FATPs, each time explaining the intention, process and timeframe, to ensure the understanding and therefore the acceptance of the intervention.
Besides, the Health Shuras, allows interaction with community leaders and representatives and will facilitate the identification of gaps in the provision of health services.

Indeed, regular meetings will be conducted with the community leaders and their feedbacks will be collected and considered in the decision makings for the improved services delivery. During these meetings relevant information about the mechanism and type of relief services will be shared with the communities.

The community will be able to provide recommendations and make requests of HF Directors, and conversely, HF Directors will discuss proposed plans with the community members in order to gain acceptance of all decisions and activities implemented at services delivery points. Without this direct engagement with the community, PU-AMI simply could not work in Kunar province or in areas with significant AOG presence.

Implementation Plan

PU-AMI is active in the Eastern Region since several years, its Jalalabad office has been implementing a range of health and emergency projects with WHO, CHF and ECHO and supervising the BPHS in Kunar. All activities of the proposed intervention will benefit from PU-AMI's expertise in similar current and past projects which allow a quick scaling-up and a timely implementation of the project. Besides, no part of the project will be sub granted.

Upon the allocation of the grant, a grant opening meeting is organized, involving all program and support team, to ensure everyone is aware of their role in the proposal. For example, a strong involvement of the logistics department will be necessary for the construction of the FATPs.

The project will be directly supervised and coordinated by the Emergency Coordinator. She will be supported by the Medical Coordinator, who will provide technical assistance on the several medical components of the project, capitalizing on PU-AMI's experience, and the PFA/PSS Advisor who will provide technical guidance for the implementation of PFA and PSS activities. He will be in charge of the training of the teams.

The field implementation will be directly planned and executed by:

- 1 Project Manager (Assadabad, Kunar province): bi-weekly planning of implementation based on the update of flow of displaced people and needs ; will liaise with other departments (log/fin/pharmacy) to insure supplies and admin procedures are cleared; will supervise all field activities, participation in regional coordination meeting, will be in regular contact with PPHD, WHO, OCHA and all other relevant stakeholders.

- 1 Deputy PM (Assadabad, Kunar province): link between coordination and activities, following supplies, movements, ensuring respect of data collection practices, relations with stakeholders (health shuras, elders).

They will both supervise the achievements towards indicators and the quality of the work of the following staff

- For the FATPS, 4 nurses (one in each FATP), who will work under the direct supervision of the director of the health facility, but also report to the project team

- 4 SHCs, each composed of 1 doctor, 2 vaccinators, 1 midwife, 1 PFA provider, 1 food distributor and 3 guards. The doctor will be the head of the SHC and supervise the provision of quality healthcare services, the proper reporting of achievements, the availability of drugs and supplementary feeding. He will be the primary focal point of the Project Manager and the Deputy Project Manager.

- 1 MHT composed of: doctor, vaccinator, midwife, PFA provider, food distributor and Health promoter and a driver. Insure the provision of basic healthcare services to the targeted beneficiaries as per the movement plan shared by PPHD. The movements might vary in the occurrence of an outbreak. Once again the doctor will be the primary focal point of the Project Manager and the Deputy Project Manager.

- 1 M/E Officer (Eastern Region): consolidation and analysis of data from HMIS reports and visit reports, distribution lists. He/she is directly supervised by the Emergency Coordinator, and will maintain the overall database, provide analysis on trends, updates on achievements of indicators and produce quick information reports.

Coordination with other Organizations in project area

Name of the organization	Areas/activities of collaboration and rationale
PPHD	Referral of SAM with complications. Organization of MHT
AADA	Referral of protection
UNFPA	Supply of Dignity Kits
UNICEF	Supply of RUTF
WFP	Supply of RUSF, micronutrients

Environment Marker Of The Project

A+: Neutral Impact on environment with mitigation or enhancement

Gender Marker Of The Project

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

Justify Chosen Gender Marker Code

Eastern Afghanistan, and Afghanistan more globally, is very sensitive in terms of gender issues. Afghanistan's dominant traditions and customary practices have caused the community and women to perceive unequal family and societal relationships as a natural and immutable condition. Women have rarely been a part of political, social and economic decision-making processes.

In the construction of this project, as always, PU-AMI has paid particular attention to adopt a gender-sensitive approach, to improve women's capacities and involvement in decision-making processes, while being realistic regarding cultural barriers.

In the MHT and each SHC, women receive health education on key practices and behaviors to improve theirs and their family health. This is even more important that the messages disseminated will be mainly about hygiene promotion, immunization and mother and child health, domains traditionally seen as women's responsibilities. Men will also receive the messages in order to increase the involvement of fathers in child health and hygiene promotion activities and to ensure a better understanding about maternal healthcare to ease the access for women.

Besides, in all activities, capacity building and skill strengthening of female staff are included. This will promote female empowerment through work. Trainings are conducted with a gender specific approach considering the requirement of mahram for some female staff, the need for separate rooms for breaks and the arrangements of the training room. Trainers pay specific attention to female participation to ensure everyone is getting the most out of the trainings.

Protection Mainstreaming

With the ongoing emergency interventions, PU-AMI has increased its best practices in Protection of beneficiaries. The strictest confidentiality on caseloads and beneficiaries lists will be ensured. Additionally the use of protection check-list from the Protection Cluster, adapted to the intervention in Nangarhar, will ensure the respect of the four key elements of Protection Mainstreaming, which are : prioritize safety, dignity and avoid causing harm, meaningful access, accountability and participation and empowerment.

The extended access that PU-AMI enjoys in Kunar will benefit people in hard-to-reach areas to be assisted with life-saving aid, creating a sphere of confidence that proved to be successful for reaching victims of gender-based violence or persons with disabilities (including mental health problems). Within the Protection Cluster PU-AMI is participating to the development of an effective referral network for the different categories of vulnerabilities with partners already active.
PU-AMI also follows international guidelines on protection such as the SPHRE, IASC or Protection Mainstreaming (WVI) , designing all the activities, processes and safeguards on the key principal of "do no Harm."

Country Specific Information

Safety and Security

Kunar is one of the 34 provinces of Afghanistan located in the Eastern part of the country. Its capital is Asadabad. It has a population of about 428,800.
It is one of the four security challenging provinces due to long border with Pakistan which has allowed the ease access of AOGs into the province. It is believed that AOGs like IEA, ISIS, TTP and HIA may be present in the province.
The Eastern provinces represent a relatively small geographical area where a proportionately high number of clashes have occurred between AOG, IS, IMF and ANSF. Kunar province has recorded the highest actual number of security incidents so far in 2017 (from January to 09 August 2017) with1677 incidents. If we see by the districts where we are planning to operate, in Dara e Pech 175, in Ghaziabad 125, in Khas Kunar 34, in Marawara 163 and in Shigal 85, Watarpoor District 129, occurred incidents as per the information we have from International NGO Safety Organization (INSO).
Clashes continued in Kunar provinces during August, too. In addition to the Taliban, there are IS strongholds in Kunar province. Throughout May 2017, there was cross-border shelling between Pakistan and Afghanistan security forces which started in 2016.
PU- AMI focused to implement specific security procedure and control the movement of health staff. The security management system in the field is in charge of the Area Coordinator, with the help of the security focal points. Indeed, Field teams and INSO are the primary source of information of the security context, and weekly analysis are made in Jalalabad Office.

Access

PU-AMI has had a significant presence delivering humanitarian assistance in the proposed program areas for years. The areas we have been present for more than 30 years are indicated below.
• Khas Kunar - has 3 Health Facilities namely Khas Kunar CHC, Mangwal BHC, Shali SHC.
• Marwara PU-AMI has 1 Marwara BHC & 2 SHCs in Bacha and Petaw
• Shigal – 2 BHCs (Shigal BHC, Latchail BHC), & 3 SHCs (Law Sen,Madish & Shultan)
• Watapur – 2 BHCs (Watapur, Quro, 2 SHCs (Managal, Dewos)
• Ghaziabad – 1 BHC(Nishegam), 2 SHCs (Darin & Eilgal)
• Dar I Pech – 1 BHC(Manugai), 2 BHCs (Korangal, Barkandai), 2 SHCs (Shoraik, Lechalam)

As a result, our large & efficient presence for years we believe has enabled us create good relationships and strong acceptance within the community which we deem will significantly contribute for the successful implementation of this new project allowing us access to the people in need. Further, we have already access to these places through the existing program and the same will apply for the new project, too.

Access :

• Keep on establishing and maintaining positive relations and negotiating for access with the different actors in the proposed program area.
• We will have a security focal point in the centers to help us gather security information systematically, analyse and based on the outcome, apply the required actions to adapt to the context and to ensure safe operations
• Keep on Adhering to humanitarian principles so that all the actors would view us as an organization who is only there to deliver humanitarian assistant in a neutral, impartial & transparent manner
• Security Awareness and Management – Keep on assessing the security situation, Updating our security policies regularly to ensure our standard matches to the context, staff, program and asset are kept safe
• Keep on respecting the local norms, culture and delivering humanitarian assistance through the acceptance strategy.
• Involving communities in what we do and in some of the decisions we make as required
• Regularly developing the capacity of our staff in the areas like communication, negotiation for smooth relationship. Providing timely information for our staff so that they are always up-to-date to respond to questions that may be raised by the community or other groups about our presence, work etc
• Keeping low profile so that we will not attract too much attention and targeted

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	Expatriate Support staff	S	5	6,341.99	12	16.67	63,432.58
	Coordination team in Kabul is composed by Head Of Mission, Finance Coordinator, Logistic Coordinator and Grants Officer. Support team in Jalalabad is composed by Field Logistician. They are working on the coordination and over management of PU-AMI projects. Salary, international transportation costs and perdiem are included.						
1.2	Expatriate Program staff	D	3	4,508.30	12	25.00	40,574.70
	Expatriates Program Staff is composed by Emergency Coordinator, Pharmacist and PFA Advisor. They are working on the well implementation of the program on the field. Salary and perdiem are included						
1.3	National Support Coordination staff	S	45	431.28	12	25.00	58,222.80
	Financial, HR, Logistic and Security teams in Kabul. They are working on the good follow up of global support activites as Finance and internal audit (4 person), HR (3) and Logistic (4); ensuring the security of goods, persons and buildings (guards 16, driver 6, national security manager 1 and radio operators 5); and cleaning and cooking (6) office and guesthouse. Only salary is included.						
1.4	National Support Field staff	S	19	509.80	12	25.00	29,058.60
	Financial, HR, Logistic and Security teams in Jalalabad. They are working on the daily follow up of direct support activites in the field as well as the well-keeping of goods, staff and bases.The team consists on: 2 Finance & HR, 4 Logistic, 1 Radio operator, 7 Guards and 5 housekeeping staff. Only salary is included.						
1.5	National Program Coordination staff	D	3	1,166.45	12	25.00	10,498.05
	National Program team in Kabul is composed by National M&E et HMIS manager, Pharmacy manager and National pharmacy manager.They are managing, supervising, and monitoring the technical activities, ensure representation to clusters. Only salary is included.						
1.6	Technical Program Field staff	D	51	293.73	12	100.00	179,762.76
	The technical program team Kunar is composed by: *- 1 Project Manager (Assadabad, Kunar province): bi-weekly planning of implementation based on the update of flow of displaced people and needs ; will liaise with other departments (log/fin/pharmacy) to insure supplies and admin procedures are cleared; will supervise all field activities, participation in regional coordination meeting, will be in regular contact with PPHD, WHO, OCHA and all other relevant stakeholders.* *- 1 Deputy PM (Assadabad, Kunar province): link between coordination and activities, following supplies, movements, ensuring respect of data collection practices, relations with stakeholders (health shuras, elders).* *They will both supervise the achievements towards indicators and the quality of the work of the following staff* *- For the FATPS, 4 nurses (one in each FATP), who will work under the direct supervision of the director of the health facility, but also report to the project team* *- 4 SHCs, each composed of 1 doctor, 2 vaccinators, 1 midwife, 1 PFA provider, 1 food distributor and 3 guards. The doctor will be the head of the SHC and supervise the provision of quality healthcare services, the proper reporting of achievements, the availability of drugs and supplementary feeding. He will be the primary focal point of the Project Manager and the Deputy Project Manager.* *- 1 MHT composed of: doctor, vaccinator, midwife, PFA provider, food distributor and Health promoter and a driver. Insure the provision of basic healthcare services to the targeted beneficiaries as per the movement plan shared by PPHD. The movements might vary in the occurrence of an outbreak. Once again the doctor will be the primary focal point of the Project Manager and the Deputy Project Manager.* *- 1 M/E Officer (Eastern Region): consolidation and analysis of data from HMIS reports and visit reports, distribution lists. He/she is directly supervised by the Emergency Coordinator, and will maintain the overall database, provide analysis on trends, updates on achievements of indicators and produce quick information reports.*						
	Section Total						**381,549.49**
2. Supplies, Commodities, Materials							
2.1	FATP Construction	D	4	6,634.86	1	100.00	26,539.44
	Each FATP will be built by PU-AMI contractors in the first 2 months of the project in the site of an existing health facility. The cost was estimated by our Engeneer and reflected in the BOQ						
2.2	FATP Equipment (medical and non medical)	D	4	7,474.44	1	100.00	29,897.76
	For each FATP we have to provide generator, benches, chairs and other furnitures, etc, as per BOQ // Each FATP will also be supplied by all needed medical equipment, according to BOQ (2 tabs combined)						
2.3	FATP Drugs and consumables (emergency kits)	D	4	291.01	9	100.00	10,476.36
	Drugs and consumables according to BOQ for 4 FATP						
2.4	FATP Running Costs	D	4	214.58	9	100.00	7,724.88

	RC for 4 FATP, including electricty, heather etc						
2.5	SHC Rehabilitation	D	4	2,000.00	1	100.00	8,000.00
	The SHC need to be rehabilitated before starting the project						
2.6	SHC Equipment (medical and non medical)	D	4	3,576.10	1	100.00	14,304.40
	For each SHC we have to provide blanket, bedsheets tables, chairs, etc, as per BOQ						
2.7	SHC Drugs and Consumables	D	4	885.27	10	100.00	35,410.80
	Provision of medicine and drugs for four SHC on a 10-month basis. The SHCs will be replenished according to their consumption.						
2.8	SHC RC	D	4	211.46	10	100.00	8,458.40
	RC for 4 SHC including electricity, heather, etc						
2.9	SHC Freezer	D	4	3,280.00	1	100.00	13,120.00
	Each SHC needs the purchase of a freezer in order to keep vaccines at suitable temperature (RCW50 or solar)						
2.10	SHC Vehicles	D	4	522.00	10	100.00	20,880.00
	1 vehicule per SHC for mobilizing the staff						
2.11	MHT Equipment (medical and non medical)	D	1	1,403.00	1	100.00	1,403.00
	For the MHT we have to provide, desk, chairs, etc as per BOQ as well as all needed medical equipment, according to BOQ.						
2.12	MHT Drugs and Consumables	D	1	907.28	12	100.00	10,887.36
	Provision of medicine and drugs for four MHT on a 12-month basis. The MHTs will be replenished according to their consumption.						
2.13	MHT RC	D	1	183.30	12	100.00	2,199.60
	RC for 1 MHT						
2.14	MHT Mini Van	D	1	493.40	12	100.00	5,920.80
	Mini bus for the mobile team in Kunar						
2.15	IEC material for Health + Nutrition	D	1	1,320.00	1	100.00	1,320.00
	Health : IEC materials like posters for mental health, malaria leaflets, HIV posters, brochures, etc according to BOQ // IEC materials for nutrition like leaflets, posters and brochures according to BOQ						
2.16	HMIS tools for Health + Nutrition	D	1	1,479.00	1	100.00	1,479.00
	Health : HMIS tools like panflets, cards, tallysheets according to BOQ // Nutrition: HMIS Nutrition tools like panflets, cards, tallysheet according to BOQ						
2.17	Health trainings	D	1	14.38	123	100.00	1,768.74
	HMIS training: 3 days training for 10 people // Infection prevention training: 3 days training for 10 people // EPI refresher: 4 day training for 9 people // Managing Drug supply and rational use of drugs: 3 day training for 5 people // Basic life saving: 3 day training for 4 people We provide meals, accomodation, transport and handout (detailed cost in BOQ)						
2.18	Nutrition Trainings	D	25	14.37	3	100.00	1,077.75
	3 days IMAM training for 20 people and 3 day community outreach training for 5 people, We provide meals, accomodation, transport and handout (detailed cost in BOQ)						
2.19	Protection trainings	D	1	18.94	189	100.00	3,579.66
	PFA refresher training for 6 people for 12 days, PSS training for 6 people for 12 days, clinical management of rape training for 5 people for 3 days. We provide meals, accomodation, transport and handout, (detailed cost in BOQ), as well as training for cluster partners						
2.20	Equipment of PSS/PFA room	D	4	293.71	1	100.00	1,174.84
	Carpet, floor materesses, cushions, curtains, kettle, mugs….						
2.21	PFA/PSS accessories for children	D	5	289.00	1	100.00	1,445.00
	Toys, colouring books, colouring pencils, various items to faciliate the interaction with and expression of children						

2.22	PFA/PSS accessories for adults	D	5	289.50	1	100.00	1,447.50
	Tea, sugar, knitting needles and yarn to facilitate interaction with and expression of adutls						
2.23	Blouses	D	74	25.40	1	100.00	1,879.60
	74 blouses for 34 staff						
2.24	Display Boards	D	8	97.00	1	100.00	776.00
	Display boards for FATP and SHC						
2.25	Freight	D	3	3,482.05	1	100.00	10,446.15
	In order to deliver the drugs and equipment from Kabul to Kunar, trucks will be rented. This also includes the freight from HQ to Kabul office for equipment and drugs bought at HQ level.						
	Section Total						**221,617.04**
3. Equipment							
3.1	Laptop	D	4	623.79	1	100.00	2,495.16
	reduced to 4. Previous laptops used by program staff are passed on to support staff. Under this project, a new laptop will be needed for CHF PM/PFA advisor / Deputy PM and Nutrition officer)						
3.2	Printer and scanner	D	1	2,806.73	1	100.00	2,806.73
	reduced to one Printer/Scanner						
	Section Total						**5,301.89**
4. Contractual Services							
4.1	Daily workers	D	8	19.82	12	100.00	1,902.72
	Daily workers are sometimes required for non technical tasks in support activities.						
4.2	Vehicle costs program	D	1	458.20	12	100.00	5,498.40
	1 vehicle is used in Kunar by the program team for the implementation and supervision of the activities						
4.3	Vehicle costs support	S	3	155.00	3	100.00	1,395.00
	Fuel for 2 vehicles used for management and support team in Kabul and 1 extra vehicle stays in stand-by for security purposes						
	Section Total						**8,796.12**
5. Travel							
5.1	Domestic Flights	S	3	280.00	12	25.00	2,520.00
	3 round trip tickets are budgeted during 3 months for field team to come to Kabul for coordination and stakeholders meetings, and for coordination team to visit the field to supervise the activities and provide support. Due to seucrity reasons expatraites are not alllowed to travel by road.						
	Section Total						**2,520.00**
6. Transfers and Grants to Counterparts							
NA	NA	NA	0	0.00	0	0	0.00
	NA						
	Section Total						**0.00**
7. General Operating and Other Direct Costs							
7.1	Office and GH rent, RC and maintenance coordination	S	2	3,831.75	12	25.00	22,990.50
	3 months of the costs of coordination office in Kabul will be affected to this project. In coordination we currently have 1 office and 1 guesthouse. The allocated amount will cover a part of the global cost for monthly rent, taxes, charges, costs of rehabilitation and maintenance.						
7.2	Office rent, RC and maintenance field	S	1	2,453.00	12	25.00	7,359.00
	3 months cost of the base of Jalalabad will be affected to this project. The field base combines office, guesthouse and stock. The allocated amount will cover a part of the global cost for monthly rent, taxes, charges, costs of rehabilitation and maintenance.						

7.3	Furniture, equipment and stationaries coordination	S	2	669.61	12	25.00	4,017.66
	The office supplies costs are determined by estimating both the program staff needs during the implementation of the project and the historical average office supplies. It includes stationeries and also small materials, furniture and equipment for the coordination office						
7.4	Furniture, equipment and stationaries field	S	1	492.10	12	25.00	1,476.30
	The office supplies costs are determined by estimating both the program staff needs during the implementation of the project and the historical average office supplies. It includes stationeries and also small materials, furniture and equipment for Jalalabad.						
7.5	Generator cost coordination	S	4	176.00	12	25.00	2,112.00
	Cost of generators maintenance must be taken into account in order to enable the proper coverage of the equipment functioning. Generators must be used during energy blackouts, in order to assure that the team will be able to continue working and handling the different activities to assure the implementation of the project. This includes 2 generators in coordination: office and guesthouse						
7.6	Generator cost field	S	1	493.40	12	25.00	1,480.20
	Cost of generator maintenance must be taken into account in order to enable the proper coverage of the equipment functioning. Generator must be used during energy blackouts to assure that the team will be able to continue working and handling the different activities to assure the implementation of the project.						
7.7	Communication costs coordination	S	1	4,216.00	4	25.00	4,216.00
	This line covers all the costs related to mobile and satellite phone, as well as internet of coordination office and warehouse. A full coverage of the phone costs of the team directly working on the project is requested. The coverage of the rest of the communication expenses will be shared among different projects.						
7.8	Communication costs field	S	1	3,116.00	4	25.00	3,116.00
	This line covers all the costs related to mobile and satellite phone, as well as internet of Jalalabad. A full coverage of the phone costs of the team directly working on the project is requested. The coverage of the rest of the communication expenses will be shared among different projects.						
7.9	Vehicle costs support	S	3	769.00	12	25.00	6,921.00
	3 vehicles are monthly needed in Kabul to ensure movement of international and national staff, 1 vehicle is used by logistics for purchase and transportation of goods and 1 vehicle is keep in stand by for security.						
7.10	Security costs	S	1	312.63	1	100.00	312.63
	In order to guarantee an adequate security enviromment in PU-AMI premises, rehabilitation, maintenance and improvement are done according to the needs.						
7.11	Bank fees	S	1	373.57	12	25.00	1,120.71
	This includes bank fees incurred when receiving or transferring funds, when paying suppliers and salaries, and other bank charges.						
	Section Total						**55,122.00**
SubTotal			336.00				**674,906.54**
Direct							465,155.56
Support							209,750.98
PSC Cost							
PSC Cost Percent							7.00
PSC Amount							47,243.46
Total Cost							**722,150.00**

Project Locations

Location	Estimated percentage of budget for each location	Estimated number of beneficiaries for each location					Activity Name
		Men	Women	Boys	Girls	Total	
Kunar -> Watapur	20	2,449	2,216	640	596	5,901	Activity 1.1.1 : Four integrated first aid trauma posts (FATP) are established in conflict affected areas of Kunar Province BPHS and EPHS packages remains unable to respond to emergency situations, such as those

frequently witnessed in Kunar as a result of ongoing protracted conflicts. The nature of the conflict is bringing inflow of weapon-related trauma cases requiring sustained emergency life-saving medical support. In Kunar in 2016 alone, according to PU-AMI ECHO database, 25,264 trauma cases of which 2,249 due to conflict, have been reported.

First aid trauma posts will be established to increase the capacity of local health facilities to deal with the upsurge of trauma cases due to conflict in their vicinity.
Data of 2015, 2016 and first 7 months of 2017 was reviewed to identify the existing health facilities receiving the highest number of trauma cases (conflict induced or not). Following health facilities were chosen for integration of a FATP.
? District Khas Kunar, Khas Kunar CHC
? District Marawara, Marawara BHC
? District Bar Kunar, Asmar CHC
? District Watapur, Quro BHC

In accordance with PPHD and Health Cluster Coordinator, decision was made to have FATPs integrated in existing BHC/CHC to leave the possibility of integration in the BPHS once the emergency intervention is over, thus keeping in mind the exit strategy after the emergency intervention. The goals to prevent death and disability in injured patients can be categorized into three broad sets of needs:
1. Life-threatening injuries are appropriately treated, promptly and in accordance with appropriate priorities, so as to maximize the likelihood of survival.
2. Potentially disabling injuries are treated appropriately, so as to minimize functional impairment and to maximize the return to independence and to participation in community life.
3. Pain and psychological suffering are minimized.

The set-up of these FATPs will be achievable through all different aspects of trauma cares resources that would be necessary to assure such care. These include human resources (staffing and training) and physical resources (infrastructure, equipment and supplies) that should be in place to assure optimal care of the injured patient at the range of health facilities.
In working towards decreasing the burden of death and disability from injury, a spectrum of activities will be considered, ranging from surveillance and basic prevention programs, to trauma management/stabilization and referral.

The drawing of the FATP was done by the PU-AMI engineer based on the constraints linked to each location (availability of terrain, etc) and on recommendations of PPHD and director of the health facility to ensure its acceptance and integration in the functioning of the facility. Essential notions such as access and hygiene standards (ease to clean) were obviously taken into consideration. (Drawings and BOQ attached, respectively in Annexes 06 and 05)

Together, the Engineer with the Project Manager will regularly monitor the construction progress and will ensure that FATPs are established according the calendar and standards.
Activity 1.1.1 : Screening for MAM and SAM

In the seven priority districts considered under this allocation, there are important gaps in coverage for both SAM and MAM. According to Nutrition Cluster data, the best coverage for SAM is in Shygal with a 90% coverage, while it ranges between 16 to 38 % in all other districts. MAM coverage rates go from 13% and 37%: these alarmingly low rates emphasis the relevance of

nutrition programs.

Nutrition activities are fully and complementary part of the integrated approach of PU-AMI, and will benefit of the quality health services providing for vulnerable population as an entry point for screening of children aged 0-59 months as well as PLW.

MAM and SAM screening and detection will be conducted in the five health facilities operated by PU-AMI in the frame of this CHF allocation, in hard to reach areas of Kunar province, i.e
• Four sub health centers located in
District Dar I Pech, Wardish Tangi village
District Ghazadabad, Sooki village
District Shygal, Bar Galayee village
District Watapur, Dargo village
• One mobile health team that will be visiting underserved host communities as well as locations with high concentrations of IDPs and returnees in the seven priority districts of Kunar province.

MAM and SAM screening will be done by the midwife in all above mentioned locations, especially when it comes to screening of PLW, which can only be done by a woman for cultural reasons. Depending on workload, she might be assisted by the doctor.

Screening will be done using MUAC as well as checking for oedema and weight for height.
The material for screening will be partly provided by the Nutrition partners (UNICEF and WFP) and complementary items will be purchased by PU-AMI

At the health facility level monitoring of this activity will be conducted by the head of the health facility , He or she will observe daily children screening and the proper filling of screening registration by the midwife/nurse The nutrition officer will also participate in the monitoring by crosschecking the adequate screening and registration procedures.
Activity 1.1.1 : Provide Psychological first aid to conflict affected IDPs and returnees and host communities:

PU-AMI has implemented PFA services in close coordination with WHO and the mental health department of MoPH in Kunar and Nangarhar provinces, progressively scaling up since 2014 and conducting trainings in PFA for other NGOs and service providers'

Significant psychological harm remains one of the dramatically underreported consequences of insecure contexts. The implementation in the past 3 years of PFA services shows how, following decades of protracted conflict, the population is in dire need of psychosocial support. PFA services provided in Kunar through health workers and in Nangarhar through mobile clinics confirm the needs for such services in addition to more traditional primary health care. The MoPH, PU-AMI, and other implementing partners reaffirmed throughout 2016 the need to strengthen and expand PFA services for populations affected by the conflict that are regularly exposed to suffering and violence. Mainstreaming psychological support and improving the inclusion of such activities in the MoPH priorities is a long-term structural undertaking which requires slow but constant steps.

A PFA provider will be operational in each of the five health facilities (four sub health centers and one mobile health team) operated by PUAMI in Kunar province under this allocation. Health is an

ideal entry point for the acceptance and therefore provision of PFA services.Since mental health is not a common medical area, well-understood and accepted by the population in Afghanistan, the targeted beneficiary will be informed of the purpose, goals and advantages of the PFA interventions. Community elders and shuras will also be sensitized to the need for mental health services.
The PFA provider will ensure the screenings, counseling, and referrals of traumatized persons to the AADA counselor in the district hospital. This method to ensure mental health services to traumatized persons has proved its value and necessity, notably for people affected by displacement.
S/He will provide initial PFA response with individuals or groups to help them cope with stress symptoms and prevent the development of trauma and related psychological disorders.

Supportive supervision and refresher/follow-up working sessions will be organized regularly by expatriate Psychologist Adviser (with extensive experience in clinical psychology) to develop the quality of the services provided.

Activity 1.1.2 : Provide psychosocial support to conflict affected IDPs, returnees and host communities

For those beneficiaries who have long lasting trauma and couldn't access PFA in due time (PFA needs to be provided within 1 month after the trauma) as well as for victims of protracted traumas (such as domestic violence), the only current counselor available is in the District Hospital, and therefore inaccessible to the most vulnerable due to the travel cost.

Psychosocial support will help individuals and communities heal psychological wounds and rebuild social structures. Adequate psychosocial support activities will
? Prevent distress and suffering from evolving into something more severe
? Help people cope better and become reconciliated to everyday life
? Help beneficiaries resume a normal life
? Meet community identified needs

PSS activities will be implemented at the SHC and MHT level, and will be implemented according to WHO IADC Guidelines on Mental Health and Psychosocial Support in Emergency Settings
At MHT level, a PSS counselor will provide blanket PSS services to women and girls while the health promoter will engage with males on advocacy/awareness raising about issues.
At the SHC level, both individual and collective sessions will be organized to provide adapted services to the range of needs of patients, with a special focus on needs of women.
Children will participate in group sessions, which will be coordinated by the PSS worker and facilitated through activities encouraging them to express themselves in a creative way, as well as to interact with another.

The prevalence of GBV particularly remains high in Afghanistan, with most GBV cases concealed and driven by socio-cultural beliefs, values and practices. The latest Afghanistan Demographic Health Survey indicates that half (53%) of the ever-married women age 15-49 have experienced physical violence at least once. Though PU-AMI will not actively seek GBV cases, PSS patients will include GBV survivors. PU-AMI teams will be trained on basic PSS, clinical management of rape (CMR) and referral to specialized services. PU-AMI will coordinate with family protection centers (one stop GBV

service delivery points in Asadabad provincial, Kama district and Jalalabad regional hospitals, all of which are funded by UNFPA funds and managed by AADA and IMC) as well as with other stakeholders as necessary. UNFPA dignity kits (designed for women and girls) will be provided as part of the GBV response.

From previous projects in Kunar province, PU-AMI has recorded that most of the people seeking protection services are adults (91%) , with many more men (59%) than women (32%) seeking these services.
While the focus so far was on PFA, through the introduction of PSS, PU-AMI intends to increase the catchment of women and children. With the lack of experience and data on group sessions of PSS, the targets have been set at 50% for each gender.

Furthermore, to promote PFA and PSS activities , training on PFA and PSS will be provided to Protection Cluster partners to strengthen the overall protection response throughout the country.

Identity of beneficiaries will remain confidential, through the use of a coding system.

Activity 1.1.2 : SAM and MAM case management

Children with SAM without complications will be admitted in the OPD SAM Program and will be provided with Ready-to-Use Therapeutic Food (RUTF), that will be provided by UNICEF. According to the estimated caseload, PU-AMI expects to need 858 boxes (or 128,700 sachets) of RUTF.
Children with MAM will be admitted in the OPD MAM program and will be provided with Ready-to-Use Supplementary Food (RUSF), provided by WFP. Estimated caseload brings the need to 231,660 sachets.
Cases of SAM with medical complications can’t be treated within the SHC or MHTs, as they require a comprehensive treatment that can only be provided through appropriate structures in IPD. They will therefore be referred to the nearest stabilization center in Kunar province. PU-AMI teams will follow up on the referral with the IPD SAM.

Based on PU-AMI 2016 nutrition database for Kunar, the admission rates are about 43% for boys and 57% for girls, beneficiaries have therefore been calculated accordingly.
The PLWs detected with acute malnutrition will all receive SuperCereals as well as multiple micronutrients, with estimated needs mounting up to 12,870 kg of supercereal and 478,764 tablets of micronutrients.
The treatment provided will be based on the national IMAM protocol, and includes the provision of systematic medical treatment and nutritional support. RUTF and RUSF is expected to be provided by WFP and UNICEF depending on the cases and needs of the patients., but PU-AMI will also constitute a buffer stock to cope with possible supply breakdown (Estimated Supplementary Feeding requirements are detailed in Annex 12)
The quantities required have been estimated based on caseloads in similar structures currently managed by PU-AMI, however the above mentioned figures might vary over the course of the project implementation. PU-AMI will regularly coordinate with both WFP and UNICEF to keep both organizations informed about the actual consumption and forecasted needs.

A food distributor will distribute the necessary supplementary feeding rations according to IMAM protocol.

Part of the follow up will be conducted by community mobilizers, who will actively search for the absent or defaulter cases in order to find out about the causes and solve it as possible to get them back to the programs and follow ups. The aim will be to decrease the number of default cases.

The Community mobilizers will be trained on screening, defaulter tracing, and referral for malnutrition at community level and nutrition education. They will be supervised by the doctor. Overall technical supervision of the nutrition activities, and ensuring IMAM protocol is respected will be done by the Nutrition Program Manager and the Health Coordinator

At the health facility level, monitoring of this activity will be conducted by the head of the health facility. He or she will observe daily admission of children in the program and also proper filling of OPD SAM/MAM cards and registration by the nutrition nurse. The nutrition officer will crosscheck the cards and registrations and will also randomly verify SAM and MAM cases accordingly to IMAM guidelines. Based on PU-AMI experience, verification committees will be established for verification of acutely malnourished PLWs to avoid miss use of food rations

Activity 1.1.2 : Procurement and distribution of essential medical supplies and equipment to four FATPs

For all facilities treating emergency trauma cases, equipment will be provided by PU-AMI, following ICRC standards. (BOQ attached in Annex 07)
In order to ensure the quality of trauma cares services, PU-AMI will ensure the FATPs are provided with all adequate medical equipment, consumables and drugs. This will be done through international procurement of drugs and local purchase for supplies that will follow PU-AMI own and donor's procurement rules for pharmaceuticals respecting Afghanistan Ministry of Health approved medical items.
PU-AMI medical procurement is led by the Health Department, consisting of a health coordinator and a pharmacist at mission level with technical support from HQ Pharmacist and HQ Health Advisor.
Drugs and medical supplies will be stored in the PU-AMI pharmacy in Jalalabad before being dispatched to the FATPs. Stock and consumption will be monitored by the pharmacist using software and checked by the health coordinator.

PU-AMI pharmacy department will monitor the process of procurement and distribution of essential medical supplies and equipments using PU-AMI and ICRC standards. Stock cards, pharmacy checklists, receive notes will be used to monitor the adequate amount of supplies to FATPs.
Activity 1.1.3 : Provision of essential trauma care services

Emergency trauma kits (including medical equipment, drugs and consumables, BOQ attached, Annex 07) will be delivered to those four health facilities. Both doctors and nurses are obviously important for a smooth running of the FATP. One provides assessment and diagnosis while the other offers aid, physical and psychological treatment. In short, they are both complementary factors to what makes the FATP operate efficiently.
The most important function of the doctor will be to identify and treat life-threatening conditions

and then to assess the patient carefully for other complaints or findings that may require referral. The nurse will be in charge of providing first essential trauma care to patients. Since the FATPs are attached to an existing health facility, the doctor of the adjacent health facility (CHC or BHC) will also be operational in the FATP. Under CHF funding, PU-AMI will provide an additional nurse which will be dedicated full time to the FATP. The nurses will receive refresher training on Basic Life Saving.

The minimum package of First Aid Care/ trauma care at the FATP comprises early detection, initial medical care for severe injury or sudden illness using a certain amount of drugs and equipment to perform primary intervention and assessment to fulfill the basic principles of trauma care, which are to preserve life, to prevent further harm and to keep the patient condition's stable. This may include applying first aid techniques, airway and/or shock management, fluid resuscitation, caring burns, injury and wounds management, stabilization and promote recovery including dispensing of medication.

Strict protocols will be applied, according to national guidelines to always reach the highest quality of services. Patient records will be kept through a registration system (administrative registration and medical details taken by the doctor respecting confidential management of sensitive data).
Diagnostic and treatment protocols will be based on MoPH national guidelines.

Establishment of a referral system to secondary health facility level: The teams will be in continuous coordination with surrounding Hospital in case of referral needed. The referral will be done through an ambulance.

Security allowing, monthly supervision visits will be carried out by CHF programject manager to monitor the delivery of essential trauma care services. Supervision checklists will be used during supervision visits. Trauma registers will be checked for verifying the delivery of trauma services. Monthly reporting formats will be developed for each site to report their monthly achievement and will be stored in trauma database.
Activity 1.1.3 : IYCF promotion and counseling

IYCF promotion will be used for prevention of malnutrition as well as part of the recovery process.
This key strategy represents an opportunity to increase awareness by providing relevant information to communities with healthcare access difficulties, and making a final impact on the wellbeing of the infant, young child, and also among the female population.
The dissemination of key nutrition messages will be the responsibility of the whole team, i.e. doctor, midwife, community mobilizer and food distributor.
Information sessions will be supported by IEC material.

PU-AMI will set up a range of IYCF prevention of malnutrition awareness sessions and training including:
? Increase knowledge and sensitize care givers and community members on health and nutrition (IYCF) key messages, through IYCF training to female nurses, midwives, doctors and health promoters
? Deliver IYCF certified training and nutrition education messages through group discussions, sensitization campaigns for key community members and opinion leaders, specially the one

that are located far away
? Use already existing relevant and adapted IYCF IEC/BCC materials through participatory methods with the communities
? Pre-test and post-test will be applied in a didactic practical way, as evidence of participation, and acquired and applied knowledge among the community participants
? The midwives will conduct counseling during the PNC visit and also regular education on early initiation of breast feeding, exclusive breast feeding, and complementary feeding. They will also conduct breast feeding counseling to lactating women who has breast feeding problems
? Ensure better surveillance among communities and health workers to respond to cases of acute malnutrition
? Periodic report of IYCF activities. At HFs level there will be registrations and monthly reports which will be collected by the supervisor and entered into the nutrition data base, for the respective analysis at the provincial and central level and final submission to the PND and the Nutrition Cluster.

Monitoring of this activity will be conducted by the head of the health facility , He or she will observe daily education sessions and breast feeding counseling performed by the nurse or midwife. The Nutrition Officer will crosscheck the HF's IYCF report with nutrition data base
Activity 1.1.4 : Capacity building of Health and Nutrition staff

The program will enhance capacity of Health and Nutrition staff in diagnosis and management of SAM and MAM affected children and PLW through trainings, workshops and regular coaching to improve knowledge and skills in order to improve nutrition services delivery to the beneficiaries and promote project sustainability.
PU-AMI aims to:
? Train medical staffs on IMAM that will be involved in managing moderate and severe acute malnutrition (m/f)
? Participate in the trainings conducted by other stakeholders to carry out community based nutrition screening (MUAC and oedema detection) and referral of malnourished children, defaulter tracing, conduction of nutrition and health education in the intervention areas (m/f)
? Ensure effective reporting and information sharing with other partners at the governorate and national levels including MoH, Nutrition Cluster in a timely manner
? Ensure better data collection mechanisms at OTPs and SFP sites
? Participate actively in Nutrition Cluster and sector coordination meetings both at National and province level to discuss nutrition and health related activities to improve outcomes in targeted districts

The following subjects will be included in the trainings:
? Breastfeeding counseling, highlighting the importance of breastfeeding, common difficulties and related recommendations
? Education about recommendations of nutrition during pregnancy and breastfeeding periods
? Hygienic preparation of food
? Complementary feeding

Regular monitoring of the activities by the Programject Manager and the Nutrition Officer could reveal need for additional training: on the job training may be provided on the spot. Should the identified need be broader, a formal training session might also be organized. The output of the training will be monitored by pre and post tests.
Activity 1.2.1 : Four sub health centers are

established in hard to reach districts of Kunar Province

4 locations in need of a sub health center have been identified with the support of PPHD and based on data on populations and current white areas
District Dar I Pech, Wardish Tangi village
District Ghazadabad, Sooki village
District Shygal, Bar Galayee village
District Watapur, Dargo village

All locations are more than 2 hours walk from the closest health facility

In each village, PU-AMI teams will reach out to local representatives, community elders and shuras, will present and explain the project and thus will ask that a building should be lent to PU-AMI for the duration of the project in each of the four locations. PU-AMI teams will ensure that communities understand the reasons behind the opening of the health facility as well as the scope and limitation of the funding, including the project end date. The communities will be consulted regarding the recruitment of staff to gain their support, though PU-AMI will always seek the best qualified and experienced persons for the role.
Engagement with the community Shura and Health Shura will continue throughout the project on a regular basis, through monthly meetings (and extra ad hoc meetings depending on needs)

Once the agreement with local representatives for the use of the building is signed, PU-AMI engineer will proceed with leading its renovation. Indeed, the building will have to be adapted to meet the requirements of a health facility, in terms of access (wheelchair or stretcher), layout and hygiene requirements (tiling of the delivery room for example)

Each SHC will be staffed with one doctor, one midwife, two vaccinators (1 male and 1 female) and a cleaner/guard. The female vaccinator will operate within the SHC while the male vaccinator can conduct outreach vaccinations. A majority of the patients will be female (for TT vaccination) who do not accept to be vaccinated by men for cultural reasons, or children in need of OPV, as Kunar is the province which is most affected by polio (4 of the 6 cases recorded in 2016 were recorded in Kunar province)

PU-AMI will announce the vacancies with ACBAR and locally in Asadabad as well as in the nearest health facilities. Special attention will be given to hiring female staff including midwives and fixed vaccinators if possible, as PU-AMI is already aware this will be challenging. Salaries and other benefits will conform to the MoPH salary scale in order to prepare the staff for a potential integration into the BPHS system at a later date.

As BPHS implementer, PUAMI will collaborate with MoPH to support the integration of the SHC in the BPHS.

Project team will supervise the Health facilities and will ensure that the health facilities are established according the standards for the health services provision. Supervision and monitoring checklists will be used during supervision visits. PU-AMI team will assess the buildings provided by the communities to arrange it according the MoPH standards.
Activity 1.2.2 : One Mobile Health Teams is established and provides mobile services in hard to reach districts

Currently only 3 MHTs are active in all of Kunar province: one is run by ARCS, one has been recently set up by AADA and PU-AMI also has a mobile health clinic as a part of the BPHS activities implemented in Kunar. In a province with a high number of IDPs (over 8700 IDPs according to most recent OCHA data available) and returnees, where displacements are regular due to conflict between various AOGs, this remains insufficient to cover the needs.
PU-AMI will provide an additional MHT under the CHF, to ensure a better coverage of the needs of IDPs, returnees and host populations in hard to reach areas.
The area of operation of the MHT is defined in collaboration with the PPHD, who coordinates the action of the various implementers of health services in the province.

Each MHT will be staffed by 1 Medical Doctor (MD), 1 nurse, 1 vaccinator, 1 midwife and 1 health promoter The doctor will be dedicated to patient consultations, establishing diagnosis, writing prescriptions and treating the occasional emergency case
The vaccinator will be fully dedicated to vaccination (TT and OPV and measles vaccination in case of an outbreak)
The midwife is in charge of ANC and PNC, family planning and attending emergency deliveries in the home of beneficiaries.
The health promoter will be in charge of health education, sensitization, community awareness, and explaining to patients how to properly use drugs. He will conduct health education to the patients based on IEC material approved by MoPH.

All staff will receive a 3 days refresher training on RUD (Rational Usage of Drugs) and 3 days refresher training on HMIS (Health Management Information System) based on lesson learnt of previous CHF experience. Follow up training might be provided as per need.
Waste management will also be part of the refresher training plan to ensure the MHT intervention will have no negative impact on the environment. Cooperation with BPHS health facilities is already in place and medical waste will be brought to the closest health facility for adequate waste management

Regular supervision and monitoring visits will be carried out to the MHT, applying supervision checklists. Activity plan for MHT will be developed in coordination with PPHD and DoRR to reach IDPs and provide them with essential primary health services
Activity 1.2.3 : Procurement and distribution of essential medical supplies and equipment to five health facilities:

For all previous mentioned health facilities (4 SHC and 1 MHT) PU-AMI considers the MHT as a health facility, as the provided services reflect those of a static health facility, but have the advantage of reaching more remote and disseminated beneficiaries. PU-AMI will use the MoPH standard list of drugs and supplies in order to provision the health facilities with items which would also be provided if the facilities were part of the BPHS. As there is currently no BPHS support or overlap, CHF would provide the financial support for all supplies

Procurement for the health facilities will be arranged by the Project Manager according to consumption rates of comparable health facilities and based on data on the most common diseases in Afghanistan.

In order to ensure the quality of health services, PU-AMI will ensure the health facilities and the

MHT are provided with all adequate medical consumables and drugs. This will be done through international procurement of drugs and local purchase for supplies that will follow PU-AMI own and donor's procurement rules for pharmaceuticals respecting Afghanistan Ministry of Health approved medical items.
PU-AMI medical procurement is led by the Health Department, consisting of a health coordinator and a pharmacist at mission level with technical support from HQ Pharmacist and HQ Health Advisor.
Drugs and medical supplies will be stored in the PU-AMI pharmacy in Jalalabad before being dispatched to the Health facilities and MHT. Stock and consumption will be monitored by the pharmacist using software and checked by the health coordinator.

PU-AMI will receive the standard vaccines from the provincial cold chain which is managed by the Provincial EPI Management Team (PEMT). This Provincial EPI Management Team is represented by an EPI Officer of the Directorate of Public Health. They will provide the vaccines requested by PU-AMI for the supported health facilities. PU-AMI will be in charge of the transport from PEMT to the said health facility, ensuring that the cold chain is respected and the vaccines maintained in the appropriate conditions during their transportation.

Though PEMT should also provide RCW50 refrigerators for vaccine vials conservation, so far challenges have been observed in neighboring regions and the unreliable supply of the RCW50 refrigerators have impacted the immunization services in remote and hard to reach areas. Therefore PU-AMI will keep the option of procuring them. Should the RCW50 refrigerators finally be made available by the PEMT, the funds will be used to procure supplementary equipment or drugs for the HF

Pharmacy stock cards and checklists will be used to ensure the adequate distribution and availability of all essential drugs in the health facilities. PU-AMI pharmacy team will regularly analyze pharmacy data and provide feedback to the health staff about the utilization of services and consumption of drugs. During supervision visits, the pharmacy stock will be observed and supervised for the rational use of drugs.
Activity 1.2.4 : Delivery of essential primary health care, mother and child health care services and immunization in five health facilities (4SHC and 1 MHT)

Services offered will conform to the MoPH standard guidelines and practices in order to maintain a consistent approach throughout the province. Services include a wide range of health services (preventive and curative consultations, including acute, chronic, injuries, health and hygiene promotion and referrals to secondary care facilities;

Amongst the delivery of the primary healthcare package, a specific attention will be given to the most vulnerable beneficiaries. In that regard, huge needs have been confirmed for pregnant and lactating women; PU-AMI Midwives reported that a dedicated service is very much appreciated, also for cultural reasons: without much community networks or protection, women tend to avoid going to health facilities; once PU-AMI midwives share their phone numbers, they regularly receive calls asking for guidance and orientation. As such, MNCH services provision will be ensured by one midwife per HF. This allows women in hard to reach areas to benefit from ANC, PNC, and FP services. Midwives will

also ensure the timely referral of full-term pregnant women to deliver in closest HFs or hospital or, if not possible, try to ensure assisted home delivery, as this happened on exceptional cases. To that purpose, midwives will provide consultation and orientation taking into account the availability of services in the HFs and hospitals
Based on total catchment population of the 5 HF (4 SHC and 1 MHT), providing services to a total of 18 600 beneficiaries, and on pregnancy rate data from PU AMI HMIS in Kunar, it is estimated that approximately 4% of the catchment population will be pregnant women.
Though through these services, PU-AMI hopes to serve all pregnant women, the target has been established at 50% of the latter, i.e a total of 372 pregnant individuals.
Based on HMIS data from Kunar, it is estimated that 8% of the individuals consulting for antenatal care visits are under 18 years old and therefore fall under the category of “girls”

All routine immunization including OPV and Tetanus Toxoid vaccinations will be provided to children under one year old and women (pregnant and non pregnant). In addition, medical staff and health promoter will raise awareness on benefits of vaccine, risk of vaccine preventable diseases, awareness on polio virus and its prevention by polio drops. Awareness messages will increase sensitization of communities regarding vaccine preventable disease.
Considering the specificity of Kunar context, PU-AMI aims is repeating successful past experience by adding a vaccinator to each newly opened SHC. One female vaccinator will perform fixed vaccination services in the health facility, motivating mothers to come to the clinic in a way to increase coverage of ANC services as well, while a male vaccinator will provide outreach immunization services in the more remote corners of each catchment area.

PU-AMI being the BPHS implementer, this will facilitate the organization of staff training for the following topics:
? HMIS Practical Training;
? Infection Prevention;
? Management of Drug Supplies and rational prescriptions
? Practical immunization training (for nurses only)
Other trainings may be organized depending on needs

Supervision checklists will be used during supervision visits and the findings will be shared with the PM and the Emergency Coordinator, for the necessary improvements and follow ups. Data of monthly reports will be crosschecked with health facility registers to ensure the consistency and accuracy of data. Standard treatment guidelines and treatment protocols will be used to provide quality services

Activity 1.2.5 : Participation in DEWS and outbreak management and response:

Through its MHT PU-AMI will be regularly accessing IDP sites as well as host communities who remain hard to reach and underserved.
PU-AMI will participate in the DEWS response
? MHT team can be contacted by previously visited communities if a disease outbreak is suspected. In this case, PU-AMI will inform PPHD about the change of field activity for the day and keep PPHD informed about the status of the outbreak (confirmed or not, number of cases, need for follow up, etc)
? MHT team may also be called upon by the PPHD if they hear of a suspected outbreak. The

							process will then be the same, MHT team going to the location of suspected outbreak and keeping PPHD informed about the outcome of the visit. Good collaboration with the PPHD DEWS Officer will be essential, and will be maintained through regular coordination meetings. PU-AMI MHT may also join an outbreak response team in case of a larger outbreak. Outbreak reports will systematically be shared with PPHD HMIS officer, PPHD DEWS officer as well as WHO focal point
Kunar -> Marawara	16	278	179	98	83	638	Activity 1.1.1 : Four integrated first aid trauma posts (FATP) are established in conflict affected areas of Kunar Province BPHS and EPHS packages remains unable to respond to emergency situations, such as those frequently witnessed in Kunar as a result of ongoing protracted conflicts. The nature of the conflict is bringing inflow of weapon-related trauma cases requiring sustained emergency life-saving medical support. In Kunar in 2016 alone, according to PU-AMI ECHO database, 25,264 trauma cases of which 2,249 due to conflict, have been reported. First aid trauma posts will be established to increase the capacity of local health facilities to deal with the upsurge of trauma cases due to conflict in their vicinity. Data of 2015, 2016 and first 7 months of 2017 was reviewed to identify the existing health facilities receiving the highest number of trauma cases (conflict induced or not). Following health facilities were chosen for integration of a FATP. ? District Khas Kunar, Khas Kunar CHC ? District Marawara, Marawara BHC ? District Bar Kunar, Asmar CHC ? District Watapur, Quro BHC In accordance with PPHD and Health Cluster Coordinator, decision was made to have FATPs integrated in existing BHC/CHC to leave the possibility of integration in the BPHS once the emergency intervention is over, thus keeping in mind the exit strategy after the emergency intervention. The goals to prevent death and disability in injured patients can be categorized into three broad sets of needs: 1. Life-threatening injuries are appropriately treated, promptly and in accordance with appropriate priorities, so as to maximize the likelihood of survival. 2. Potentially disabling injuries are treated appropriately, so as to minimize functional impairment and to maximize the return to independence and to participation in community life. 3. Pain and psychological suffering are minimized. The set-up of these FATPs will be achievable through all different aspects of trauma cares resources that would be necessary to assure such care. These include human resources (staffing and training) and physical resources (infrastructure, equipment and supplies) that should be in place to assure optimal care of the injured patient at the range of health facilities. In working towards decreasing the burden of death and disability from injury, a spectrum of activities will be considered, ranging from surveillance and basic prevention programs, to trauma management/stabilization and referral. The drawing of the FATP was done by the PU-AMI engineer based on the constraints linked to

each location (availability of terrain, etc) and on recommendations of PPHD and director of the health facility to ensure its acceptance and integration in the functioning of the facility. Essential notions such as access and hygiene standards (ease to clean) were obviously taken into consideration. (Drawings and BOQ attached, respectively in Annexes 06 and 05)

Together, the Engineer with the Project Manager will regularly monitor the construction progress and will ensure that FATPs are established according the calendar and standards.
Activity 1.1.2 : Procurement and distribution of essential medical supplies and equipment to four FATPs

For all facilities treating emergency trauma cases, equipment will be provided by PU-AMI, following ICRC standards. (BOQ attached in Annex 07)
In order to ensure the quality of trauma cares services, PU-AMI will ensure the FATPs are provided with all adequate medical equipment, consumables and drugs. This will be done through international procurement of drugs and local purchase for supplies that will follow PU-AMI own and donor's procurement rules for pharmaceuticals respecting Afghanistan Ministry of Health approved medical items.
PU-AMI medical procurement is led by the Health Department, consisting of a health coordinator and a pharmacist at mission level with technical support from HQ Pharmacist and HQ Health Advisor.
Drugs and medical supplies will be stored in the PU-AMI pharmacy in Jalalabad before being dispatched to the FATPs. Stock and consumption will be monitored by the pharmacist using software and checked by the health coordinator.

PU-AMI pharmacy department will monitor the process of procurement and distribution of essential medical supplies and equipments using PU-AMI and ICRC standards. Stock cards, pharmacy checklists, receive notes will be used to monitor the adequate amount of supplies to FATPs.
Activity 1.1.3 : Provision of essential trauma care services

Emergency trauma kits (including medical equipment, drugs and consumables, BOQ attached, Annex 07) will be delivered to those four health facilities. Both doctors and nurses are obviously important for a smooth running of the FATP. One provides assessment and diagnosis while the other offers aid, physical and psychological treatment. In short, they are both complementary factors to what makes the FATP operate efficiently.
The most important function of the doctor will be to identify and treat life-threatening conditions and then to assess the patient carefully for other complaints or findings that may require referral. The nurse will be in charge of providing first essential trauma care to patients. Since the FATPs are attached to an existing health facility, the doctor of the adjacent health facility (CHC or BHC) will also be operational in the FATP. Under CHF funding, PU-AMI will provide an additional nurse which will be dedicated full time to the FATP. The nurses will receive refresher training on Basic Life Saving.

The minimum package of First Aid Care/ trauma care at the FATP comprises early detection, initial medical care for severe injury or sudden illness using a certain amount of drugs and equipment to perform primary intervention and assessment to fulfill the basic principles of trauma care, which are to preserve life, to

							prevent further harm and to keep the patient condition’s stable. This may include applying first aid techniques, airway and/or shock management, fluid resuscitation, caring burns, injury and wounds management, stabilization and promote recovery including dispensing of medication. Strict protocols will be applied, according to national guidelines to always reach the highest quality of services. Patient records will be kept through a registration system (administrative registration and medical details taken by the doctor respecting confidential management of sensitive data). Diagnostic and treatment protocols will be based on MoPH national guidelines. Establishment of a referral system to secondary health facility level: The teams will be in continuous coordination with surrounding Hospital in case of referral needed. The referral will be done through an ambulance. Security allowing, monthly supervision visits will be carried out by CHF programject manager to monitor the delivery of essential trauma care services. Supervision checklists will be used during supervision visits. Trauma registers will be checked for verifying the delivery of trauma services. Monthly reporting formats will be developed for each site to report their monthly achievement and will be stored in trauma database.
Kunar -> Shigal Wa sheltan	10	1,783	1,762	483	457	4,485	Activity 1.1.1 : Screening for MAM and SAM In the seven priority districts considered under this allocation, there are important gaps in coverage for both SAM and MAM. According to Nutrition Cluster data, the best coverage for SAM is in Shygal with a 90% coverage, while it ranges between 16 to 38 % in all other districts. MAM coverage rates go from 13% and 37%: these alarmingly low rates emphasis the relevance of nutrition programs. Nutrition activities are fully and complementary part of the integrated approach of PU-AMI, and will benefit of the quality health services providing for vulnerable population as an entry point for screening of children aged 0-59 months as well as PLW. MAM and SAM screening and detection will be conducted in the five health facilities operated by PU-AMI in the frame of this CHF allocation, in hard to reach areas of Kunar province, i.e • Four sub health centers located in District Dar I Pech, Wardish Tangi village District Ghazadabad, Sooki village District Shygal, Bar Galayee village District Watapur, Dargo village • One mobile health team that will be visiting underserved host communities as well as locations with high concentrations of IDPs and returnees in the seven priority districts of Kunar province. MAM and SAM screening will be done by the midwife in all above mentioned locations, especially when it comes to screening of PLW, which can only be done by a woman for cultural reasons. Depending on workload, she might be assisted by the doctor. Screening will be done using MUAC as well as checking for oedema and weight for height. The material for screening will be partly provided by the Nutrition partners (UNICEF and WFP) and complementary items will be purchased by PU-AMI

At the health facility level monitoring of this activity will be conducted by the head of the health facility , He or she will observe daily children screening and the proper filling of screening registration by the midwife/nurse The nutrition officer will also participate in the monitoring by crosschecking the adequate screening and registration procedures.
Activity 1.1.1 : Provide Psychological first aid to conflict affected IDPs and returnees and host communities:

PU-AMI has implemented PFA services in close coordination with WHO and the mental health department of MoPH in Kunar and Nangarhar provinces, progressively scaling up since 2014 and conducting trainings in PFA for other NGOs and service providers'

Significant psychological harm remains one of the dramatically underreported consequences of insecure contexts. The implementation in the past 3 years of PFA services shows how, following decades of protracted conflict, the population is in dire need of psychosocial support. PFA services provided in Kunar through health workers and in Nangarhar through mobile clinics confirm the needs for such services in addition to more traditional primary health care. The MoPH, PU-AMI, and other implementing partners reaffirmed throughout 2016 the need to strengthen and expand PFA services for populations affected by the conflict that are regularly exposed to suffering and violence. Mainstreaming psychological support and improving the inclusion of such activities in the MoPH priorities is a long-term structural undertaking which requires slow but constant steps.

A PFA provider will be operational in each of the five health facilities (four sub health centers and one mobile health team) operated by PUAMI in Kunar province under this allocation. Health is an ideal entry point for the acceptance and therefore provision of PFA services.Since mental health is not a common medical area, well-understood and accepted by the population in Afghanistan, the targeted beneficiary will be informed of the purpose, goals and advantages of the PFA interventions. Community elders and shuras will also be sensitized to the need for mental health services.
The PFA provider will ensure the screenings, counseling, and referrals of traumatized persons to the AADA counselor in the district hospital. This method to ensure mental health services to traumatized persons has proved its value and necessity, notably for people affected by displacement.
S/He will provide initial PFA response with individuals or groups to help them cope with stress symptoms and prevent the development of trauma and related psychological disorders.

Supportive supervision and refresher/follow-up working sessions will be organized regularly by expatriate Psychologist Adviser (with extensive experience in clinical psychology) to develop the quality of the services provided.

Activity 1.1.2 : Provide psychosocial support to conflict affected IDPs, returnees and host communities

For those beneficiaries who have long lasting trauma and couldn't access PFA in due time (PFA needs to be provided within 1 month after the trauma) as well as for victims of protracted traumas (such as domestic violence), the only current counselor available is in the District Hospital, and therefore inaccessible to the most

vulnerable due to the travel cost.

Psychosocial support will help individuals and communities heal psychological wounds and rebuild social structures. Adequate psychosocial support activities will
? Prevent distress and suffering from evolving into something more severe
? Help people cope better and become reconciliated to everyday life
? Help beneficiaries resume a normal life
? Meet community identified needs

PSS activities will be implemented at the SHC and MHT level, and will be implemented according to WHO IADC Guidelines on Mental Health and Psychosocial Support in Emergency Settings
At MHT level, a PSS counselor will provide blanket PSS services to women and girls while the health promoter will engage with males on advocacy/awareness raising about issues.
At the SHC level, both individual and collective sessions will be organized to provide adapted services to the range of needs of patients, with a special focus on needs of women.
Children will participate in group sessions, which will be coordinated by the PSS worker and facilitated through activities encouraging them to express themselves in a creative way, as well as to interact with another.

The prevalence of GBV particularly remains high in Afghanistan, with most GBV cases concealed and driven by socio-cultural beliefs, values and practices. The latest Afghanistan Demographic Health Survey indicates that half (53%) of the ever-married women age 15-49 have experienced physical violence at least once. Though PU-AMI will not actively seek GBV cases, PSS patients will include GBV survivors. PU-AMI teams will be trained on basic PSS, clinical management of rape (CMR) and referral to specialized services. PU-AMI will coordinate with family protection centers (one stop GBV service delivery points in Asadabad provincial, Kama district and Jalalabad regional hospitals, all of which are funded by UNFPA funds and managed by AADA and IMC) as well as with other stakeholders as necessary. UNFPA dignity kits (designed for women and girls) will be provided as part of the GBV response.

From previous projects in Kunar province, PU-AMI has recorded that most of the people seeking protection services are adults (91%) , with many more men (59%) than women (32%) seeking these services.
While the focus so far was on PFA, through the introduction of PSS, PU-AMI intends to increase the catchment of women and children. With the lack of experience and data on group sessions of PSS, the targets have been set at 50% for each gender.

Furthermore, to promote PFA and PSS activities , training on PFA and PSS will be provided to Protection Cluster partners to strengthen the overall protection response throughout the country.

Identity of beneficiaries will remain confidential, through the use of a coding system.

Activity 1.1.2 : SAM and MAM case management

Children with SAM without complications will be admitted in the OPD SAM Program and will be provided with Ready-to-Use Therapeutic Food (RUTF), that will be provided by UNICEF. According to the estimated caseload, PU-AMI expects to need 858 boxes (or 128,700 sachets) of RUTF.

Children with MAM will be admitted in the OPD MAM program and will be provided with Ready-to-Use Supplementary Food (RUSF), provided by WFP. Estimated caseload brings the need to 231,660 sachets.
Cases of SAM with medical complications can't be treated within the SHC or MHTs, as they require a comprehensive treatment that can only be provided through appropriate structures in IPD. They will therefore be referred to the nearest stabilization center in Kunar province. PU-AMI teams will follow up on the referral with the IPD SAM.

Based on PU-AMI 2016 nutrition database for Kunar, the admission rates are about 43% for boys and 57% for girls, beneficiaries have therefore been calculated accordingly.
The PLWs detected with acute malnutrition will all receive SuperCereals as well as multiple micronutrients, with estimated needs mounting up to 12,870 kg of supercereal and 478,764 tablets of micronutrients.
The treatment provided will be based on the national IMAM protocol, and includes the provision of systematic medical treatment and nutritional support. RUTF and RUSF is expected to be provided by WFP and UNICEF depending on the cases and needs of the patients., but PU-AMI will also constitute a buffer stock to cope with possible supply breakdown (Estimated Supplementary Feeding requirements are detailed in Annex 12)
The quantities required have been estimated based on caseloads in similar structures currently managed by PU-AMI, however the above mentioned figures might vary over the course of the project implementation. PU-AMI will regularly coordinate with both WFP and UNICEF to keep both organizations informed about the actual consumption and forecasted needs.

A food distributor will distribute the necessary supplementary feeding rations according to IMAM protocol.

Part of the follow up will be conducted by community mobilizers, who will actively search for the absent or defaulter cases in order to find out about the causes and solve it as possible to get them back to the programs and follow ups. The aim will be to decrease the number of default cases.

The Community mobilizers will be trained on screening, defaulter tracing, and referral for malnutrition at community level and nutrition education. They will be supervised by the doctor. Overall technical supervision of the nutrition activities, and ensuring IMAM protocol is respected will be done by the Nutrition Program Manager and the Health Coordinator

At the health facility level, monitoring of this activity will be conducted by the head of the health facility. He or she will observe daily admission of children in the program and also proper filling of OPD SAM/MAM cards and registration by the nutrition nurse. The nutrition officer will crosscheck the cards and registrations and will also randomly verify SAM and MAM cases accordingly to IMAM guidelines. Based on PU-AMI experience, verification committees will be established for verification of acutely malnourished PLWs to avoid miss use of food rations

Activity 1.1.3 : IYCF promotion and counseling

IYCF promotion will be used for prevention of malnutrition as well as part of the recovery process.
This key strategy represents an opportunity to

increase awareness by providing relevant information to communities with healthcare access difficulties, and making a final impact on the wellbeing of the infant, young child, and also among the female population.
The dissemination of key nutrition messages will be the responsibility of the whole team, i.e. doctor, midwife, community mobilizer and food distributor.
Information sessions will be supported by IEC material.

PU-AMI will set up a range of IYCF prevention of malnutrition awareness sessions and training including:
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? Deliver IYCF certified training and nutrition education messages through group discussions, sensitization campaigns for key community members and opinion leaders, specially the one that are located far away
? Use already existing relevant and adapted IYCF IEC/BCC materials through participatory methods with the communities
? Pre-test and post-test will be applied in a didactic practical way, as evidence of participation, and acquired and applied knowledge among the community participants
? The midwives will conduct counseling during the PNC visit and also regular education on early initiation of breast feeding, exclusive breast feeding, and complementary feeding. They will also conduct breast feeding counseling to lactating women who has breast feeding problems
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? Periodic report of IYCF activities. At HFs level there will be registrations and monthly reports which will be collected by the supervisor and entered into the nutrition data base, for the respective analysis at the provincial and central level and final submission to the PND and the Nutrition Cluster.

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The program will enhance capacity of Health and Nutrition staff in diagnosis and management of SAM and MAM affected children and PLW through trainings, workshops and regular coaching to improve knowledge and skills in order to improve nutrition services delivery to the beneficiaries and promote project sustainability.
PU-AMI aims to:
? Train medical staffs on IMAM that will be involved in managing moderate and severe acute malnutrition (m/f)
? Participate in the trainings conducted by other stakeholders to carry out community based nutrition screening (MUAC and oedema detection) and referral of malnourished children, defaulter tracing, conduction of nutrition and health education in the intervention areas (m/f)
? Ensure effective reporting and information sharing with other partners at the governorate and national levels including MoH, Nutrition Cluster in a timely manner
? Ensure better data collection mechanisms at OTPs and SFP sites
? Participate actively in Nutrition Cluster and

sector coordination meetings both at National and province level to discuss nutrition and health related activities to improve outcomes in targeted districts

The following subjects will be included in the trainings:
? Breastfeeding counseling, highlighting the importance of breastfeeding, common difficulties and related recommendations
? Education about recommendations of nutrition during pregnancy and breastfeeding periods
? Hygienic preparation of food
? Complementary feeding

Regular monitoring of the activities by the Programject Manager and the Nutrition Officer could reveal need for additional training: on the job training may be provided on the spot. Should the identified need be broader, a formal training session might also be organized. The output of the training will be monitored by pre and post tests.
Activity 1.2.1 : Four sub health centers are established in hard to reach districts of Kunar Province

4 locations in need of a sub health center have been identified with the support of PPHD and based on data on populations and current white areas
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District Shygal, Bar Galayee village
District Watapur, Dargo village

All locations are more than 2 hours walk from the closest health facility

In each village, PU-AMI teams will reach out to local representatives, community elders and shuras, will present and explain the project and thus will ask that a building should be lent to PU-AMI for the duration of the project in each of the four locations. PU-AMI teams will ensure that communities understand the reasons behind the opening of the health facility as well as the scope and limitation of the funding, including the project end date. The communities will be consulted regarding the recruitment of staff to gain their support, though PU-AMI will always seek the best qualified and experienced persons for the role.
Engagement with the community Shura and Health Shura will continue throughout the project on a regular basis, through monthly meetings (and extra ad hoc meetings depending on needs)

Once the agreement with local representatives for the use of the building is signed, PU-AMI engineer will proceed with leading its renovation. Indeed, the building will have to be adapted to meet the requirements of a health facility, in terms of access (wheelchair or stretcher), layout and hygiene requirements (tiling of the delivery room for example)

Each SHC will be staffed with one doctor, one midwife, two vaccinators (1 male and 1 female) and a cleaner/guard. The female vaccinator will operate within the SHC while the male vaccinator can conduct outreach vaccinations. A majority of the patients will be female (for TT vaccination) who do not accept to be vaccinated by men for cultural reasons, or children in need of OPV, as Kunar is the province which is most affected by polio (4 of the 6 cases recorded in 2016 were recorded in Kunar province)

PU-AMI will announce the vacancies with ACBAR and locally in Asadabad as well as in the nearest health facilities. Special attention will be

given to hiring female staff including midwives and fixed vaccinators if possible, as PU-AMI is already aware this will be challenging. Salaries and other benefits will conform to the MoPH salary scale in order to prepare the staff for a potential integration into the BPHS system at a later date.

As BPHS implementer, PUAMI will collaborate with MoPH to support the integration of the SHC in the BPHS.

Project team will supervise the Health facilities and will ensure that the health facilities are established according the standards for the health services provision. Supervision and monitoring checklists will be used during supervision visits. PU-AMI team will assess the buildings provided by the communities to arrange it according the MoPH standards.
Activity 1.2.2 : One Mobile Health Teams is established and provides mobile services in hard to reach districts

Currently only 3 MHTs are active in all of Kunar province: one is run by ARCS, one has been recently set up by AADA and PU-AMI also has a mobile health clinic as a part of the BPHS activities implemented in Kunar. In a province with a high number of IDPs (over 8700 IDPs according to most recent OCHA data available) and returnees, where displacements are regular due to conflict between various AOGs, this remains insufficient to cover the needs.
PU-AMI will provide an additional MHT under the CHF, to ensure a better coverage of the needs of IDPs, returnees and host populations in hard to reach areas.
The area of operation of the MHT is defined in collaboration with the PPHD, who coordinates the action of the various implementers of health services in the province.

Each MHT will be staffed by 1 Medical Doctor (MD), 1 nurse, 1 vaccinator, 1 midwife and 1 health promoter The doctor will be dedicated to patient consultations, establishing diagnosis, writing prescriptions and treating the occasional emergency case
The vaccinator will be fully dedicated to vaccination (TT and OPV and measles vaccination in case of an outbreak)
The midwife is in charge of ANC and PNC, family planning and attending emergency deliveries in the home of beneficiaries.
The health promoter will be in charge of health education, sensitization, community awareness, and explaining to patients how to properly use drugs. He will conduct health education to the patients based on IEC material approved by MoPH.

All staff will receive a 3 days refresher training on RUD (Rational Usage of Drugs) and 3 days refresher training on HMIS (Health Management Information System) based on lesson learnt of previous CHF experience. Follow up training might be provided as per need.
Waste management will also be part of the refresher training plan to ensure the MHT intervention will have no negative impact on the environment. Cooperation with BPHS health facilities is already in place and medical waste will be brought to the closest health facility for adequate waste management

Regular supervision and monitoring visits will be carried out to the MHT, applying supervision checklists. Activity plan for MHT will be developed in coordination with PPHD and DoRR to reach IDPs and provide them with essential primary health services
Activity 1.2.3 : Procurement and distribution of

essential medical supplies and equipment to five health facilities:

For all previous mentioned health facilities (4 SHC and 1 MHT) PU-AMI considers the MHT as a health facility, as the provided services reflect those of a static health facility, but have the advantage of reaching more remote and disseminated beneficiaries. PU-AMI will use the MoPH standard list of drugs and supplies in order to provision the health facilities with items which would also be provided if the facilities were part of the BPHS. As there is currently no BPHS support or overlap, CHF would provide the financial support for all supplies

Procurement for the health facilities will be arranged by the Project Manager according to consumption rates of comparable health facilities and based on data on the most common diseases in Afghanistan.

In order to ensure the quality of health services, PU-AMI will ensure the health facilities and the MHT are provided with all adequate medical consumables and drugs. This will be done through international procurement of drugs and local purchase for supplies that will follow PU-AMI own and donor's procurement rules for pharmaceuticals respecting Afghanistan Ministry of Health approved medical items.
PU-AMI medical procurement is led by the Health Department, consisting of a health coordinator and a pharmacist at mission level with technical support from HQ Pharmacist and HQ Health Advisor.
Drugs and medical supplies will be stored in the PU-AMI pharmacy in Jalalabad before being dispatched to the Health facilities and MHT. Stock and consumption will be monitored by the pharmacist using software and checked by the health coordinator.

PU-AMI will receive the standard vaccines from the provincial cold chain which is managed by the Provincial EPI Management Team (PEMT). This Provincial EPI Management Team is represented by an EPI Officer of the Directorate of Public Health. They will provide the vaccines requested by PU-AMI for the supported health facilities. PU-AMI will be in charge of the transport from PEMT to the said health facility, ensuring that the cold chain is respected and the vaccines maintained in the appropriate conditions during their transportation.

Though PEMT should also provide RCW50 refrigerators for vaccine vials conservation, so far challenges have been observed in neighboring regions and the unreliable supply of the RCW50 refrigerators have impacted the immunization services in remote and hard to reach areas. Therefore PU-AMI will keep the option of procuring them. Should the RCW50 refrigerators finally be made available by the PEMT, the funds will be used to procure supplementary equipment or drugs for the HF

Pharmacy stock cards and checklists will be used to ensure the adequate distribution and availability of all essential drugs in the health facilities. PU-AMI pharmacy team will regularly analyze pharmacy data and provide feedback to the health staff about the utilization of services and consumption of drugs. During supervision visits, the pharmacy stock will be observed and supervised for the rational use of drugs.
Activity 1.2.4 : Delivery of essential primary health care, mother and child health care services and immunization in five health facilities (4SHC and 1 MHT)

Services offered will conform to the MoPH standard guidelines and practices in order to maintain a consistent approach throughout the province. Services include a wide range of health services (preventive and curative consultations, including acute, chronic, injuries, health and hygiene promotion and referrals to secondary care facilities;

Amongst the delivery of the primary healthcare package, a specific attention will be given to the most vulnerable beneficiaries. In that regard, huge needs have been confirmed for pregnant and lactating women; PU-AMI Midwives reported that a dedicated service is very much appreciated, also for cultural reasons: without much community networks or protection, women tend to avoid going to health facilities; once PU-AMI midwives share their phone numbers, they regularly receive calls asking for guidance and orientation. As such, MNCH services provision will be ensured by one midwife per HF. This allows women in hard to reach areas to benefit from ANC, PNC, and FP services. Midwives will also ensure the timely referral of full-term pregnant women to deliver in closest HFs or hospital or, if not possible, try to ensure assisted home delivery, as this happened on exceptional cases. To that purpose, midwives will provide consultation and orientation taking into account the availability of services in the HFs and hospitals
Based on total catchment population of the 5 HF (4 SHC and 1 MHT), providing services to a total of 18 600 beneficiaries, and on pregnancy rate data from PU AMI HMIS in Kunar, it is estimated that approximately 4% of the catchment population will be pregnant women.
Though through these services, PU-AMI hopes to serve all pregnant women, the target has been established at 50% of the latter, i.e a total of 372 pregnant individuals.
Based on HMIS data from Kunar, it is estimated that 8% of the individuals consulting for antenatal care visits are under 18 years old and therefore fall under the category of “girls”

All routine immunization including OPV and Tetanus Toxoid vaccinations will be provided to children under one year old and women (pregnant and non pregnant). In addition, medical staff and health promoter will raise awareness on benefits of vaccine, risk of vaccine preventable diseases, awareness on polio virus and its prevention by polio drops. Awareness messages will increase sensitization of communities regarding vaccine preventable disease.
Considering the specificity of Kunar context, PU-AMI aims is repeating successful past experience by adding a vaccinator to each newly opened SHC. One female vaccinator will perform fixed vaccination services in the health facility, motivating mothers to come to the clinic in a way to increase coverage of ANC services as well, while a male vaccinator will provide outreach immunization services in the more remote corners of each catchment area.

PU-AMI being the BPHS implementer, this will facilitate the organization of staff training for the following topics:
? HMIS Practical Training;
? Infection Prevention;
? Management of Drug Supplies and rational prescriptions
? Practical immunization training (for nurses only)
Other trainings may be organized depending on needs

Supervision checklists will be used during supervision visits and the findings will be shared

							with the PM and the Emergency Coordinator, for the necessary improvements and follow ups. Data of monthly reports will be crosschecked with health facility registers to ensure the consistency and accuracy of data. Standard treatment guidelines and treatment protocols will be used to provide quality services Activity 1.2.5 : Participation in DEWS and outbreak management and response: Through its MHT PU-AMI will be regularly accessing IDP sites as well as host communities who remain hard to reach and underserved. PU-AMI will participate in the DEWS response ? MHT team can be contacted by previously visited communities if a disease outbreak is suspected. In this case, PU-AMI will inform PPHD about the change of field activity for the day and keep PPHD informed about the status of the outbreak (confirmed or not, number of cases, need for follow up, etc) ? MHT team may also be called upon by the PPHD if they hear of a suspected outbreak. The process will then be the same, MHT team going to the location of suspected outbreak and keeping PPHD informed about the outcome of the visit. Good collaboration with the PPHD DEWS Officer will be essential, and will be maintained through regular coordination meetings. PU-AMI MHT may also join an outbreak response team in case of a larger outbreak. Outbreak reports will systematically be shared with PPHD HMIS officer, PPHD DEWS officer as well as WHO focal point
Kunar -> Dara-e-Pech	10	1,578	1,567	432	408	3,985	Activity 1.1.1 : Screening for MAM and SAM In the seven priority districts considered under this allocation, there are important gaps in coverage for both SAM and MAM. According to Nutrition Cluster data, the best coverage for SAM is in Shygal with a 90% coverage, while it ranges between 16 to 38 % in all other districts. MAM coverage rates go from 13% and 37%: these alarmingly low rates emphasis the relevance of nutrition programs. Nutrition activities are fully and complementary part of the integrated approach of PU-AMI, and will benefit of the quality health services providing for vulnerable population as an entry point for screening of children aged 0-59 months as well as PLW. MAM and SAM screening and detection will be conducted in the five health facilities operated by PU-AMI in the frame of this CHF allocation, in hard to reach areas of Kunar province, i.e • Four sub health centers located in District Dar I Pech, Wardish Tangi village District Ghazadabad, Sooki village District Shygal, Bar Galayee village District Watapur, Dargo village • One mobile health team that will be visiting underserved host communities as well as locations with high concentrations of IDPs and returnees in the seven priority districts of Kunar province. MAM and SAM screening will be done by the midwife in all above mentioned locations, especially when it comes to screening of PLW, which can only be done by a woman for cultural reasons. Depending on workload, she might be assisted by the doctor.

Screening will be done using MUAC as well as checking for oedema and weight for height.
The material for screening will be partly provided by the Nutrition partners (UNICEF and WFP) and complementary items will be purchased by PU-AMI

At the health facility level monitoring of this activity will be conducted by the head of the health facility , He or she will observe daily children screening and the proper filling of screening registration by the midwife/nurse The nutrition officer will also participate in the monitoring by crosschecking the adequate screening and registration procedures.
Activity 1.1.1 : Provide Psychological first aid to conflict affected IDPs and returnees and host communities:

PU-AMI has implemented PFA services in close coordination with WHO and the mental health department of MoPH in Kunar and Nangarhar provinces, progressively scaling up since 2014 and conducting trainings in PFA for other NGOs and service providers'

Significant psychological harm remains one of the dramatically underreported consequences of insecure contexts. The implementation in the past 3 years of PFA services shows how, following decades of protracted conflict, the population is in dire need of psychosocial support. PFA services provided in Kunar through health workers and in Nangarhar through mobile clinics confirm the needs for such services in addition to more traditional primary health care. The MoPH, PU-AMI, and other implementing partners reaffirmed throughout 2016 the need to strengthen and expand PFA services for populations affected by the conflict that are regularly exposed to suffering and violence. Mainstreaming psychological support and improving the inclusion of such activities in the MoPH priorities is a long-term structural undertaking which requires slow but constant steps.

A PFA provider will be operational in each of the five health facilities (four sub health centers and one mobile health team) operated by PUAMI in Kunar province under this allocation. Health is an ideal entry point for the acceptance and therefore provision of PFA services.Since mental health is not a common medical area, well-understood and accepted by the population in Afghanistan, the targeted beneficiary will be informed of the purpose, goals and advantages of the PFA interventions. Community elders and shuras will also be sensitized to the need for mental health services.
The PFA provider will ensure the screenings, counseling, and referrals of traumatized persons to the AADA counselor in the district hospital. This method to ensure mental health services to traumatized persons has proved its value and necessity, notably for people affected by displacement.
S/He will provide initial PFA response with individuals or groups to help them cope with stress symptoms and prevent the development of trauma and related psychological disorders.

Supportive supervision and refresher/follow-up working sessions will be organized regularly by expatriate Psychologist Adviser (with extensive experience in clinical psychology) to develop the quality of the services provided.

Activity 1.1.2 : Provide psychosocial support to conflict affected IDPs, returnees and host communities

For those beneficiaries who have long lasting

trauma and couldn't access PFA in due time (PFA needs to be provided within 1 month after the trauma) as well as for victims of protracted traumas (such as domestic violence), the only current counselor available is in the District Hospital, and therefore inaccessible to the most vulnerable due to the travel cost.

Psychosocial support will help individuals and communities heal psychological wounds and rebuild social structures. Adequate psychosocial support activities will
? Prevent distress and suffering from evolving into something more severe
? Help people cope better and become reconciliated to everyday life
? Help beneficiaries resume a normal life
? Meet community identified needs

PSS activities will be implemented at the SHC and MHT level, and will be implemented according to WHO IADC Guidelines on Mental Health and Psychosocial Support in Emergency Settings
At MHT level, a PSS counselor will provide blanket PSS services to women and girls while the health promoter will engage with males on advocacy/awareness raising about issues.
At the SHC level, both individual and collective sessions will be organized to provide adapted services to the range of needs of patients, with a special focus on needs of women.
Children will participate in group sessions, which will be coordinated by the PSS worker and facilitated through activities encouraging them to express themselves in a creative way, as well as to interact with another.

The prevalence of GBV particularly remains high in Afghanistan, with most GBV cases concealed and driven by socio-cultural beliefs, values and practices. The latest Afghanistan Demographic Health Survey indicates that half (53%) of the ever-married women age 15-49 have experienced physical violence at least once. Though PU-AMI will not actively seek GBV cases, PSS patients will include GBV survivors. PU-AMI teams will be trained on basic PSS, clinical management of rape (CMR) and referral to specialized services. PU-AMI will coordinate with family protection centers (one stop GBV service delivery points in Asadabad provincial, Kama district and Jalalabad regional hospitals, all of which are funded by UNFPA funds and managed by AADA and IMC) as well as with other stakeholders as necessary. UNFPA dignity kits (designed for women and girls) will be provided as part of the GBV response.

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Engagement with the community Shura and Health Shura will continue throughout the project on a regular basis, through monthly meetings (and extra ad hoc meetings depending on needs)

Once the agreement with local representatives for the use of the building is signed, PU-AMI engineer will proceed with leading its renovation. Indeed, the building will have to be adapted to meet the requirements of a health facility, in terms of access (wheelchair or stretcher), layout and hygiene requirements (tiling of the delivery room for example)

Each SHC will be staffed with one doctor, one midwife, two vaccinators (1 male and 1 female) and a cleaner/guard. The female vaccinator will operate within the SHC while the male vaccinator can conduct outreach vaccinations. A majority of the patients will be female (for TT vaccination) who do not accept to be vaccinated by men for cultural reasons, or children in need of OPV, as Kunar is the province which is most affected by polio (4 of the 6 cases recorded in 2016 were

recorded in Kunar province)

PU-AMI will announce the vacancies with ACBAR and locally in Asadabad as well as in the nearest health facilities. Special attention will be given to hiring female staff including midwives and fixed vaccinators if possible, as PU-AMI is already aware this will be challenging. Salaries and other benefits will conform to the MoPH salary scale in order to prepare the staff for a potential integration into the BPHS system at a later date.

As BPHS implementer, PUAMI will collaborate with MoPH to support the integration of the SHC in the BPHS.

Project team will supervise the Health facilities and will ensure that the health facilities are established according the standards for the health services provision. Supervision and monitoring checklists will be used during supervision visits. PU-AMI team will assess the buildings provided by the communities to arrange it according the MoPH standards.
Activity 1.2.2 : One Mobile Health Teams is established and provides mobile services in hard to reach districts

Currently only 3 MHTs are active in all of Kunar province: one is run by ARCS, one has been recently set up by AADA and PU-AMI also has a mobile health clinic as a part of the BPHS activities implemented in Kunar. In a province with a high number of IDPs (over 8700 IDPs according to most recent OCHA data available) and returnees, where displacements are regular due to conflict between various AOGs, this remains insufficient to cover the needs.
PU-AMI will provide an additional MHT under the CHF, to ensure a better coverage of the needs of IDPs, returnees and host populations in hard to reach areas.
The area of operation of the MHT is defined in collaboration with the PPHD, who coordinates the action of the various implementers of health services in the province.

Each MHT will be staffed by 1 Medical Doctor (MD), 1 nurse, 1 vaccinator, 1 midwife and 1 health promoter The doctor will be dedicated to patient consultations, establishing diagnosis, writing prescriptions and treating the occasional emergency case
The vaccinator will be fully dedicated to vaccination (TT and OPV and measles vaccination in case of an outbreak)
The midwife is in charge of ANC and PNC, family planning and attending emergency deliveries in the home of beneficiaries.
The health promoter will be in charge of health education, sensitization, community awareness, and explaining to patients how to properly use drugs. He will conduct health education to the patients based on IEC material approved by MoPH.

All staff will receive a 3 days refresher training on RUD (Rational Usage of Drugs) and 3 days refresher training on HMIS (Health Management Information System) based on lesson learnt of previous CHF experience. Follow up training might be provided as per need.
Waste management will also be part of the refresher training plan to ensure the MHT intervention will have no negative impact on the environment. Cooperation with BPHS health facilities is already in place and medical waste will be brought to the closest health facility for adequate waste management

Regular supervision and monitoring visits will be

carried out to the MHT, applying supervision checklists. Activity plan for MHT will be developed in coordination with PPHD and DoRR to reach IDPs and provide them with essential primary health services
Activity 1.2.3 : Procurement and distribution of essential medical supplies and equipment to five health facilities:

For all previous mentioned health facilities (4 SHC and 1 MHT) PU-AMI considers the MHT as a health facility, as the provided services reflect those of a static health facility, but have the advantage of reaching more remote and disseminated beneficiaries. PU-AMI will use the MoPH standard list of drugs and supplies in order to provision the health facilities with items which would also be provided if the facilities were part of the BPHS. As there is currently no BPHS support or overlap, CHF would provide the financial support for all supplies

Procurement for the health facilities will be arranged by the Project Manager according to consumption rates of comparable health facilities and based on data on the most common diseases in Afghanistan.

In order to ensure the quality of health services, PU-AMI will ensure the health facilities and the MHT are provided with all adequate medical consumables and drugs. This will be done through international procurement of drugs and local purchase for supplies that will follow PU-AMI own and donor's procurement rules for pharmaceuticals respecting Afghanistan Ministry of Health approved medical items.
PU-AMI medical procurement is led by the Health Department, consisting of a health coordinator and a pharmacist at mission level with technical support from HQ Pharmacist and HQ Health Advisor.
Drugs and medical supplies will be stored in the PU-AMI pharmacy in Jalalabad before being dispatched to the Health facilities and MHT. Stock and consumption will be monitored by the pharmacist using software and checked by the health coordinator.

PU-AMI will receive the standard vaccines from the provincial cold chain which is managed by the Provincial EPI Management Team (PEMT). This Provincial EPI Management Team is represented by an EPI Officer of the Directorate of Public Health. They will provide the vaccines requested by PU-AMI for the supported health facilities. PU-AMI will be in charge of the transport from PEMT to the said health facility, ensuring that the cold chain is respected and the vaccines maintained in the appropriate conditions during their transportation.

Though PEMT should also provide RCW50 refrigerators for vaccine vials conservation, so far challenges have been observed in neighboring regions and the unreliable supply of the RCW50 refrigerators have impacted the immunization services in remote and hard to reach areas. Therefore PU-AMI will keep the option of procuring them. Should the RCW50 refrigerators finally be made available by the PEMT, the funds will be used to procure supplementary equipment or drugs for the HF

Pharmacy stock cards and checklists will be used to ensure the adequate distribution and availability of all essential drugs in the health facilities. PU-AMI pharmacy team will regularly analyze pharmacy data and provide feedback to the health staff about the utilization of services and consumption of drugs. During supervision visits, the pharmacy stock will be observed and

supervised for the rational use of drugs.
Activity 1.2.4 : Delivery of essential primary health care, mother and child health care services and immunization in five health facilities (4SHC and 1 MHT)

Services offered will conform to the MoPH standard guidelines and practices in order to maintain a consistent approach throughout the province. Services include a wide range of health services (preventive and curative consultations, including acute, chronic, injuries, health and hygiene promotion and referrals to secondary care facilities;

Amongst the delivery of the primary healthcare package, a specific attention will be given to the most vulnerable beneficiaries. In that regard, huge needs have been confirmed for pregnant and lactating women; PU-AMI Midwives reported that a dedicated service is very much appreciated, also for cultural reasons: without much community networks or protection, women tend to avoid going to health facilities; once PU-AMI midwives share their phone numbers, they regularly receive calls asking for guidance and orientation. As such, MNCH services provision will be ensured by one midwife per HF. This allows women in hard to reach areas to benefit from ANC, PNC, and FP services. Midwives will also ensure the timely referral of full-term pregnant women to deliver in closest HFs or hospital or, if not possible, try to ensure assisted home delivery, as this happened on exceptional cases. To that purpose, midwives will provide consultation and orientation taking into account the availability of services in the HFs and hospitals
Based on total catchment population of the 5 HF (4 SHC and 1 MHT), providing services to a total of 18 600 beneficiaries, and on pregnancy rate data from PU AMI HMIS in Kunar, it is estimated that approximately 4% of the catchment population will be pregnant women.
Though through these services, PU-AMI hopes to serve all pregnant women, the target has been established at 50% of the latter, i.e a total of 372 pregnant individuals.
Based on HMIS data from Kunar, it is estimated that 8% of the individuals consulting for antenatal care visits are under 18 years old and therefore fall under the category of “girls”

All routine immunization including OPV and Tetanus Toxoid vaccinations will be provided to children under one year old and women (pregnant and non pregnant). In addition, medical staff and health promoter will raise awareness on benefits of vaccine, risk of vaccine preventable diseases, awareness on polio virus and its prevention by polio drops. Awareness messages will increase sensitization of communities regarding vaccine preventable disease.
Considering the specificity of Kunar context, PU-AMI aims is repeating successful past experience by adding a vaccinator to each newly opened SHC. One female vaccinator will perform fixed vaccination services in the health facility, motivating mothers to come to the clinic in a way to increase coverage of ANC services as well, while a male vaccinator will provide outreach immunization services in the more remote corners of each catchment area.

PU-AMI being the BPHS implementer, this will facilitate the organization of staff training for the following topics:
? HMIS Practical Training;
? Infection Prevention;
? Management of Drug Supplies and rational prescriptions

							? Practical immunization training (for nurses only) Other trainings may be organized depending on needs Supervision checklists will be used during supervision visits and the findings will be shared with the PM and the Emergency Coordinator, for the necessary improvements and follow ups. Data of monthly reports will be crosschecked with health facility registers to ensure the consistency and accuracy of data. Standard treatment guidelines and treatment protocols will be used to provide quality services Activity 1.2.5 : Participation in DEWS and outbreak management and response: Through its MHT PU-AMI will be regularly accessing IDP sites as well as host communities who remain hard to reach and underserved. PU-AMI will participate in the DEWS response ? MHT team can be contacted by previously visited communities if a disease outbreak is suspected. In this case, PU-AMI will inform PPHD about the change of field activity for the day and keep PPHD informed about the status of the outbreak (confirmed or not, number of cases, need for follow up, etc) ? MHT team may also be called upon by the PPHD if they hear of a suspected outbreak. The process will then be the same, MHT team going to the location of suspected outbreak and keeping PPHD informed about the outcome of the visit. Good collaboration with the PPHD DEWS Officer will be essential, and will be maintained through regular coordination meetings. PU-AMI MHT may also join an outbreak response team in case of a larger outbreak. Outbreak reports will systematically be shared with PPHD HMIS officer, PPHD DEWS officer as well as WHO focal point
Kunar -> Khaskunar	18	322	190	107	90	709	Activity 1.1.1 : Four integrated first aid trauma posts (FATP) are established in conflict affected areas of Kunar Province BPHS and EPHS packages remains unable to respond to emergency situations, such as those frequently witnessed in Kunar as a result of ongoing protracted conflicts. The nature of the conflict is bringing inflow of weapon-related trauma cases requiring sustained emergency life-saving medical support. In Kunar in 2016 alone, according to PU-AMI ECHO database, 25,264 trauma cases of which 2,249 due to conflict, have been reported. First aid trauma posts will be established to increase the capacity of local health facilities to deal with the upsurge of trauma cases due to conflict in their vicinity. Data of 2015, 2016 and first 7 months of 2017 was reviewed to identify the existing health facilities receiving the highest number of trauma cases (conflict induced or not). Following health facilities were chosen for integration of a FATP. ? District Khas Kunar, Khas Kunar CHC ? District Marawara, Marawara BHC ? District Bar Kunar, Asmar CHC ? District Watapur, Quro BHC In accordance with PPHD and Health Cluster Coordinator, decision was made to have FATPs integrated in existing BHC/CHC to leave the possibility of integration in the BPHS once the emergency intervention is over, thus keeping in mind the exit strategy after the emergency intervention. The goals to prevent death and

disability in injured patients can be categorized into three broad sets of needs:
1. Life-threatening injuries are appropriately treated, promptly and in accordance with appropriate priorities, so as to maximize the likelihood of survival.
2. Potentially disabling injuries are treated appropriately, so as to minimize functional impairment and to maximize the return to independence and to participation in community life.
3. Pain and psychological suffering are minimized.

The set-up of these FATPs will be achievable through all different aspects of trauma cares resources that would be necessary to assure such care. These include human resources (staffing and training) and physical resources (infrastructure, equipment and supplies) that should be in place to assure optimal care of the injured patient at the range of health facilities.
In working towards decreasing the burden of death and disability from injury, a spectrum of activities will be considered, ranging from surveillance and basic prevention programs, to trauma management/stabilization and referral.

The drawing of the FATP was done by the PU-AMI engineer based on the constraints linked to each location (availability of terrain, etc) and on recommendations of PPHD and director of the health facility to ensure its acceptance and integration in the functioning of the facility. Essential notions such as access and hygiene standards (ease to clean) were obviously taken into consideration. (Drawings and BOQ attached, respectively in Annexes 06 and 05)

Together, the Engineer with the Project Manager will regularly monitor the construction progress and will ensure that FATPs are established according the calendar and standards.
Activity 1.1.2 : Procurement and distribution of essential medical supplies and equipment to four FATPs

For all facilities treating emergency trauma cases, equipment will be provided by PU-AMI, following ICRC standards. (BOQ attached in Annex 07)
In order to ensure the quality of trauma cares services, PU-AMI will ensure the FATPs are provided with all adequate medical equipment, consumables and drugs. This will be done through international procurement of drugs and local purchase for supplies that will follow PU-AMI own and donor's procurement rules for pharmaceuticals respecting Afghanistan Ministry of Health approved medical items.
PU-AMI medical procurement is led by the Health Department, consisting of a health coordinator and a pharmacist at mission level with technical support from HQ Pharmacist and HQ Health Advisor.
Drugs and medical supplies will be stored in the PU-AMI pharmacy in Jalalabad before being dispatched to the FATPs. Stock and consumption will be monitored by the pharmacist using software and checked by the health coordinator.

PU-AMI pharmacy department will monitor the process of procurement and distribution of essential medical supplies and equipments using PU-AMI and ICRC standards. Stock cards, pharmacy checklists, receive notes will be used to monitor the adequate amount of supplies to FATPs.
Activity 1.1.3 : Provision of essential trauma care services

Emergency trauma kits (including medical

							equipment, drugs and consumables, BOQ attached, Annex 07) will be delivered to those four health facilities. Both doctors and nurses are obviously important for a smooth running of the FATP. One provides assessment and diagnosis while the other offers aid, physical and psychological treatment. In short, they are both complementary factors to what makes the FATP operate efficiently. The most important function of the doctor will be to identify and treat life-threatening conditions and then to assess the patient carefully for other complaints or findings that may require referral. The nurse will be in charge of providing first essential trauma care to patients. Since the FATPs are attached to an existing health facility, the doctor of the adjacent health facility (CHC or BHC) will also be operational in the FATP. Under CHF funding, PU-AMI will provide an additional nurse which will be dedicated full time to the FATP. The nurses will receive refresher training on Basic Life Saving. The minimum package of First Aid Care/ trauma care at the FATP comprises early detection, initial medical care for severe injury or sudden illness using a certain amount of drugs and equipment to perform primary intervention and assessment to fulfill the basic principles of trauma care, which are to preserve life, to prevent further harm and to keep the patient condition's stable. This may include applying first aid techniques, airway and/or shock management, fluid resuscitation, caring burns, injury and wounds management, stabilization and promote recovery including dispensing of medication. Strict protocols will be applied, according to national guidelines to always reach the highest quality of services. Patient records will be kept through a registration system (administrative registration and medical details taken by the doctor respecting confidential management of sensitive data). Diagnostic and treatment protocols will be based on MoPH national guidelines. Establishment of a referral system to secondary health facility level: The teams will be in continuous coordination with surrounding Hospital in case of referral needed. The referral will be done through an ambulance. Security allowing, monthly supervision visits will be carried out by CHF programject manager to monitor the delivery of essential trauma care services. Supervision checklists will be used during supervision visits. Trauma registers will be checked for verifying the delivery of trauma services. Monthly reporting formats will be developed for each site to report their monthly achievement and will be stored in trauma database.
Kunar -> Barkunar	16	129	142	67	59	397	Activity 1.1.1 : Four integrated first aid trauma posts (FATP) are established in conflict affected areas of Kunar Province BPHS and EPHS packages remains unable to respond to emergency situations, such as those frequently witnessed in Kunar as a result of ongoing protracted conflicts. The nature of the conflict is bringing inflow of weapon-related trauma cases requiring sustained emergency life-saving medical support. In Kunar in 2016 alone, according to PU-AMI ECHO database, 25,264 trauma cases of which 2,249 due to conflict, have been reported. First aid trauma posts will be established to increase the capacity of local health facilities to deal with the upsurge of trauma cases due to

conflict in their vicinity.
Data of 2015, 2016 and first 7 months of 2017 was reviewed to identify the existing health facilities receiving the highest number of trauma cases (conflict induced or not). Following health facilities were chosen for integration of a FATP.
? District Khas Kunar, Khas Kunar CHC
? District Marawara, Marawara BHC
? District Bar Kunar, Asmar CHC
? District Watapur, Quro BHC

In accordance with PPHD and Health Cluster Coordinator, decision was made to have FATPs integrated in existing BHC/CHC to leave the possibility of integration in the BPHS once the emergency intervention is over, thus keeping in mind the exit strategy after the emergency intervention. The goals to prevent death and disability in injured patients can be categorized into three broad sets of needs:
1. Life-threatening injuries are appropriately treated, promptly and in accordance with appropriate priorities, so as to maximize the likelihood of survival.
2. Potentially disabling injuries are treated appropriately, so as to minimize functional impairment and to maximize the return to independence and to participation in community life.
3. Pain and psychological suffering are minimized.

The set-up of these FATPs will be achievable through all different aspects of trauma cares resources that would be necessary to assure such care. These include human resources (staffing and training) and physical resources (infrastructure, equipment and supplies) that should be in place to assure optimal care of the injured patient at the range of health facilities.
In working towards decreasing the burden of death and disability from injury, a spectrum of activities will be considered, ranging from surveillance and basic prevention programs, to trauma management/stabilization and referral.

The drawing of the FATP was done by the PU-AMI engineer based on the constraints linked to each location (availability of terrain, etc) and on recommendations of PPHD and director of the health facility to ensure its acceptance and integration in the functioning of the facility. Essential notions such as access and hygiene standards (ease to clean) were obviously taken into consideration. (Drawings and BOQ attached, respectively in Annexes 06 and 05)

Together, the Engineer with the Project Manager will regularly monitor the construction progress and will ensure that FATPs are established according the calendar and standards.
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PU-AMI medical procurement is led by the Health Department, consisting of a health coordinator and a pharmacist at mission level with technical support from HQ Pharmacist and HQ Health Advisor.

							Drugs and medical supplies will be stored in the PU-AMI pharmacy in Jalalabad before being dispatched to the FATPs. Stock and consumption will be monitored by the pharmacist using software and checked by the health coordinator. PU-AMI pharmacy department will monitor the process of procurement and distribution of essential medical supplies and equipments using PU-AMI and ICRC standards. Stock cards, pharmacy checklists, receive notes will be used to monitor the adequate amount of supplies to FATPs. Activity 1.1.3 : Provision of essential trauma care services Emergency trauma kits (including medical equipment, drugs and consumables, BOQ attached, Annex 07) will be delivered to those four health facilities. Both doctors and nurses are obviously important for a smooth running of the FATP. One provides assessment and diagnosis while the other offers aid, physical and psychological treatment. In short, they are both complementary factors to what makes the FATP operate efficiently. The most important function of the doctor will be to identify and treat life-threatening conditions and then to assess the patient carefully for other complaints or findings that may require referral. The nurse will be in charge of providing first essential trauma care to patients. Since the FATPs are attached to an existing health facility, the doctor of the adjacent health facility (CHC or BHC) will also be operational in the FATP. Under CHF funding, PU-AMI will provide an additional nurse which will be dedicated full time to the FATP. The nurses will receive refresher training on Basic Life Saving. The minimum package of First Aid Care/ trauma care at the FATP comprises early detection, initial medical care for severe injury or sudden illness using a certain amount of drugs and equipment to perform primary intervention and assessment to fulfill the basic principles of trauma care, which are to preserve life, to prevent further harm and to keep the patient condition’s stable. This may include applying first aid techniques, airway and/or shock management, fluid resuscitation, caring burns, injury and wounds management, stabilization and promote recovery including dispensing of medication. Strict protocols will be applied, according to national guidelines to always reach the highest quality of services. Patient records will be kept through a registration system (administrative registration and medical details taken by the doctor respecting confidential management of sensitive data). Diagnostic and treatment protocols will be based on MoPH national guidelines. Establishment of a referral system to secondary health facility level: The teams will be in continuous coordination with surrounding Hospital in case of referral needed. The referral will be done through an ambulance. Security allowing, monthly supervision visits will be carried out by CHF programject manager to monitor the delivery of essential trauma care services. Supervision checklists will be used during supervision visits. Trauma registers will be checked for verifying the delivery of trauma services. Monthly reporting formats will be developed for each site to report their monthly achievement and will be stored in trauma database.

Kunar -> Ghaziabad	10	1,496	1,489	411	389	3,785	Activity 1.1.1 : Screening for MAM and SAM In the seven priority districts considered under this allocation, there are important gaps in coverage for both SAM and MAM. According to Nutrition Cluster data, the best coverage for SAM is in Shygal with a 90% coverage, while it ranges between 16 to 38 % in all other districts. MAM coverage rates go from 13% and 37%: these alarmingly low rates emphasis the relevance of nutrition programs. Nutrition activities are fully and complementary part of the integrated approach of PU-AMI, and will benefit of the quality health services providing for vulnerable population as an entry point for screening of children aged 0-59 months as well as PLW. MAM and SAM screening and detection will be conducted in the five health facilities operated by PU-AMI in the frame of this CHF allocation, in hard to reach areas of Kunar province, i.e • Four sub health centers located in District Dar I Pech, Wardish Tangi village District Ghazadabad, Sooki village District Shygal, Bar Galayee village District Watapur, Dargo village • One mobile health team that will be visiting underserved host communities as well as locations with high concentrations of IDPs and returnees in the seven priority districts of Kunar province. MAM and SAM screening will be done by the midwife in all above mentioned locations, especially when it comes to screening of PLW, which can only be done by a woman for cultural reasons. Depending on workload, she might be assisted by the doctor. Screening will be done using MUAC as well as checking for oedema and weight for height. The material for screening will be partly provided by the Nutrition partners (UNICEF and WFP) and complementary items will be purchased by PU-AMI At the health facility level monitoring of this activity will be conducted by the head of the health facility , He or she will observe daily children screening and the proper filling of screening registration by the midwife/nurse The nutrition officer will also participate in the monitoring by crosschecking the adequate screening and registration procedures. Activity 1.1.1 : Provide Psychological first aid to conflict affected IDPs and returnees and host communities: PU-AMI has implemented PFA services in close coordination with WHO and the mental health department of MoPH in Kunar and Nangarhar provinces, progressively scaling up since 2014 and conducting trainings in PFA for other NGOs and service providers' Significant psychological harm remains one of the dramatically underreported consequences of insecure contexts. The implementation in the past 3 years of PFA services shows how, following decades of protracted conflict, the population is in dire need of psychosocial support. PFA services provided in Kunar through health workers and in Nangarhar through mobile clinics confirm the needs for such services in addition to more traditional primary health care. The MoPH, PU-AMI, and other implementing partners reaffirmed throughout 2016 the need to strengthen and expand PFA services for populations affected by the conflict that are regularly exposed to suffering and violence.

Mainstreaming psychological support and improving the inclusion of such activities in the MoPH priorities is a long-term structural undertaking which requires slow but constant steps.

A PFA provider will be operational in each of the five health facilities (four sub health centers and one mobile health team) operated by PUAMI in Kunar province under this allocation. Health is an ideal entry point for the acceptance and therefore provision of PFA services.Since mental health is not a common medical area, well-understood and accepted by the population in Afghanistan, the targeted beneficiary will be informed of the purpose, goals and advantages of the PFA interventions. Community elders and shuras will also be sensitized to the need for mental health services.
The PFA provider will ensure the screenings, counseling, and referrals of traumatized persons to the AADA counselor in the district hospital. This method to ensure mental health services to traumatized persons has proved its value and necessity, notably for people affected by displacement.
S/He will provide initial PFA response with individuals or groups to help them cope with stress symptoms and prevent the development of trauma and related psychological disorders.

Supportive supervision and refresher/follow-up working sessions will be organized regularly by expatriate Psychologist Adviser (with extensive experience in clinical psychology) to develop the quality of the services provided.

Activity 1.1.2 : Provide psychosocial support to conflict affected IDPs, returnees and host communities

For those beneficiaries who have long lasting trauma and couldn't access PFA in due time (PFA needs to be provided within 1 month after the trauma) as well as for victims of protracted traumas (such as domestic violence), the only current counselor available is in the District Hospital, and therefore inaccessible to the most vulnerable due to the travel cost.

Psychosocial support will help individuals and communities heal psychological wounds and rebuild social structures. Adequate psychosocial support activities will
? Prevent distress and suffering from evolving into something more severe
? Help people cope better and become reconciliated to everyday life
? Help beneficiaries resume a normal life
? Meet community identified needs

PSS activities will be implemented at the SHC and MHT level, and will be implemented according to WHO IADC Guidelines on Mental Health and Psychosocial Support in Emergency Settings
At MHT level, a PSS counselor will provide blanket PSS services to women and girls while the health promoter will engage with males on advocacy/awareness raising about issues.
At the SHC level, both individual and collective sessions will be organized to provide adapted services to the range of needs of patients, with a special focus on needs of women.
Children will participate in group sessions, which will be coordinated by the PSS worker and facilitated through activities encouraging them to express themselves in a creative way, as well as to interact with another.

The prevalence of GBV particularly remains high in Afghanistan, with most GBV cases concealed and driven by socio-cultural beliefs, values and

practices. The latest Afghanistan Demographic Health Survey indicates that half (53%) of the ever-married women age 15-49 have experienced physical violence at least once. Though PU-AMI will not actively seek GBV cases, PSS patients will include GBV survivors. PU-AMI teams will be trained on basic PSS, clinical management of rape (CMR) and referral to specialized services. PU-AMI will coordinate with family protection centers (one stop GBV service delivery points in Asadabad provincial, Kama district and Jalalabad regional hospitals, all of which are funded by UNFPA funds and managed by AADA and IMC) as well as with other stakeholders as necessary. UNFPA dignity kits (designed for women and girls) will be provided as part of the GBV response.

From previous projects in Kunar province, PU-AMI has recorded that most of the people seeking protection services are adults (91%) , with many more men (59%) than women (32%) seeking these services.
While the focus so far was on PFA, through the introduction of PSS, PU-AMI intends to increase the catchment of women and children. With the lack of experience and data on group sessions of PSS, the targets have been set at 50% for each gender.

Furthermore, to promote PFA and PSS activities , training on PFA and PSS will be provided to Protection Cluster partners to strengthen the overall protection response throughout the country.

Identity of beneficiaries will remain confidential, through the use of a coding system.

Activity 1.1.2 : SAM and MAM case management

Children with SAM without complications will be admitted in the OPD SAM Program and will be provided with Ready-to-Use Therapeutic Food (RUTF), that will be provided by UNICEF. According to the estimated caseload, PU-AMI expects to need 858 boxes (or 128,700 sachets) of RUTF.
Children with MAM will be admitted in the OPD MAM program and will be provided with Ready-to-Use Supplementary Food (RUSF), provided by WFP. Estimated caseload brings the need to 231,660 sachets.
Cases of SAM with medical complications can’t be treated within the SHC or MHTs, as they require a comprehensive treatment that can only be provided through appropriate structures in IPD. They will therefore be referred to the nearest stabilization center in Kunar province. PU-AMI teams will follow up on the referral with the IPD SAM.

Based on PU-AMI 2016 nutrition database for Kunar, the admission rates are about 43% for boys and 57% for girls, beneficiaries have therefore been calculated accordingly.
The PLWs detected with acute malnutrition will all receive SuperCereals as well as multiple micronutrients, with estimated needs mounting up to 12,870 kg of supercereal and 478,764 tablets of micronutrients.
The treatment provided will be based on the national IMAM protocol, and includes the provision of systematic medical treatment and nutritional support. RUTF and RUSF is expected to be provided by WFP and UNICEF depending on the cases and needs of the patients., but PU-AMI will also constitute a buffer stock to cope with possible supply breakdown (Estimated Supplementary Feeding requirements are detailed in Annex 12)
The quantities required have been estimated based on caseloads in similar structures

currently managed by PU-AMI, however the above mentioned figures might vary over the course of the project implementation. PU-AMI will regularly coordinate with both WFP and UNICEF to keep both organizations informed about the actual consumption and forecasted needs.

A food distributor will distribute the necessary supplementary feeding rations according to IMAM protocol.

Part of the follow up will be conducted by community mobilizers, who will actively search for the absent or defaulter cases in order to find out about the causes and solve it as possible to get them back to the programs and follow ups. The aim will be to decrease the number of default cases.

The Community mobilizers will be trained on screening, defaulter tracing, and referral for malnutrition at community level and nutrition education. They will be supervised by the doctor. Overall technical supervision of the nutrition activities, and ensuring IMAM protocol is respected will be done by the Nutrition Program Manager and the Health Coordinator

At the health facility level, monitoring of this activity will be conducted by the head of the health facility. He or she will observe daily admission of children in the program and also proper filling of OPD SAM/MAM cards and registration by the nutrition nurse. The nutrition officer will crosscheck the cards and registrations and will also randomly verify SAM and MAM cases accordingly to IMAM guidelines. Based on PU-AMI experience, verification committees will be established for verification of acutely malnourished PLWs to avoid miss use of food rations

Activity 1.1.3 : IYCF promotion and counseling

IYCF promotion will be used for prevention of malnutrition as well as part of the recovery process.
This key strategy represents an opportunity to increase awareness by providing relevant information to communities with healthcare access difficulties, and making a final impact on the wellbeing of the infant, young child, and also among the female population.
The dissemination of key nutrition messages will be the responsibility of the whole team, i.e. doctor, midwife, community mobilizer and food distributor.
Information sessions will be supported by IEC material.

PU-AMI will set up a range of IYCF prevention of malnutrition awareness sessions and training including:
? Increase knowledge and sensitize care givers and community members on health and nutrition (IYCF) key messages, through IYCF training to female nurses, midwives, doctors and health promoters
? Deliver IYCF certified training and nutrition education messages through group discussions, sensitization campaigns for key community members and opinion leaders, specially the one that are located far away
? Use already existing relevant and adapted IYCF IEC/BCC materials through participatory methods with the communities
? Pre-test and post-test will be applied in a didactic practical way, as evidence of participation, and acquired and applied knowledge among the community participants
? The midwives will conduct counseling during the PNC visit and also regular education on early initiation of breast feeding, exclusive breast

feeding, and complementary feeding. They will also conduct breast feeding counseling to lactating women who has breast feeding problems
? Ensure better surveillance among communities and health workers to respond to cases of acute malnutrition
? Periodic report of IYCF activities. At HFs level there will be registrations and monthly reports which will be collected by the supervisor and entered into the nutrition data base, for the respective analysis at the provincial and central level and final submission to the PND and the Nutrition Cluster.

Monitoring of this activity will be conducted by the head of the health facility , He or she will observe daily education sessions and breast feeding counseling performed by the nurse or midwife. The Nutrition Officer will crosscheck the HF's IYCF report with nutrition data base
Activity 1.1.4 : Capacity building of Health and Nutrition staff

The program will enhance capacity of Health and Nutrition staff in diagnosis and management of SAM and MAM affected children and PLW through trainings, workshops and regular coaching to improve knowledge and skills in order to improve nutrition services delivery to the beneficiaries and promote project sustainability. PU-AMI aims to:
? Train medical staffs on IMAM that will be involved in managing moderate and severe acute malnutrition (m/f)
? Participate in the trainings conducted by other stakeholders to carry out community based nutrition screening (MUAC and oedema detection) and referral of malnourished children, defaulter tracing, conduction of nutrition and health education in the intervention areas (m/f)
? Ensure effective reporting and information sharing with other partners at the governorate and national levels including MoH, Nutrition Cluster in a timely manner
? Ensure better data collection mechanisms at OTPs and SFP sites
? Participate actively in Nutrition Cluster and sector coordination meetings both at National and province level to discuss nutrition and health related activities to improve outcomes in targeted districts

The following subjects will be included in the trainings:
? Breastfeeding counseling, highlighting the importance of breastfeeding, common difficulties and related recommendations
? Education about recommendations of nutrition during pregnancy and breastfeeding periods
? Hygienic preparation of food
? Complementary feeding

Regular monitoring of the activities by the Programject Manager and the Nutrition Officer could reveal need for additional training: on the job training may be provided on the spot. Should the identified need be broader, a formal training session might also be organized. The output of the training will be monitored by pre and post tests.
Activity 1.2.1 : Four sub health centers are established in hard to reach districts of Kunar Province

4 locations in need of a sub health center have been identified with the support of PPHD and based on data on populations and current white areas
District Dar I Pech, Wardish Tangi village
District Ghazadabad, Sooki village
District Shygal, Bar Galayee village
District Watapur, Dargo village

All locations are more than 2 hours walk from the closest health facility

In each village, PU-AMI teams will reach out to local representatives, community elders and shuras, will present and explain the project and thus will ask that a building should be lent to PU-AMI for the duration of the project in each of the four locations. PU-AMI teams will ensure that communities understand the reasons behind the opening of the health facility as well as the scope and limitation of the funding, including the project end date. The communities will be consulted regarding the recruitment of staff to gain their support, though PU-AMI will always seek the best qualified and experienced persons for the role.
Engagement with the community Shura and Health Shura will continue throughout the project on a regular basis, through monthly meetings (and extra ad hoc meetings depending on needs)

Once the agreement with local representatives for the use of the building is signed, PU-AMI engineer will proceed with leading its renovation. Indeed, the building will have to be adapted to meet the requirements of a health facility, in terms of access (wheelchair or stretcher), layout and hygiene requirements (tiling of the delivery room for example)

Each SHC will be staffed with one doctor, one midwife, two vaccinators (1 male and 1 female) and a cleaner/guard. The female vaccinator will operate within the SHC while the male vaccinator can conduct outreach vaccinations. A majority of the patients will be female (for TT vaccination) who do not accept to be vaccinated by men for cultural reasons, or children in need of OPV, as Kunar is the province which is most affected by polio (4 of the 6 cases recorded in 2016 were recorded in Kunar province)

PU-AMI will announce the vacancies with ACBAR and locally in Asadabad as well as in the nearest health facilities. Special attention will be given to hiring female staff including midwives and fixed vaccinators if possible, as PU-AMI is already aware this will be challenging. Salaries and other benefits will conform to the MoPH salary scale in order to prepare the staff for a potential integration into the BPHS system at a later date.

As BPHS implementer, PUAMI will collaborate with MoPH to support the integration of the SHC in the BPHS.

Project team will supervise the Health facilities and will ensure that the health facilities are established according the standards for the health services provision. Supervision and monitoring checklists will be used during supervision visits. PU-AMI team will assess the buildings provided by the communities to arrange it according the MoPH standards.
Activity 1.2.2 : One Mobile Health Teams is established and provides mobile services in hard to reach districts

Currently only 3 MHTs are active in all of Kunar province: one is run by ARCS, one has been recently set up by AADA and PU-AMI also has a mobile health clinic as a part of the BPHS activities implemented in Kunar. In a province with a high number of IDPs (over 8700 IDPs according to most recent OCHA data available) and returnees, where displacements are regular due to conflict between various AOGs, this remains insufficient to cover the needs.
PU-AMI will provide an additional MHT under the

CHF, to ensure a better coverage of the needs of IDPs, returnees and host populations in hard to reach areas.
The area of operation of the MHT is defined in collaboration with the PPHD, who coordinates the action of the various implementers of health services in the province.

Each MHT will be staffed by 1 Medical Doctor (MD), 1 nurse, 1 vaccinator, 1 midwife and 1 health promoter The doctor will be dedicated to patient consultations, establishing diagnosis, writing prescriptions and treating the occasional emergency case
The vaccinator will be fully dedicated to vaccination (TT and OPV and measles vaccination in case of an outbreak)
The midwife is in charge of ANC and PNC, family planning and attending emergency deliveries in the home of beneficiaries.
The health promoter will be in charge of health education, sensitization, community awareness, and explaining to patients how to properly use drugs. He will conduct health education to the patients based on IEC material approved by MoPH.

All staff will receive a 3 days refresher training on RUD (Rational Usage of Drugs) and 3 days refresher training on HMIS (Health Management Information System) based on lesson learnt of previous CHF experience. Follow up training might be provided as per need.
Waste management will also be part of the refresher training plan to ensure the MHT intervention will have no negative impact on the environment. Cooperation with BPHS health facilities is already in place and medical waste will be brought to the closest health facility for adequate waste management

Regular supervision and monitoring visits will be carried out to the MHT, applying supervision checklists. Activity plan for MHT will be developed in coordination with PPHD and DoRR to reach IDPs and provide them with essential primary health services
Activity 1.2.3 : Procurement and distribution of essential medical supplies and equipment to five health facilities:

For all previous mentioned health facilities (4 SHC and 1 MHT) PU-AMI considers the MHT as a health facility, as the provided services reflect those of a static health facility, but have the advantage of reaching more remote and disseminated beneficiaries. PU-AMI will use the MoPH standard list of drugs and supplies in order to provision the health facilities with items which would also be provided if the facilities were part of the BPHS. As there is currently no BPHS support or overlap, CHF would provide the financial support for all supplies

Procurement for the health facilities will be arranged by the Project Manager according to consumption rates of comparable health facilities and based on data on the most common diseases in Afghanistan.

In order to ensure the quality of health services, PU-AMI will ensure the health facilities and the MHT are provided with all adequate medical consumables and drugs. This will be done through international procurement of drugs and local purchase for supplies that will follow PU-AMI own and donor's procurement rules for pharmaceuticals respecting Afghanistan Ministry of Health approved medical items.
PU-AMI medical procurement is led by the Health Department, consisting of a health coordinator and a pharmacist at mission level with technical support from HQ Pharmacist and

HQ Health Advisor.
Drugs and medical supplies will be stored in the PU-AMI pharmacy in Jalalabad before being dispatched to the Health facilities and MHT. Stock and consumption will be monitored by the pharmacist using software and checked by the health coordinator.

PU-AMI will receive the standard vaccines from the provincial cold chain which is managed by the Provincial EPI Management Team (PEMT). This Provincial EPI Management Team is represented by an EPI Officer of the Directorate of Public Health. They will provide the vaccines requested by PU-AMI for the supported health facilities. PU-AMI will be in charge of the transport from PEMT to the said health facility, ensuring that the cold chain is respected and the vaccines maintained in the appropriate conditions during their transportation.

Though PEMT should also provide RCW50 refrigerators for vaccine vials conservation, so far challenges have been observed in neighboring regions and the unreliable supply of the RCW50 refrigerators have impacted the immunization services in remote and hard to reach areas. Therefore PU-AMI will keep the option of procuring them. Should the RCW50 refrigerators finally be made available by the PEMT, the funds will be used to procure supplementary equipment or drugs for the HF

Pharmacy stock cards and checklists will be used to ensure the adequate distribution and availability of all essential drugs in the health facilities. PU-AMI pharmacy team will regularly analyze pharmacy data and provide feedback to the health staff about the utilization of services and consumption of drugs. During supervision visits, the pharmacy stock will be observed and supervised for the rational use of drugs.
Activity 1.2.4 : Delivery of essential primary health care, mother and child health care services and immunization in five health facilities (4SHC and 1 MHT)

Services offered will conform to the MoPH standard guidelines and practices in order to maintain a consistent approach throughout the province. Services include a wide range of health services (preventive and curative consultations, including acute, chronic, injuries, health and hygiene promotion and referrals to secondary care facilities;

Amongst the delivery of the primary healthcare package, a specific attention will be given to the most vulnerable beneficiaries. In that regard, huge needs have been confirmed for pregnant and lactating women; PU-AMI Midwives reported that a dedicated service is very much appreciated, also for cultural reasons: without much community networks or protection, women tend to avoid going to health facilities; once PU-AMI midwives share their phone numbers, they regularly receive calls asking for guidance and orientation. As such, MNCH services provision will be ensured by one midwife per HF. This allows women in hard to reach areas to benefit from ANC, PNC, and FP services. Midwives will also ensure the timely referral of full-term pregnant women to deliver in closest HFs or hospital or, if not possible, try to ensure assisted home delivery, as this happened on exceptional cases. To that purpose, midwives will provide consultation and orientation taking into account the availability of services in the HFs and hospitals
Based on total catchment population of the 5 HF (4 SHC and 1 MHT), providing services to a total of 18 600 beneficiaries, and on pregnancy rate

data from PU AMI HMIS in Kunar, it is estimated that approximately 4% of the catchment population will be pregnant women.
Though through these services, PU-AMI hopes to serve all pregnant women, the target has been established at 50% of the latter, i.e a total of 372 pregnant individuals.
Based on HMIS data from Kunar, it is estimated that 8% of the individuals consulting for antenatal care visits are under 18 years old and therefore fall under the category of “girls”

All routine immunization including OPV and Tetanus Toxoid vaccinations will be provided to children under one year old and women (pregnant and non pregnant). In addition, medical staff and health promoter will raise awareness on benefits of vaccine, risk of vaccine preventable diseases, awareness on polio virus and its prevention by polio drops. Awareness messages will increase sensitization of communities regarding vaccine preventable disease.
Considering the specificity of Kunar context, PU-AMI aims is repeating successful past experience by adding a vaccinator to each newly opened SHC. One female vaccinator will perform fixed vaccination services in the health facility, motivating mothers to come to the clinic in a way to increase coverage of ANC services as well, while a male vaccinator will provide outreach immunization services in the more remote corners of each catchment area.

PU-AMI being the BPHS implementer, this will facilitate the organization of staff training for the following topics:
? HMIS Practical Training;
? Infection Prevention;
? Management of Drug Supplies and rational prescriptions
? Practical immunization training (for nurses only)
Other trainings may be organized depending on needs

Supervision checklists will be used during supervision visits and the findings will be shared with the PM and the Emergency Coordinator, for the necessary improvements and follow ups. Data of monthly reports will be crosschecked with health facility registers to ensure the consistency and accuracy of data. Standard treatment guidelines and treatment protocols will be used to provide quality services

Activity 1.2.5 : Participation in DEWS and outbreak management and response:

Through its MHT PU-AMI will be regularly accessing IDP sites as well as host communities who remain hard to reach and underserved.
PU-AMI will participate in the DEWS response
? MHT team can be contacted by previously visited communities if a disease outbreak is suspected. In this case, PU-AMI will inform PPHD about the change of field activity for the day and keep PPHD informed about the status of the outbreak (confirmed or not, number of cases, need for follow up, etc)
? MHT team may also be called upon by the PPHD if they hear of a suspected outbreak. The process will then be the same, MHT team going to the location of suspected outbreak and keeping PPHD informed about the outcome of the visit.

Good collaboration with the PPHD DEWS Officer will be essential, and will be maintained through regular coordination meetings.

PU-AMI MHT may also join an outbreak response team in case of a larger outbreak.

							Outbreak reports will systematically be shared with PPHD HMIS officer, PPHD DEWS officer as well as WHO focal point

Documents

Category Name	Document Description
Project Supporting Documents	Annex 01 - Reference Map_Kunar province.pdf
Project Supporting Documents	Annex 02 - Risk Analysis.pdf
Project Supporting Documents	Annex 03 - CHF Humanitarin Access Contengency Plan.pdf
Project Supporting Documents	Annex 04 - Beneficiary calculations.xlsx
Project Supporting Documents	Annex 06 - Health FATP Drawings.pdf
Project Supporting Documents	Annex 13 - Nutrition Supp Feeding needs.xlsx
Project Supporting Documents	Annex 16 - Cluster Endorsement Health.pdf
Project Supporting Documents	Annex 17 - Cluster Endorsement Nut.pdf
Project Supporting Documents	Annex 18 - Cluster Endorsement Prot.pdf
Project Supporting Documents	Annex 19 - Need Assessment.pdf
Project Supporting Documents	Annex 20 - BOQs - REVISED.xlsx
Grant Agreement	PU-AMI - 6860 - GA - Signed by HC.pdf