Requesting Organization :	INTERSOS
Allocation Type :	2017 2nd Standard Allocation

Primary Cluster	Sub Cluster	Percentage
HEALTH		60.00
PROTECTION	Gender Based Violence	30.00
WATER, SANITATION AND HYGIENE		10.00
		100

Project Title :	Multi-sector integrated emergency response in 4 hard to reach, conflict-affected districts in Kandahar province
Allocation Type Category :	Core activities

OPS Details

Project Code :		**Fund Project Code :**	AFG-17/3481/SA2/H-APC-WASH/INGO/6777
Cluster :		**Project Budget in US$:**	689,268.53
Planned project duration :	9 months	**Priority:**	
Planned Start Date :	20/10/2017	**Planned End Date :**	19/07/2018
Actual Start Date:	20/10/2017	**Actual End Date:**	19/07/2018

Project Summary :

Protracted humanitarian crisis and conflict; displacement; failure in governance and a deep social-economic crisis have a devastating impact on the Afghan population, in particular for the most vulnerable population groups and those caught-up in the active conflict-zones. Southern region, in particular Kandahar Province, is one of the critical areas affected and INTERSOS aims to provide multi-sectoral emergency response program in some of the hard to reach and underserved districts in Kandahar, Arghistan, Maywand, Khakrez and Shah Wali Kot.

INTERSOS opts for a complementary, integrated and comprehensive response strategy combining support for emergency health services provided by the BPHS service provider BARAN in their static centers (health facilities – HF), strengthening trauma care and by complementing the services of the HFs by running mobile outreach teams to bridge the gaps between the communities located in white remote areas (active conflict or AoG-controlled) and the health facilities that are (almost all) located in the government controlled areas, focusing on RH services, supporting the work of CHWs, enhancing community mobilization and awareness for health-WASH. The integrated Health Package will focus on Trauma Care and Reproductive Health (ANC, deliveries, PNC and family planning), complemented by health education and hygiene promotion. INTERSOS will have case managers and social workers linked to the mobile health teams that will be providing PSFA & PSS to identified protection cases (GBV, PwSN) in need of case management services and conduct collective PSS sessions for most vulnerable groups, in addition to protection awareness which could contribute to enhanced protection and actual prevention from protection issues. The use of mobile teams will allow for high flexibility to redirect life-saving services to those communities most in need, mainly in white areas of selected districts, ensuring coverage and provision of health services enabling families who would otherwise not be able to access treatment - either because of the prohibitive costs of travel or insecurity - to get their children the life-saving assistance they need.

The project's general objective is to contribute to the reduction of maternal, child and trauma related morbidity and mortality associated with diseases and hazards resulting from deficient (or non-existing) health services, poor environmental health conditions and lack of protective environment in conflict-affected communities. This intervention is part of an integrated multi-sectorial humanitarian response plan for Kandahar Province to be implemented by INTERSOS in 2017/2018 in order to address the dire basic needs of and provide essential services for (documented and undocumented) Afghani Returnees (Pakistan) and IDPs, in addition to Afghani conflict affected (host) communities. As result from the Multi-sector Assessment conducted by INTERSOS in 15 districts of the province, identified needs are already being addressed by INTERSOS in Kandahar town (IDPs high concentration areas), Maywand, Zheray and Spin Boldak districts through a multi-donor and multi-sectoral program funded by USAID/OFDA, UNHCR and UNICEF in health, nutrition, WASH, livelihood protection and EiE sectors. With the present intervention similar emergency response package will be extended to Arghistan, Khakrez and Shah Wali Kot districts.

The program will target 42.798 individuals > 29% men, 53% women, 9% boy and 9% girls > 24% IDP, 8% returnees (DR and UR) and 68% most vulnerable local (host) community (HC).

Direct beneficiaries :

Men	Women	Boys	Girls	Total

13,464	24,606	4,178	4,178	46,426

Other Beneficiaries :

Beneficiary name	Men	Women	Boys	Girls	Total
Refugees	0	0	0	0	0
Internally Displaced People	3,231	5,906	1,003	1,003	11,143
Host Communities	9,155	16,731	2,841	2,841	31,568
Other	1,077	1,969	334	334	3,714

Indirect Beneficiaries :

The family members of the direct beneficiaries of the present intervention are to be considered indirect beneficiaries of the present intervention. Considering that the average composition of an Afghani family is nearly 7 (6.9 in Kandahar) members and per INTERSOS' MSA 27.5% of population are CU5 and 6% are PLW, the approximate number of indirect beneficiaries will be 291.697 people (about 59% of the population in the targeted districts).

(Please note that the “family” does NOT equal the “household” as more families may share in rural Kandahar the same roof and the same kitchen pot).

Catchment Population:

According to the World Bank’s Afghanistan National Solidarity Program Database (which is the most updated available demographic database for the area: November 2016), the total population of the 4 districts amounts at 510.264 persons or 77.605 families in 532 villages. INTERSOS in its recent assessment registered in the whole Kandahar province a perceived sufficient accessibility to Health Services of 24%. Therefore, it is assumed a prudential 30% catchment i.e. 153.079 people; geographic catchment minimal estimation at 160 villages.

Link with allocation strategy :

The proposed intervention fits under the objectives of the CHF Second Standard Allocation for 2017 since it aims to support the provision of life-saving assistance for people in four hard to reach and underserved districts in Kandahar Province, identified as having acute humanitarian needs, through a multi-sectoral and integrated approach.

In particular, the project will contribute to improved access to essential life-saving trauma care, increased access to and utilization of basic and comprehensive Emergency Obstetric and Neonatal Care (EmONC) and other RH services in white conflict-affected areas in Kandahar Province, thus aligning with the 2017 HRP SO4: Humanitarian conditions in hard-to-access areas of Afghanistan are improved and to the Health Cluster Objective 2: Ensure access to essential basic and emergency health services for white conflict-affected areas and overburdened services due to population movements. As such the project will make sure that the targeted communities have improved access to PHC services, incl. RH services, and improve people’s access to basic emergency services, especially for first aid, basic trauma and EmONC. The project will under no circumstances lead to duplication since it is being implemented by INTERSOS in partnership with BPHS-implementer BARAN and all proposed activities have been verified in terms of needs, complementarity of existing services and service reach and limitation. The project activities will focus on training of staff and health workers to ensure better outreach and to enhance quality of service provision at HF level. major community awareness campaigns to improve prevention and health seeking behavior (self-referral), especially but not exclusively for pre- and post-natal care and safe delivery; procurement of supplies, drugs and kits for the provision of first aid, RH and Emergency PHC services. Moreover, the project foresees the rehabilitation of WASH facilities in the targeted HFs and an integrated health and WASH awareness campaign, thus aligning to WASH cluster strategic objectives for 2017. The project provides for GBV and protection mainstreaming, medical teams will be trained in PSS/PSFA (psycho-social first aid) as critical elements in the package of essential life-saving health-care services, also trained in case identification, referral and confidentiality and consent as core protection principles, and provided with information on available referral pathways.

Similarly, the project is aligned with the allocation objectives for APC focusing on districts that are increasingly contested with decreasing central government administrative and security control; applying community based approaches to reaffirming the neutral and impartial principals of humanitarian assistance by local stakeholders and authorities; placing people at the centre of the humanitarian situation analysis and presenting response strategies that do the same; response fits in multi-sector analysis and response for specific area. In fact, the intervention includes mobile outreach protection services to women, men, girls and boys including principled referrals and PSS support to conflict affected people and the provision of protection services (including health, psychosocial, legal and safety) to GBV survivors and PwSN and at risk of abuse and exploitation.

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
James A. Williams	Head of Mission	afghanistan@intersos.org	0093 791612524
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BACKGROUND

1. Humanitarian context analysis

Afghanistan is experiencing one of the longest chronic and complex emergency situations globally, deeply affecting the most vulnerable population groups: women, children and elders among others. This is characterized by recurrent conflict coupled with new and prolonged displacement, both internal and external. In 2017, 202.100 individuals have been verified as displaced (01 Jan-21 August 2017) to be added to the 661.287 recorded during 2016, record year for Afghanistan in term of displacement. 56% of displaced are women and children. Additionally, in 2016, there has been a significant increase in returns from Pakistan and Iran as a result of fear of arrest and/or deportation and deteriorating living and security conditions in Pakistan. Overall, since 1 January till 19 August 2017, 307.523 undocumented Afghans spontaneously returned or were deported from Pakistan or Iran and 45.300 registered Afghans have returned to Afghanistan from Pakistan (UNHCR). Based on IOM data, Kandahar represents the top three provinces of final destination for undocumented returnees.
Ongoing displacement waves combined with inadequate shelter and sanitation and insufficient and unsafe water are posing further stress on the health system, with potential for life threatening infectious disease outbreaks. Mass refugee return is raising concerns due to no or inadequate immunization against preventable diseases. Conflict/war related trauma, physical injuries and mass displacement have increased people's needs for health services and medical care far surpassing the capacity and resources of the basic services available through the health system. The lack of capacity of the health services are reflected at national level by high infant and maternal mortality rates (IMR 73/1000 and MMR 327/100,000), low immunization coverage and access to quality health and nutrition care. Only 32.9% of deliveries take place in health facilities and 27.7% of post-natal care is provided by trained health staff, while about 1 million women in reproductive age (15-49 y) is in need of reproductive health services, including emergency obstetric care in the most affected areas. There is sub-optimal immunization coverage in one quarter of the districts which results in widespread outbreaks of measles and pertussis among <5 years old children as almost all the major outbreaks are reported from the conflict affected locations. There is limited availability of sufficiently trained (especially female) health staff: only 22%/21% of Afghanistan's doctors/nurses are women. This has a heavy impact in a country where cultural beliefs often require that women be treated only by female health workers. Gaps in health services also include lack of maternal care and problems in the delivery of treatment for survivors of GBV. Overall there is also a complete lack of PSFA at both the community and facility level and case management for any protection cases (including GBV). Humanitarian action in Afghanistan continues to suffer systemic problems in assisting and protecting women and girls. The continued tendency to focus mostly on addressing practical needs such as girls' education, reproductive health, and GBV means that strategic needs based on socially constructed roles, differing capacities and vulnerabilities are not analyzed and addressed. Disaster response activities are still largely based on a set of assumptions that all people are equal in the face of a disaster. The extent of GBV in emergencies in Afghanistan is not well captured resulting in a failure to provide adequate protection support and services to the most vulnerable. Overall there is a lack of in depth protection analysis for Afghanistan as a whole and specifically for Kandahar. Also protection services on the ground are limited and there is a lack of community-based programming, while humanitarian space and access are severely negatively affected by the ongoing instability and insecurity.

2. Needs assessment

INTERSOS completed in March 2017 a MSA for 15 out of 17 districts in Kandahar province, focused on Health, Nutrition, Mortality, FS and WASH for Kandahar Province in partnership with local NGO HRDA and in strict coordination with BARAN, the Kandahar BPHS implementer. The most relevant findings of the MSA in terms of PHC are: (i) 27.5% of the population is U5, about 40% are women in reproductive age and 6% are PLW; (ii) 17.3% IDP and 3.2% returnees mixed with the host population at rural level; (iii) 87% of the population states living in rural area; (iv) The high caseload of trauma patients: 26% due to violent death (accident by cars or weapons), with 3% of death occurring during migration and 10% in the previous location; (v) Only 24% reported to have access to health services within 1 hour of distance, while the majority of the respondents reported 'distance' to be a constraint to access services (geographical and security related – 64%) and 9% reported finance as main problem to access health services; (vi) CBR was 1.96/10,000/day; CMR was 0.79/10,000 day and U5MR was 1.10/10,000/day. Cross checking assessments findings with the Health Facilities' (HFs) coverage by BARAN (H-IMS) and Health Cluster priorities, INTERSOS confirms that Arghistan, Khakrez, Shah Wali Kot and Maywand are under-served and are among the districts which showed very worrying trends in terms of health and nutrition data as well as being destabilized by ongoing population movements. For a population of over 510.200 inhabitants, there are only 10 HFs and no operational FATP (1 FATP was operational in Arghistan by since July 2017 is not functioning). From March 2016 till March 2017, 10.225 trauma cases were treated in these HFs. These 4 districts include 9 white area villages for a total population of 50.500 people with a complete lack of health posts. No humanitarian organization is operating in these areas. In Kandahar province the BPHS is provided by local NGO BARAN as implementer for all Kandahar. While nutrition and reproductive health services are part of BPHS, trauma care is not. BARAN, due to lack of resources is unable to provide all the services and the main concerns are raised for reproductive health services. While these services are foreseen to be provided to the population at community level and per referral at HF level, there are a number of gaps leading to increased morbidity and mortality, especially for child and mother: (i) Lack of trained (female) CHWs and overall not enough CHWs, lack of motivation, supervision and community outreach and referral by CHWs; (ii) Lack of community awareness on RH, and WASH issues (34% of population have access to no latrine and to practice open defection (OD) and 70% use only water for hand washing); (iii) Lack of trained and dedicated health staff per component at HF level: lack of trained female midwifes, (iv) Lack of BEmONC services and lack on community awareness on safe delivery. There is little to no attention in Kandahar for comprehensive protection emergency response, with exception of legal assistance for documentation and HLP rights and there is an assistance program for PwSN for returnees and IDPs. Meanwhile there is no attention to individual case management services for all protection cases once identified. Referral mechanisms/pathways are not adequately mapped or known. And overall there is little understanding on protection concepts at community level, especially amongst those population groups most vulnerable to protection violations, leading to lack of reporting and analysis on the type and trends in violations occurring. Per INTERSOS consultation with the protection cluster and NNGOs in Kandahar, there are no real GBV services available on district level in the South (except in Kandahar city). There appears to be misconception/lack of understanding on the cases typologies, there is deep under-reporting and lack of central reporting.

3. Description Of Beneficiaries

Direct beneficiaries of the present project are extremely vulnerable men, women, girls, and boys, who are at high risk of being exposed to violence and abuse at large in Arghistan, Khakrez, Maywand and Shah Wali Kot districts. Women affected by pregnancy related emergencies, GBV survivors and women/children at risk, and victims of injury and trauma are among the beneficiaries. These beneficiaries frequently belong to the non-resident component of the community (IDP and returnees) surviving in a condition of high vulnerability. Moreover the total percentage of these non-residents in the identified districts reaches 32% of the total creating a heavy overburden on the available services, which in turn affect also the host community. Please find attached the breakdown of the beneficiaries' calculation.

Primary health care services both at HF level and through mobile teams will be accessible for all beneficiaries regardless of age, gender, nationality and status. Disable people are also included. The access to healthcare in the served communities will be supported and strengthened through the Community Health Workers (CHWs), using an approach of first level of health aid/ activation of referral pathway. Further beneficiaries will also be the medical staff and community health workers as they will benefit from trainings and coaching on health, protection and SGBV related topics, including psychosocial first aid training. Mobile health services deployment will take into account displaced population movement, therefore ensuring constant access to medical services to newly displaced population. Priority for emergency health assistance will be determined on the basis of triage medical assessment and determined urgency coding.

The most vulnerable cases will be provided with the needed support through PSFA, legal counselling, ad hoc material assistance and immediate referral for urgent life-saving cases. Case management will also be provided to identified vulnerable people, making sure that beneficiaries receive qualified psychosocial support and then also referrals to available services. Beneficiaries in need of individual assistance will be identified through the work of trained staff that will compose the mobile teams and individual assessments carried out by skilled social workers and case managers while already opened cases will be properly followed up until a case review conducted ensures the case can be closed. The integrated approach foreseen by the present initiative ensures that identification of beneficiaries is conducted through different modalities including: (i) self-referral from CHWs and COVs; (ii) referral from medical teams; (iii) with the support of community leaders, tribal sheikhs and key informants; (iv) home visits to inform the protection assessment and monitoring, and identify vulnerable or at-risk individuals. The home visits will mainly address protection issues at household and community level, while if there are traces of other concerns, such as domestic violence, SGBV issues, the individuals will be approached separately, in a safe space and interviews and/or counseling provided within the mobile units, so to guarantee confidentiality and avoid exposure to further risks and protection risks, as well as shame; (v) external referrals from other actors. Referral pathway of the targeted areas will be established and updated as well as regular coordination and smooth communication with other agencies will be maintained in order to ensure mutual referral of cases.

Finally, community members overall will be benefit from the multiple awareness sessions related to health, WASH and protection principles and protection concerns. Totally, 24,960 people will receive awareness messages.

4. Grant Request Justification

This intervention is part of an integrated multi-sectorial humanitarian response plan for Kandahar Province to be implemented by INTERSOS in order to address the dire basic needs of and provide essential services for (documented and undocumented) Afghani Returnees (Pakistan) and IDPs, in addition to Afghani conflict affected (host) communities. As resulted from the Multi-sector Assessment conducted by INTERSOS in 15 districts of the province, identified needs are already being addressed by INTERSOS in Kandahar town (IDPs high concentration areas), Maywand, Zheray and Spin Boldak districts through a multi-donor and multi-sectoral program funded by USAID/OFDA, UNHCR and UNICEF in health, nutrition, WASH, livelihood protection and EiE sectors. With the present project INTERSOS aims at expanding further its multi-sector response to additional hard to reach, underserved and conflict-affected districts of Kandahar province targeting Maywand district only for trauma care considering that other activities are already provided in the district by INTERSOS through the program mentioned above, therefore are not herewith replicated in order to avoid overlapping.
INTERSOS opts for a complementary, integrated and comprehensive response strategy combining support for emergency health services provided by BARAN at HF level (trauma care and ANC/PNC), and by complementing the services of the HFs by running mobile outreach teams in white areas and missed catchment areas linked to each target HF, focusing on RH services, supporting the work of CHWs, enhancing community mobilization and awareness for health and WASH. The intervention also introduces individual and collective PSS with a special focus on women, girls and children, covering prevention and response services for GBV cases and PwSN. INTERSOS has clear evidence that health, including RH, is an acceptable entry point at community level to tackle more 'sensitive' subjects such as protection, mental health issues and GBV. Please note that INTERSOS would not duplicate the services provided by the actors working in health services (BARAN/DOPH/AHDS) in the targeted locations but complement and fill remaining gaps, especially in those 'white areas' where outreach services are currently not provided.
INTERSOS has a long standing presence and experience working in Afghanistan (since 2001) and currently has operational offices in Kabul and Kandahar. INTERSOS' humanitarian response strategy for Afghanistan is paying attention to emergency needs of the conflict-affected population, in particular IDPs, documented and undocumented returnees and vulnerable/isolated host communities. INTERSOS' country strategy is to provide for emergency response capacity in 4 main sectors: protection (including Education in Emergency), health-nutrition, livelihood and WASH. As such INTERSOS shall develop and implement a multi-sector humanitarian program, opting for a community-based approach. INTERSOS has already dedicated Health Personnel, international expert in Protection in Kandahar, and conducted multiple coordination meetings with BARAN/DoPH and other relevant stakeholders and humanitarian actors. INTERSOS believes to be in a privileged position for the re-establishment of its operation in Kandahar due to: (i) active emergency response on-going in some of the most remote districts of the province; (ii) new and comprehensive multi-sectoral assessments conducted in the province; (iii) several months of study and internal investment to ensure the deep knowledge and understanding of the context essential to guarantee the feasibility of the proposed action. (iv) preliminary discussions with the local leaders of the selected districts to introduce the organization, its profile and its core values; (v) strong and long-standing expertise in protection and in deep-field activities in complex setting. The project will provide clear deliverable in line with this allocation strategy and 2017 HRP.

5. Complementarity

INTERSOS' humanitarian response strategy for Kandahar (and Afghanistan more broadly) is to work on geographical coverage, per needs on the ground with a focus on the 'white areas' where communities are really under-served (able to go where others cannot or do not want to go) with strong community acceptance and engagement strategy, to scale up response capacity, implement integrated multi-sector program (protection, health-nutrition, WASH and FS/livelihoods – with EiE as part of protection programming), strong nationalization of staff policy combined with exploring national partnerships with Afghan civil society organizations. Overall INTERSOS believes in integrated and multi-sectoral programming - with focus on hot-spots/specific areas. To address humanitarian and protection needs of the most vulnerable population groups/communities in Kandahar province, INTERSOS is currently implementing a multi-donor integrated program focusing on health-nutrition, protection, WASH, livelihood and EiE. This INTERSOS proposed intervention aims to contribute to the protection and upholding of the fundamental rights of women, girls, boys, and men affected by the complex emergency in Kandahar province – Afghanistan, through systematic and coordinated protection monitoring/assessment, specific protection service delivery, and community-based mobilization, mitigation, and prevention activities creating a protection-conducive environment. INTERSOS traditionally departs from a strong protection mandate, understanding that tackling protection issues requires integrated and comprehensive multi-sector programming, applying a community-based, culture and conflict sensitive approach. This also allows INTERSOS to access 'white areas', working with community members for their communities. This is also why the project opts for community outreach strengthening via the already existing network of CHWs, and with COVs, working on its short falls (females, capacities in first aid and reproductive health/mother child health and quality of health education/awareness). INTERSOS has clear evidences that health, including RH, is an undervalued entry point for many communities to also start to tackle more 'sensitive' subjects such as protection, mental health issues, and GBV. The capacity building for staff and health workers will have a deep impact in terms of cascading effects, where the planned training and capacity building will provide sufficient attention to community engagement strategies, to ensure the acceptance and by-in of as many stakeholders as possible.
The protection risks in hard to reach and white areas in Kandahar have been duly analyzed and both stand-alone protection response and integrated protection activities have been foreseen in INTERSOS overall emergency response program for Kandahar:
- forced displacement is tackled through protection monitoring and training of other sectors' staff on protection issues and understanding of referral mechanism;
- explosion to fighting is tacked through referral of injured or disabled for assistance to HFs upgraded for trauma care and provision of PSFA and PSS for victim of war with trauma & collective PSS for community or PSFA for relatives (presence of psychologists and social workers to ensure very good understanding of different levels of PSS;
- collapse/lack of protective environment is tackled through GBV CM (identification, PSFA, referral (internal or external) and follow-up), reproductive health activities to permit easier implementation of GBV CM services and GBV collective PSS, GBV awareness integrated with health awareness and CHWs trained in general protection issues to ensure GBV prevention and response is included;
- negative/lack of coping mechanisms is tacked through collective PSS, identification and support to PwSN, GBV CM (identification, PSFA, referral (internal or external) and follow-up) and development of referral mechanism and awareness on it.

LOGICAL FRAMEWORK

Overall project objective

To contribute to the reduction of maternal, child and trauma related morbidity and mortality associated with diseases and hazards resulting from deficient (or non-existing) health services, poor environmental health conditions and lack of protective environment in conflict-affected communities in Kandahar provinces – Afghanistan.

HEALTH

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Objective 1: Ensure access to emergency health services, effective trauma care and mass casualty management for shock affected people	SO1: Immediate humanitarian needs of shock affected populations are met - including conflict and natural disaster affected and IDPs, refugees and returning Afghans from armed conflict	50
Objective 2: 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	50

Contribution to Cluster/Sector Objectives : The present project contributes to 2017 HRP SO4: Humanitarian conditions in hard-to-access areas of Afghanistan are improved and to the Health Objective 1: Ensure access to emergency health services, effective trauma care and mass casualty management for shock affected people since it aims at upgrading services in 10 Health Facilities and 1 FATP in Kandahar Province (Arghistan, Maywand, Khakrez and Shah Wali Kot districts), strengthening at local level the capacity to prevent avoidable deaths and disabilities from war trauma. Training and capacity building of medical staff and CHWs is foreseen to support basic trauma care and improve mass casualty management to conflict affected populations in hard to reach and underserved areas.
The project also contributes to Health Objective 2: Ensure access to essential basic and emergency health services for white conflict-affected areas and overburdened services due to population movements with the upgrade of 8 HFs, for the delivery of maternity care and emergency obstetric care services in 3 target districts (Arghistan, Khakrez and Shah Wali Kot) through establishment and up-scaling of EmONC services. Please note that mobile health team and support for EmONC services in Maywand district is not included since INTERSOS is already conducting such activities in the district through an USAID/OFDA funded program.

Outcome 1

Increased availability of essential lifesaving trauma care services (TCS) in health facilities and rehabilitation care for the conflict affected population in Maywand, Arghistan, Khakrez and Shah Wali Kot districts, including provision of psycho-social support in emergency.

Output 1.1

Description

6 HFs in the four targeted districts – Comprehensive Health Centers (CHCs) - (1 in Arghistan, 2 in Maywand, 2 in Shah Wali Kot and 1 in Khakrez) are upgraded for basic trauma care and 1 FATP in Arghistan is revitalized. To note that 3 of the CHCs (Tanabacha Kondalan CHC, Bande Themor CHC and Khakrez CHC) are located in active conflict areas.
Totally, in the four districts there are 10 HFs: 1 CHC (Arghistan CHC), 1 Sub Health Center (SHC) (Bala Zera SHC) in Arghistan, 2 CHCs in Maywand , 2 CHCs (Wayan CHC and Tanabacha Kondalan, both in white area), 1 Basic Health Center (BHC) (Shah Wali Kot) and 1 SHC in Shah Wali Kot, 1 SHC and 1 CHC in Khakrez. However, only CHCs will be upgraded for trauma care due to the following: (i) BHCs and SHCs don't have night duty MD/Nurse; (ii) BHCs and SHCs have not suitable place for FATP activities; (iii) BHCs and SHCs don't have any inpatient services.
Base line: There are no FATPs in Khakrez, Maywand and Shah Wali Kot districts while also the FATP available in Arghistan district is not functioning since few months after the LNGO managing it completed the project. Meanwhile, in none of the 1 HFs there is specific attention/capacity for basic trauma care as it is not part of the BPHS. As consequence, the present project foresees that the existing CHCs will be upgraded to provide basic trauma care to incoming cases and CHWs will also be trained in first aid and basic trauma care. The HFs however cannot be considered as full-fledged FATPs and that is also not the aim of this upgrade, but is to increase access and availability of trauma services in these hard to reach and under-served areas. Additionally, the FATP in Arghistan district will be revitalized.

6 CHCs in 4 of the selected districts (Arghistan, Maywand, Khakrez and Shah Wali Kot) will be scaled up to provide basic trauma care and the FATP in Arghistan will be revitalized. Upgrade will be done by training human resources and purchasing and preposition equipment: 222 CHWs, 10 CHSs and 53 health staff (12 MD, 16 MWs, 15 Nurses, and 15 Vaccinators) from the HFs in the 4 districts will be trained in basic emergency life-saving maneuvers and referral communication protocols for emergencies in order to upgrade the local response in preventing avoidable deaths and disabilities from war trauma.

In the targeted districts there are no referral hospitals and only CHCs have ambulances available. Most transportation to HFs and FATP is done in private transportation. Once the case arrives, the case is stabilized but afterwards immediately referred to the only 2 referral hospitals in Kandahar - Kandahar & Spin Boldak - on the Government side. As such, the system for trauma emergency medicine and non-trauma care, including mass casualty response, will be organized as hub-spokes standard from field level (CHWs) to HFs to referral district level, to FATP and, if necessary, from here to third level (Kandahar and Spin Boldak hospitals). Protocols for telecommunications referral triage and basic as well as advanced life support will be followed by different levels of appropriately trained staffed and equipped resources. The golden hour for trauma care standard will be pursued as possible. This system, although basic for obvious impending constraint of resources in the actual context, has the potential to be a seminal prototype for an organized emergency medicine system in Afghanistan, which is at present basically not-existent.

Assumptions & Risks

The main risk relates to the status of the conflict. A further worsening of the situation is likely and therefore further waves of displacement with increased humanitarian needs. Please note that beneficiary targets have been calculated and set based upon figures of IDP and returnees (OCHA, UNHCR, IOM) available at the time of proposal development but eventually it is expected that these numbers will continue to increase. Meanwhile it is also expected that the vulnerability of the conflict-affected host communities will further increase and coping mechanism will further erode.

There is also the risk of it becoming increasingly difficult to distribute humanitarian aid without it being restricted by -or diverted to - government officials, opposition groups, and other political actors. As such it is almost certain that humanitarian principles will be tested and questioned by different parties to the conflict. It is fundamental that the project staff (employees and volunteers) know the operational context and risks well, are fully aware of the humanitarian principles and senior staff is equipped to conduct humanitarian access negotiations, supported by OCHA where needed and relevant.

Assumptions:
- Security situation in the targeted areas guarantees regular access in the major villages. CHWs and CHSs continue to work and access patients in case of need, since they live in the targeted communities.
- Due to the volatile security situation in Kandahar province, access could at times disrupt action's implementation, therefore INTERSOS would focus on strong community relations and acceptance in all areas of delivery. Humanitarian access negotiations per humanitarian principles.
- Availability of qualified (female) staff and community volunteers in the respective areas
- Continuous quality partnership with BARAN and local NGOs active in the field of protection for activation of referral pathways
- Actively contribute to good information sharing and coordination with different clusters, sub-clusters and its members active in the same sectors and geographical areas, ensuring maximum coverage of needs and avoid overlap, while security activation of referral pathways.

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	1				1
Means of Verification : M&E Visits, procurement of emergency kits and delivery reports, clinical data from the FATP and HFs, HMIS data, report from BARAN and PHD.							
Indicator 1.1.2	HEALTH	SA2- Number of individuals receiving trauma care services	2,352	1,411	470	470	4,703
Means of Verification : Clinical cases database report from FATP & HFs, absolute # and % of trauma and emergency patients arriving in the FATP within one hour from onset of emergency, Data at referral Hospitals, HMIS, report from BARAN, DoPH. Baseline: average of 900 trauma patients per month in the targeted areas. Target is based on the baseline: considering the presence of 31 medical personnel in the 6 CHCs that will be scaled up to basic trauma care and the 4 nurses in the FATP which will be revitalized, it is estimated that 21 trauma patients/week/HFs will be treated.							

Activities

Activity 1.1.1

Standard Activity : SA2- Improve essential live-saving trauma care activities in health facilities including through the provision of rehabilitative care and psychosocial support in emergencies;

The project will procure and preposition emergency trauma and health kits for 1 FATP and 6 basic trauma points in 6 CHCs in Arghistan, Maywand , Khakrez and Shah Wali Kot districts:

- Procure and preposition medical supplies and equipment for integrated FATP in 6 CHDs;
- Procure and distribute first aid kits for CHWs (total of 222 CHWs > 192 already present + 30 new) & replenish regularly these kits (222 kits & 222 replenishment);
- Procure and distribute first aid kits for community trained in First Aid & replenish regularly these kits (992 kits & 992 replenishment).

Activity 1.1.2

Standard Activity : SA2- Improve essential live-saving trauma care activities in health facilities including through the provision of rehabilitative care and psychosocial support in emergencies;

Health facility staff, CHWs and community members are trained in BLS and management of trauma patients:

The existing network of CHWs will be strengthened to meet the emergency needs of the communities and HFs' capacity/attention for trauma care services will be enhanced through cascade training by trained emergency medical doctors and nurses for outreach services and HFs:

HFs level:
i. Training in BLS, ALS, ATLS and ToT for 18 MD, 30 MWs and 21 Nurses: 3 days for BLS, 3 days each for ALS, ATLS and ToT courses for a total 12 days of 3 hours theory plus 3 hours practice daily i.e. 6x12= 108 hours of training. Basic PSFA training will be included in the training package for HFs medical staff by INTERSOS psychologists.

Outreach level:
ii. Cascade training from already trained emergency medical doctors and nurses (see above) to 10 CHSs (7 already present + 3 new). Training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days) plus Training of Trainers (ToT) (3 days) courses. Total 9 days of training, 6 hours daily (3 theory + 3 practice) i.e. 54 hours of training;
iii. Cascade training from the already trained 10 CHS (see above) to 222 CHWs. The training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days). Total 3 days of training, 6 hours daily i.e. 18 hours of training. During the project the health kits will be replenished of what was used;
iv. Follow up with monitoring, evaluation and counseling of the activity of the CHWs, CHSs and HFs medical staff.

Please note that PSFA training for CHSs and CHWs and GBV prevention and response training for both medical staff and outreach personnel is included in below outcome.

Certified health professionals (INTERSOS and MoH/BARAN) will conduct the relevant training.

Activity 1.1.3

Standard Activity : SA2- Improve essential live-saving trauma care activities in health facilities including through the provision of rehabilitative care and psychosocial support in emergencies;

Community Based First Aid training for community members.

992 members of the target community, corresponding to the 10% of the individuals receiving health awareness sessions, will be selected for the CBFA training and will receive First Aid Kit. The activity will follow the model of CBHFA training of ARCS: the community approach applied for this activity is deemed extremely relevant given the remoteness of the area and the lack of First Aid Point. Training will be provided by trained medical staff and strict follow up by CHWs will ensure efficiency of the selected methodology.

Outcome 2

Improved access to life-saving Primary Health Care services through scaled up emergency obstetric and newborn care service in Arghistan, Khakrez and Shah Wali Kot districts, including capacity building of key medical staff on identification of violations and existing referral pathways.

Output 2.1

Description

Support essential life-saving PHC services, and (self) referral to 8 existing HFs Arghistan (2), Khakrez (2) and Shah Wali Kot (4) districts, with a focus on outreach services by strengthening the CHW teams operating in the so-called hard to reach and 'white areas', ensuring access to life-saving Primary Health Care and maternal and child care services. Maywand district is covered for this service by INTERSOS through an OFDA funded project which will start on September 2017 for a duration of 12 months.

Baselines:
There is a lack of sufficient well trained (female) CHW per HF to ensure the outreach services in the surrounding communities. Considering the more traditional nature of Kandahar and the de-facto isolation of these particular targeted districts, there is a large lack of understanding/knowledge related to health, nutrition, wash and reproductive health issues, preventing communities/individuals to seek access to services.

Next to the overall statistics and the gaps at HF level, the people report difficulty to access the HFs due to security, distance, financial constraints and mostly rely only on CHWs providing services in the village health posts. DoPH initiated an 8 extra mobile health teams for Kandahar province to address this access gap between the community and the HFs. However these MHT are not sufficient, especially to address the RH and nutrition services. The humanitarian community is therefore invited by the DoPH to further complement BARAN and DoPH services with additional Mobile Units, that provide for integrated health (incl. RH) and nutritional services, supporting CHWs in the most remote locations, unable to cover all the needs.

High attention will be placed on prevention through awareness sessions to be conducted by the CHWs at community level. The CHW teams with their field mobility will add flexibility to the system, support to preventive and basic health care at field level and will be part of the chain of emergency help in case of need. Additionally, through the CHWs outreach intervention, community awareness will also include basic protection principles, gender related issues and services to refer to in case of survivors as victim of SGBV.

Assumptions & Risks

The main risk relates to the status of the conflict. A further worsening of the situation is likely and therefore further waves of displacement with increased humanitarian needs. Please note that beneficiary targets have been calculated and set based upon figures of IDP and returnees (OCHA, UNHCR, IOM) available at the time of proposal development but eventually it is expected that these numbers will continue to go up and increase. Meanwhile it is also expected that the vulnerability of the conflict-affected host communities will further increase and coping mechanism will further erode.

There is also the risk of it becoming increasingly difficult to distribute humanitarian aid without it being restricted by -or diverted to - government officials, opposition groups, and other political actors. As such it is almost certain that humanitarian principles will be tested and questioned by different parties to the conflict. It is fundamental that the project staff (employees and volunteers) know the operational context and risks well, are fully aware of the humanitarian principles and senior staff is equipped to conduct humanitarian access negotiations, supported by OCHA where needed and relevant.

Assumptions:
- Security situation in the targeted areas guarantees regular access in the major villages. CHWs and CHSs continue to work and access patients in case of need, since they live in the targeted communities.
- Due to the volatile security situation in Kandahar province, access could at times disrupt action's implementation, therefore INTERSOS would focus on strong community relations and acceptance in all areas of delivery. Humanitarian access negotiations per humanitarian principles.
- Availability of qualified (female) staff and community volunteers in the respective areas
- Continuous quality partnership with BARAN and local NGOs active in the field of protection for activation of referral pathways
- Actively contribute to good information sharing and coordination with different clusters, sub-clusters and its members active in the same sectors and geographical areas, ensuring maximum coverage of needs and avoid overlap, while security activation of referral pathways.

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 2.1.1	HEALTH	SA2- Number of conflict affected people in underserved areas served by emergency PHC and mobile services	8,100	13,500	2,700	2,700	27,000
Means of Verification : Procurement of PHC materials, report of HF clinical activity and CHWs reports, pre- post HF and catchment area mapping, HMIS data, reports from BARAN and PHD.							
Indicator 2.1.2	HEALTH	Number or cases referred to specialized services by health team					1,350
Means of Verification : Intake form, Referral forms, internal report. Men: 405 Women: 675 Boys: 135 Girls: 135							

Activities

Activity 2.1.1

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

Training and deployment of medical staff and health workers for community mobilization, health education and PHC outreach services:

Outreach level:
Assure OUTREACH through support for already existing CHW teams linked to 8 HFs in Arghistan, Khakrez and Shah Wali Kot districts. CHWs (in/from targeted communities) are normally already put in place by BARAN but there are gaps, therefore, INTERSOS will identify, and support additional new 30 CHWs (15 men and 15 women) and 3 new CHSs, in addition to the 94 CHWs and the 3 CHSs already operating in the three districts. Average of 62 teams of 2 CHWs (Mahram system) for a total of 124 CHWs (94 already present + 30 new).

All Trainings will be conducted in line with the guidelines of the BPHS, in cooperation with DoPH: 3 days of new training and 2 days of refresher training. CHWs and CHS (50% females) in the targeted districts are trained on community mobilization, basics of post-traumatic counselling, GBV prevention and response, ensuring relevant and timely identification of survivors and appropriate referral to relevant service providers per referral pathways and PSFA., receiving sensitization tools and CHWs health kits at the end of the training. For health education messaging special attention will be given for PLW, pre and post-natal care, including the importance of ANC and PNC, breastfeeding, and tetanus vaccination and safe delivery.

HFs level:
Also training for health staff in HFs is provided in IMCI (integrate management of childhood Illness) and Emergency obstetric and newborn care (EmONC), family planning (FP). Staff already trained will only do refreshment training, permitting immediate start-up and new staff will receive full training. Health professions (INTERSOS and PHD – and other actor relevant and interested) will benefit from training and coaching on health, protection and SGBV related topics, and PSFA.

Activity 2.1.2

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

Compose/hire/operate 3 mobile teams to support the outreach capacity of the HFs for provision of RH services in Arghistan, Khakrez and Shah Wali Kot districts, mainly focusing on white areas where no other humanitarian organizations are present.

Mobile teams will complement the RH services at HF level (ANC/PNC/family planning).
9 trained dedicated health professionals in total – per team 1 GP, 1 midwife and 1 female nurse will be supported by the network of CHWs. Additionally, 2 social workers and 1 case manager will be part of each mobile team in charge of case management and protection monitoring. BARAN/DoH are not able to provide drugs or medical equipment for the mobile teams which will, therefore, procured directly by INTERSOS.

The training for the mobile team staff will be comprehensive on EPHC – Emergency Primary Health Care and the curriculum will include clinical management of childhood diseases (IMCI), maternal health, basic internal medicine and minor surgery, TRIAGE/BLS and emergency care.

Protection integration is ensured by the presence of two social workers for each team for the identification of PWSN and case management of GBV survivors.
Moreover as part of protection mainstreaming the health professionals will also benefit from trainings and coaching on health, protection and SGBV related topics and psychosocial first aid (PSFA) for health professionals. The training will be conducted over a span of 9 days immediately after recruitment during the first month of the project.

The car of the mobile team will be a mini-bus or 4X4 that could be converted to BLS in case of emergency (delivery, casualty or critical SAM case) for immediate referral to the nearby HF or referral hospital, depending on the severity. Each CHC has an ambulance available but due to geographical coverage, distance and considering emergency, these ambulances are often not timely available or able to assist the case.

The mobile teams will be organized in coordination with BARAN/DOPH to ensure the best possible coverage of the gaps. The Mobile Team will rove 5 days per week visiting 1 or 2 locations per day, covering about 50 consultations per day.

Total number of consultancies (PHC – with focus on RH) is expected to be:
50 consultancies per day per team x 3 teams x 5 days per week x 4 weeks x 9 months = 27.000 consultations during the project duration.
The mobile team itself will have mostly attention for Mother and Child Health (MCH) (ANC/PNC/BEmONC) as such the bulk of the patients will be women and children > estimation of 70% women (WCBA – PLW), 20% children and about 10% men.
It is expected that the team also makes referrals to the HFs for further follow-up and for identified protection cases referrals to the social workers. The mobile teams will be operating from the village health posts (village health rooms).

Output 2.2

Description

BEmONC established in 8HFs in Arghistan, Khakrez and Shah Wali Kot districts.

Baseline:
HFs do provide very minimal BEmONC in these 3 districts (basic obstetrics only). This leads to 67% mothers giving birth at home and increased risks for infections and bleeding, further increasing maternal and newborn mortality.

Strengthened functional capacities of target health facilities for the provision of maternity care and emergency obstetric care services.

Assumptions & Risks

The main risk relates to the status of the conflict. A further worsening of the situation is likely and therefore further waves of displacement with increased humanitarian needs. Please note that beneficiary targets have been calculated and set based upon figures of IDP and returnees (OCHA, UNHCR, IOM) available at the time of proposal development but eventually it is expected that these numbers will continue to go up and increase. Meanwhile it is also expected that the vulnerability of the conflict-affected host communities will further increase and coping mechanism will further erode.

There is also the risk of it becoming increasingly difficult to distribute humanitarian aid without it being restricted by -or diverted to - government officials, opposition groups, and other political actors. As such it is almost certain that humanitarian principles will be tested and questioned by different parties to the conflict. It is fundamental that the project staff (employees and volunteers) know the operational context and risks well, are fully aware of the humanitarian principles and senior staff is equipped to conduct humanitarian access negotiations, supported by OCHA where needed and relevant.

Assumptions:
- Security situation in the targeted areas guarantees regular access in the major villages. CHWs and CHSs continue to work and access patients in case of need, since they live in the targeted communities.
- Due to the volatile security situation in Kandahar province, access could at times disrupt action's implementation, therefore INTERSOS would focus on strong community relations and acceptance in all areas of delivery. Humanitarian access negotiations per humanitarian principles.
- Availability of qualified (female) staff and community volunteers in the respective areas
- Continuous quality partnership with BARAN and local NGOs active in the field of protection for activation of referral pathways
- Actively contribute to good information sharing and coordination with different clusters, sub-clusters and its members active in the same sectors and geographical areas, ensuring maximum coverage of needs and avoid overlap, while security activation of referral pathways.

Indicators

			End cycle beneficiaries				End cycle
Code	**Cluster**	**Indicator**	**Men**	**Women**	**Boys**	**Girls**	**Target**
Indicator 2.2.1	HEALTH	SA2- Number of health facilities in priority districts staffed by Skilled Birth Attendant	8				8
Means of Verification : M&E Visits, Clinical data from the HFs, HMIS data, report from BARAN and PHD.							
Indicator 2.2.2	HEALTH	SA2- Number of pregnant women in conflict affected and underserved areas receiving at least two antenatal care visits		3,872		0	3,872

Means of Verification : Data from CHW, crossed with data from HF Obstetric and Newborn and HMIS data.

Baseline is 3.872 women corresponding to 70% of the total pregnant women in the catchment area. Target is calculated as 100% of the baseline meaning an average of 10 pregnant women receiving ANC per week per midwife (8 midwifes in HFs and 3 midwifes in mobile medical teams).

Activities

Activity 2.2.1

Standard Activity : Scale up priority facilities with Emergency Obstetric and Newborn care (EmONC) services;

Strengthened functional capacities of targeted HFs for the provision of maternity care and emergency obstetric care services (establish BEmONC at district level and strengthen CEmONC at referral level)

For all facilities (8):
(Performance based) Incentives for night shift midwifes available on call. 8 midwives will be trained at BEmONC standard level to staff the 8 HFs, in addition of the midwife already deployed by BARAN, when any. Additionally, activation of trusted taxis to be activated as BLS and to ensure safe travels a night for female midwifes is foreseen.

- Training by an experienced midwife to the CHSs incl. the following: Pregnancy Control and Safe Motherhood, Antenatal and Post Natal Care practices, GBV prevention and identification and referral procedures, Early recognition of pregnancy at risk and referral procedures, Triage and Stabilization / Referral of Obstetric Emergencies (5 days of training 6 hours daily 50/50% theory and practice).
- Cascade training from the already trained CHSs (see above) to CHWs. The training will include the same components as above i.e. Pregnancy Control and Safe Motherhood, Antenatal and Pre Natal Care practices, GBV prevention identification and referral procedures, Early recognition of pregnancy at risk and referral procedures, Triage and Stabilization / Referral of Obstetric Emergencies.

Activity 2.2.2

Standard Activity : Scale up priority facilities with Emergency Obstetric and Newborn care (EmONC) services;

Community health awareness sessions

Women in Childbearing age (WCBA) and Pregnant or Lactating Women (PLW) will receive health messages to improve the safety of their pregnancies and motherhood. CHWs at village level will contribute to the early recognition of pregnancy at risks giving appropriate counseling (e.g. just preventive move to temporary stay nearer to the HF BEmONC services – or CmONC in case of complications).
The health awareness sessions will also provide information on the services available at HF and MC level and on the risk of late (self) referral for complications and negative long term consequences. Other topics will include:
-sensitization about the importance of ANC and PNC;
-sensitization about the importance of tetanus vaccination during and after pregnancy for mother and child to prevent neonatal tetanus.

Awareness sessions will also include basic protection principles, gender related issues and services to refer to in case of survivors as victim of SGBV. Men will also be encouraged to participate to the awareness sessions on GBV prevention.

Sessions will be conducted at the level of the health post when patients come to visit, but the CHWs will also be encouraged to conduct home visits and more general awareness sessions.
In addition to individual (one on one) counseling, each team of CHWs will be expected to conduct a minimum of 1 awareness sessions for PLW/WCBA, including also for men/(future) fathers per month with a focus on Mother and Child Health (ANC/PNC and safe delivery).
62 teams (total of 124 CHW > 94 already present + 30 new) x 1 sessions per team per month X 8 months X 20 persons per session = 9.920 individuals to be reached (75% women and 25% men).

High attention will be placed on prevention with the sessions by the CHWs to the women at community level.

Activity 2.2.3

Standard Activity : Procurement of emergency RH kits and equipment and training and deployment of medical staff including female health workers in high risk priority districts;

Procurement for BEmONC and CEmONC:

Procurement of RH and safe delivery kits - upon availability of UNFPA and UNICEF.
HE material procurement and distribution: HE material in form of illustrated pamphlets containing the Health RH messages relevant for CBAWs and PLWs as explained in the HE sessions will be procured and distributed. Expected production # 10,000 pamphlets.
Procurement of baby kits for most vulnerable cases (500): Such kits include: diapers, wipes, hand sanitizer, blanket, baby lotion, soap and shampoo, tower and bag.

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	SO1: Immediate humanitarian needs of shock affected populations are met - including conflict and natural disaster affected and IDPs, refugees and returning Afghans from armed conflict	50
Objective 3: Support the creation of a protection-conducive environment to prevent and mitigate protection risks, as well as facilitate an effective response to protection violations	SO1: Immediate humanitarian needs of shock affected populations are met - including conflict and natural disaster affected and IDPs, refugees and returning Afghans from armed conflict	50

Contribution to Cluster/Sector Objectives : The intervention will contribute to APC Objectives 2 and 3 and, in particular, to Strategic Objective 1 through the delivery of an integrated package of protection services aiming at mitigating the main identified protection risks in hard to reach areas of Kandahar Province and responding to abuses and violations. The project provides for mobile protection services for women, men, girls and boys: protection monitoring at Household and Community Level will permit for identification of general protection trends and concerns and allows also for the identification of the most vulnerable persons in need of individual case management (Psycho-Social First Aid - PSFA, Psycho-Social Support - PSS, referral (internal and external) and follow-up). The protection services will specifically focus on GBV survivors and Persons with Specific Needs - PwSN. Community mobilization and awareness will be at the core of this community-based protection approach, working with community outreach volunteers - COVs, promoting the establishment/bolstering of existing community-based protection networks through the mobilization of community outreach volunteers, the engagement with local civil society actors and stakeholders and promoting integration and referral with other sectors (health, WASH, education, etc). Case Management will include PFA/PSS, referral and follow up and material support for the most vulnerable cases. In the case management package INTERSOS will also provide legal couselling and mediation in particular for GBV survivors. Community awareness sessions will focus on different protection-related topics, aimed to increasing knowledge, enhance positive attitudes and change practices, overall working to positive coping mechanisms and enhanced resilience. - protection related topics - linking in with health (mother and child), esp. for GBV/RH. The sessions will be tailored per different target, age and gender group. For activities relevant to GBV: protection monitoring will include reporting on GBV and will inform analysis, services for survivors will include identification, PSS package, referral (internal or external) per consent to different services and follow-up; with full consent and confidentiality. Meanwhile INTERSOS will be working on mainstreaming GBV in other sectors (incl health-nutrition and WASH), promoting referral of reported cases to INTERSOS for further assessment and case management services.

INTERSOS will focus on 3 hard to reach districts in Kandahar Province, Arghistan, Shah Wali Khot and Khakrez.

Outcome 1

Evolving protection concerns, needs and violations are monitored, analyzed and responded to in 3 districts in Kandahar province - Afghanistan, upholding fundamental rights and restoring the dignity and well-being of vulnerable shock affected populations.

Output 1.1

Description

Prolonged IDPs, undocumented returnees and vulnerable host communities (women, men, boys and girls) receiving mobile outreach protection services, including principled referrals, PSS, key life-saving messages, information and awareness on protection risks in Arghistan, Khakrez and Shah Wali Kot districts.

GBV basic package will include psychosocial services, case management, provision of dignity kits (in kind by UNFPA), establishing referral network for health and legal matters and community mobilization.

Please note that INTERSOS will already conduct similar protection intervention in Maywand district as part of the multi-sector program funded by OFDA and covering Maywand, Spin Boldak and Zheray districts.

Coordination with YHDO and BARAN will be enhanced and will continue throughout the project timeframe in order to avoid any overlapping of activities or geographical coverage.

Assumptions & Risks

INTERSOS mobile protection teams have systematic access to communities as they are recruited and roving in the target area, enhancing opportunities for community engagement and acceptance. Close cooperation with local actors will support identification and referral map development and permit for referral pathways to function and allow for easy development of SOPs for referral.

Main risks:
- Lack of commitment from community to engage in protection activities
- Reluctance to accept protection basic principles and services, as in conflict with the local culture
- Stigma for GBV cases
- Lack of existing services for referrals

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	864	2,160	648	648	4,320
Means of Verification : Weekly and Monthly reports by protection monitors, social workers, paralegal worker and community outreach volunteers. Compiled monthly protection monitoring reports will be submitted to the regional protection cluster and GBV sub-cluster Target calculation: Protection Monitoring > 1.140 Household Assessments (15/week/team/8 months) for 7.200 people & 288 FGDs (3/week/team/8 months) for 4.320 participants (15 person/FGD). Social workers will open maximum 30 cases each per week for a total of 5.760 cases. All cases will receive Psycho-Social First Aid and it is estimated that further 75% received Psycho-social support for a total of 4.320 cases (30% children, 50% women and 20% men).							
Indicator 1.1.2	PROTECTION	SA2- Number of GBV survivors receiving protection services (including health, psychosocial, legal and safety)	200	1,000	300	500	2,000
Means of Verification : Individual intake forms, individual assessment and counselling reports, referral reports, program progress reports Out of the estimated 4.320 case receiving PSS, it is estimated that 2.000 will be the GBV survivors receiving protection services (1.000 women, 500 girls, 300 boys and 200 men). Please note that, being this a standard indicator, target for men and boys cannot be entered.							
Indicator 1.1.3	PROTECTION	Number of GBV survivors receiving Dignity Kits in kind from UNFPA					1,500
Means of Verification : Way bill, distribution list Women: 1000 Girls: 500							
Indicator 1.1.4	PROTECTION	Number of community members, including COVs, receiving awareness on protection-related issues and trainings on protection topics.					4,011
Means of Verification : Attendance list, training material. Men: 2005 Women: 2005							
Indicator 1.1.5	PROTECTION	Number of Community Outreach Volunteers trained and provinding protection awareness					60
Means of Verification : Men: 30 Women: 30							

Activities

Activity 1.1.1

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

INTERSOS will activate set of 2 trained social workers (1 men and 1 women) and 1 PSS counselor per mobile team for a total of 6 social workers and 3 PSS counsellors in Arghistan, Khakrez and Shah Wali Kot districts.

For the qualifications of the social workers please find in annex the relevant TOR/job descriptions as will be published for staff recruitment. Social workers provide for PSFA (psycho-social first aid) services and PSS (psycho-social support) – individual case management, including case referral (internal and external) and organize for collective PSS, mainly for women and children (especially in case of major protection risks being identified – gender and age disaggregated). Where PSFA is on the spot and mostly one time, PSS is part of a follow-up process. However psychological counseling (PC) will only be done by dedicated psychologists – 1 referral psychologist per mobile team will be included in the team.
For the qualifications of these psychologists please find in annex the relevant TOR/job descriptions as will be published for staff recruitment.

INTERSOS protection team will be trained on case management steps and tools in line with SOPs, which will be shared by the Clusters. These include: identification, case assessment, designing of a case plan for each single individual (agreed in case meetings between trained Social Worker and Protection Officer), regular follow-ups, review of the case plan and closure in accordance with pre-established conditions. Upon identification of vulnerable women, men, girls and boys, the social workers will closely follow up, review and monitor the psychosocial progress of each individual.

INTERSOS will also seek to identify and activate a network of community outreach volunteers (20 COVs per district) to ensure identification and referral of individual cases to the social workers. COVs will also work on organizing community awareness sessions, community groups & collective PSS sessions: total of 60 COVs will be trained and actively contributing to the implementation of the protection activities, in particular ensuring community mobilization, engagement and acceptance, in addition to case identification, internal referral for assessment and case management and support case follow-up. Also protection concepts will be approached and explained (where possible) through Afghan Islamic interpretations to ensure a greater by-in. It will be made clear that protection principles are not contradicting with Islam but rather are in line with each other.

Activity 1.1.2

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

Provision of case management services for individual protection cases (GBV and PwSN).
Individual protection cases will be identified by different means: internal referral from mainly health activities, external referral by community outreach volunteers, community groups and local organizations, self-referral by cases, from other humanitarian actors. The social workers will ensure to dedicate time for PSFA and PSS and suggest the cases for internal (including for further psychological counseling by dedicated psychologist and legal counselling by dedicated lawyer) or external referrals. For all cases full consent and confidentiality will be guaranteed by the teams: basic sessions on how to ensure confidentiality, including of data, will be provided to all INTERSOS team at inception phase. INTERSOS will contract per district 1 legal counselor to provide for legal counselling mainly on information sharing/legal awareness/advice, and mediation mainly for GBV and PwSN cases. Moreover, per district, INTERSOS will seek to identify the availability of a psychologist in case of more complex cases in need of further counseling and follow-up. The focus for these roles and positions will be on female staff, as it is expected that female beneficiaries will make the majority of cases. Upon identification of vulnerable women, men, girls and boys, all the cases will have initial one-time assessment and will be provided with PSFA. Case Managers and Social Workers will closely follow up, review and monitor the psychosocial progress of each individual. PSS approach will include both individual and group activities, according to the single person's needs and case plan. An established mechanism of internal and external referral will be put in place and used whenever it is needed, with a consequent follow up in order to guarantee the provision of the service required and to monitor the impact of the service on the well-being of the person. Regular review of case plan, in case meetings within Social Workers, Case Managers and Protection Officer and evaluation of psychosocial well-being of beneficiaries receiving PSS services will be conducted in order to monitor progress on the psycho-social conditions of the cases. Upon positive results, the protection staff involved can proceed with the case closure. Identified GBV cases, as part of case management, will receive dignity kit in-kind from UNFPA (agreement with UNFPA to be developed upon approval of the present project), while the most vulnerable cases, according to given criteria, will also be provided with material assistance to cover basic needs. Referral to HFs and legal aid will be part of the package. The cases in need of follow-up will be provided with schedule as per the rotation of the mobile team (each location will be visited about every month for 2 to 3 time max). If the case also requires psychological counseling, s/he will be referred to the psychologist for sessions as per need. The social workers and psychologists can meet the cases in their homes but will also identify safe spaces where they could meet in a more confidential manner – in collaboration with local associations – where needed. Cases will receive individual follow-up till closure. The well-being and safety of the case will always be prioritized. It is estimated that each social worker will have no more than 30 open cases at the same time. It is important to have ASAP clear referral maps in place and ensure these referrals are conducted well and appropriately. Gender perspective is ensured by trained female Staff, in order to guarantee free and protected access of vulnerable women and girls to the services available. Female Staff will be mainstreamed in all services available, including PSS consultations and information dissemination on health services. Male members from the staff will also be trained on basic principles of gender equality. Internal and external referrals will be organized per developed service mapping.

Activity 1.1.3

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

Collective PSS activities organized for most vulnerable population groups at community level (CP, GBV and PwSN)

In addition to general awareness sessions on protection (see output below) the community outreach volunteers supported by the social workers will also organize more focused collective PSS sessions – i.e. support groups – for particular target groups, e.g. children engaged in child labour, widows, women at risk, unemployed men and youth, permitting them to share experiences and to discuss with the guidance of social workers on coping mechanisms and strategies (negative and positive):
- CP: child marriage, children recruited in armed groups, child labour, violence against children versus education, skill training, recreational activities, parents groups, role of school shura at community level, access to and information about available services, etc.
- GBV: child/forced marriage, deprivation of resources, domestic violence, sexual violence and exploitation versus gender equality, livelihoods and education opportunities, ensure engagement of men and women, access to and information about available services, etc.
- PwSN: disability, PLW, women at risk, chronically ill, mental health, elderly at risk and extreme poverty versus rights based approach, providing these disadvantaged groups with a platform to voice their concerns/needs/issues and provide for greater community support and acceptance, access to and information about available services, etc.

Such collective PSS session will provide a safe space for persons of concern to meet – gender and age disaggregated, exchange and also learn. In order to avoid stigmatization, the sessions will be organized as social gatherings with refreshments provided by INTERSOS: club model. So the topics and approaches in the sessions can vary depending on the target group (also age and gender considered) but the model will always be the same.
It is estimated that per month 4 such sessions will be organized per team, or in total 96 sessions (4 session x 3 teams x 8 months), for about 20 persons per session, reaching about 1.920 persons (30% children, 50% women and 20% men).

Community outreach volunteers are to be living within 500m from the targeted communities. 50% women and 50% IDPs, 20% returnees/30% host community - they support the INTERSOS protection team during the interventions, provide mobilization messages, protection promotion awareness, counselling and identify/refer the most vulnerable persons/HHs in need to the INTERSOS protection team. Selection of COVs will be conducted at village level with the consultation of shura members and village leaders to identify the most active and already engaged individuals within the community. COVs will participate to the training as per activity 1.1.4. Based on literacy level COVs will be provided with culturally-sensitive awareness material.
COVs are provided with small monthly transportation allowance and phone credits, to incentivized their commitment, and are coordinated and supervised by the protection officer. There will be 60 Community Outreach Volunteers in total, in addition to community member and members of local civil society per district that will be encouraged to establish Community Based Protection Networks and regularly meet to discuss on protection and undertake coordinated action for prevention and response activities.

Activity 1.1.4

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

Training on PSS-related concepts and approaches to community leaders, urban committees and community members

INTERSOS Protection Officer will provide training sessions to key community members within the targeted urban areas on definition of PSS, identification of vulnerable individuals, PSS approaches, sensitive communication techniques and community-based protection mechanisms, with the aim of increasing the capacity of the community to develop their own protective measures and establish mechanisms of self-reliance. Please find attached training CV. CHWs and CHSs will be as well trained in GBV protection and response and Protection concerns identification as mentioned in Activity 2.1.1 under Health sector.

171 persons (50% men & 50% women) > 6 social workers, 9 mobile health team staff, 3 psychologists, 3 legal counsellors, min. 30 local community leaders per targeted district (90), and 60 community outreach volunteers. These trainings will be conducted per district. The trainings will be conducted in Pashto by qualified trainers, taking 4 days per training.
Further on job-training and coaching will also be provided for INTERSOS staff with the support of the protection activity coordinator dedicated on the project.

Training will start from month 2 of the project.

Activity 1.1.5

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

Awareness sessions for community members on protection related issues (CP, GBV and PwSN)

Awareness sessions on protection related issues will aim to enhance community understanding on right based approaches related to CP, GBV and PwSN, aimed at community protection (foremost protection but also response), contributing to better identification, prevention and response of protection concerns and violations. The outreach activities will target community leaders to promote and advocate rights. COVs will be organizing the session at community level, supported by social workers to facilitate the awareness sessions. Understanding the traditional nature of the communities that will be targeted and to ensure community acceptance and facilitation, these sessions will be integrated where possible with the health-nutrition-WASH awareness sessions (see above). Also protection concepts will be approached and explained (where possible) through Afghan Islamic interpretations to ensure a greater by-in. It will be made clear that protection principles are not contradicting with Islam but rather are in line with each other. Therefor it will be important to also work with key stakeholders such as Islamic teachers and religious leaders from those targeted communities. Considering the delicate nature of GBV issues, these will be tackled as part of overall protection and also linked to reproductive health issues (for example child marriage) & CP issues will be tackled by looking into the importance of education, access to knowledge and overall health of the child.
For PwSN (incl. PLW, women at risk, disabled, elderly persons at risk, extremely poor, mental health case and chronically ill cases), INTERSOS will spend sufficient time on the situation of disabled as this is a particular vulnerable group that is in need for recognition of their rights and for improved services and adapted assistance (as individual but also for their families).
192 sessions will be conducted for 3.840 (30% children, 35% women and 35% men): 2 sessions x week x 4 weeks x 8 months x 20 persons per session x 3 teams = 3.840 individuals.
Only 30% will be considered as NEW/ADDITIONAL beneficiaries on top of the already reached people by other awareness session – so in the total beneficiary calculation, there will be no double counting.

Additional Targets :

WATER, SANITATION AND HYGIENE

Cluster objectives	Strategic Response Plan (SRP) objectives	Percentage of activities
Objective 1: Ensure timely access to a sufficient quantity of safe drinking water, use of adequate and gender sensitive sanitation, and appropriate means of hygiene practices by the affected population	SO4: Humanitarian conditions in hard-to-access areas of Afghanistan are improved	100

Contribution to Cluster/Sector Objectives : The interventions of the project are designed based on objective 1 of WASH cluster and in line Strategic Response Plan's (SRP) objective 4 since it aims to improve access of quality drinking water in targeted HFs and to raise awareness among target communities to contribute in reduction of water borne illnesses and vulnerabilities associated with poor sanitation and unhygienic behavior and practices.

Outcome 1

Improved access to appropriate and functioning water and sanitation facilities in HFs and enhanced community awareness in WASH good practices for conflict-affected communities in Afghanistan

Output 1.1

Description

Enhanced community knowledge and improved practices related to water and sanitation related topics and improved access to appropriate and functioning water and sanitation facilities in 10 target HFs

Assumptions & Risks

- Political and security context will not impact the project implementation.
-The communities will contribute towards project goals and results, will provide space for conducting of training and participate in the training.

Indicators

			End cycle beneficiaries				End cycle
Code	Cluster	Indicator	Men	Women	Boys	Girls	Target
Indicator 1.1.1	WATER, SANITATION AND HYGIENE	SA2- Number of institutions in need with access to appropriate WASH facilities	4	0	0	0	4
Means of Verification :							
Indicator 1.1.2	WATER, SANITATION AND HYGIENE	Number of people receiving direct Hygiene Promotion					5,760

Means of Verification : Attendance lists, monthly planning of sessions, program progress reports, KAP survey
Men: 2016
Women: 2016
Boy: 864
Girls: 864

Activities

Activity 1.1.1

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

INTERSOS will conduct small rehabilitations for 4 HFs in Arghistan (2) and Khakrez (2) per needs established and assessed with DoPH/BARAN. Please, find attached estimated BoQ for WASH rehabilitation works (latrines and bath facilities,waste management). Please note that based on consultation with WHO in Kandahar, HFs in Shah Wali Kot won't be targeted with WASH rehabilitation since WHO has already committed funds for this intervention.

The infrastructure rehabilitation of health facilities will also ensure that safe water is available (water pumping, storing and treatment). For waste management at health facilities, the rehabilitation/maintenance of infrastructure will seek to include segregation of waste (solid waste, hazardous waste (needles, knives, glass) and biological waste) (possibility to color code for segregation will be explored), including specific training about waste management system, and infections preventions. Infrastructural works include the rehabilitation or construction of incinerator and placenta pit. Please find attached the proposed design.

The rehabilitation works will be delivered by private contractors, hired locally, per bid analysis procurement process.
The financial contribution will on average not be more than 5.000 US$ for these rehabilitations.

Activity 1.1.2

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

6 Hygiene Promoters (HPs) (2 per district) will work in pairs with CHWs or COVs (there will always be 1 men and 1 women) and each team will conduct each:
8 months x 4 weeks/month x 3 days/week x 3 teams = 288 sessions each with 20 participants for a total of 5.760 beneficiaries
Please note that in the total beneficiary calculation these beneficiaries will not be double counted.

The teams will use IEC materials for hygiene promotion (leaflet, posters, and demonstration kits for hand washing) that will be adapted to the context and literacy level of the target groups.
This activity will be starting by month 2 of the project, when all other activities and staff have been recruited, ensuring a good complementarity and integration of HP with the other sectors/activities, continuing for 8 months.

Hygiene promotion session will aim to provide information on hygiene-related risks and preventive actions, such as promoting hand-washing, awareness on waterborne disease and water boiling and safe water storage and handling and hygiene behavioral change.

Awareness sessions will be conducted for different target groups. Education and communication are important components of hygiene promotion. All people have a right to know about the relationship between water, sanitation, hygiene, health and nutrition of themselves and their families. However, education alone does not necessarily result in improved practices. Knowing about the causes of disease may help, but new hygiene practices may be too unfamiliar, too difficult, or conditional on other aspect (such as access to water), especially for poor people, including displaced.

Promoting behavioral change is a gradual process that involves working closely with communities, studying existing beliefs, defining motivation strategies, designing appropriate communication tools (pictograms, posters, and practical sessions) and finally encouraging practical steps towards positive practices (establishment of WASH committees is one of these steps).
Communities will be fully engaged in the process at all stages using participatory processes, and special attention should be given to building on local knowledge and promoting existing positive traditional practices. As such the hygiene promotion will combine info sharing and community mobilization, linked to the provision of essential services.

Topics will include among others: hand-washing, personal hygiene (including for mother and child for Pregnant and Lactating Women), general session on relation WASH and health (clean water, water boiling and safe water storage and handling and clean sanitation facilities), environmental health and waste management. A KAP survey will be conducted at the beginning of the awareness sessions to draw the baseline and the final survey at the end of the campaign to measure behaviour change.

Additional Targets :

M & R

Monitoring & Reporting plan

During the first few weeks of the project, the team would undertake in-depth needs assessment and gather base line data of the operational areas. The project operational plan and design would be readjusted. INTERSOS will monthly monitor progress against the agreed work plan, using different tools and findings. Project manager reports to the Head of Mission (HOM). Admin-finance department is led by the country admin-finance officer (CAFO), supported by admin-finance assistants. There is a clear system of segregation of duties put in place to prevent possible conflict of interest, irregularities and possible fraud. INTERSOS has a dedicated team with extensive experience in health and nutrition in Kandahar and long term experience in protection, supporting other sector departments in protection mainstreaming. An expert Project Manager will supervise/direct the activities, will ensure the achievement of objectives and realization of outcomes and outputs and will be responsible for the management and coordination of the staff involved in the project. The Protection officer (PO), a GBV expert, will ensure the monitoring of all the steps of case management services ensuring close follow up of clients and the respect of basic principles and minimum standards. WASH component will be managed by a dedicated WASH team, headed by an engineer with prior experience in humanitarian WASH project delivery. INTERSOS has dedicated staff for monitoring and evaluation. PDM/monitoring activities are kept separate from the project implementation. Monitoring and evaluation staff reports back to the project managers (PMs) and the HoM. For health and nutrition services, INTERSOS will rely on the monthly H-MIS reporting system put in place for the BPHS and MoPH, but will further also add regular FGDs with community members in the targeted communities to ensure there is visible and concrete improvement in quality and availability of services provided at HF and at community level. For protection services, INTERSOS will use internal case management audits to be conducted by the protection officer (expat expert in GBV foremost) which will allow monitoring and evaluation of the quality of the follow up of individual cases and the effectiveness of the work of the case workers. Moreover the protection officer will be support by a M&E/reporting officer specifically dedicated to protection activities.
Internally INTERSOS uses a Project Appraisal Tool (PAT) that ensures the supervision of project activities' implementation, its costs and timing and it evaluates project risks as appropriate. The PAT format per project is prepared at project inception and updated/filled by the PM on monthly basis. The PM shares the monthly PAT update with the HOM, PAC and PC. INTERSOS has M&E officer in Kabul and Kandahar already who would collate this information on a monthly basis and provide analysis on expected and achieved results, disaggregated by gender and age. The M&E officers would also travel to different locations every month and hold FGD with the shura members and community and check the accuracy of the data.There would be feedback mechanism established at the shura level. The M&E officer would report his findings to INTERSOS SMT in Kandahar on a monthly basis and recommend corrective measures. Some of the recommendations would feed into the annual capacity building of staff, stockpiling and replenishing stocks. He would also develop and manage data base. The Health and Nutrition officer, Protection officer and the WASH coordinator would report regularly to the Cluster on the progress made. PM would meet WHO, DOPH and other stakeholders and share information of health, WASH and protection aspects of the communities. Project activity planning goes hand in hand with good financial and procurement planning: INTERSOS ensures each project has a monthly updated financial and procurement plan, combined with weekly liquidity planning.

Workplan

Activitydescription	Year	1	2	3	4	5	6	7	8	9	10	11	12
Activity 1.1.1: INTERSOS will activate set of 2 trained social workers (1 men and 1 women) and 1 PSS counselor per mobile team for a total of 6 social workers and 3 PSS counsellors in Arghistan, Khakrez and Shah Wali Kot districts. For the qualifications of the social workers please find in annex the relevant TOR/job descriptions as will be published for staff recruitment. Social workers provide for PSFA (psycho-social first aid) services and PSS (psycho-social support) – individual case management, including case referral (internal and external) and organize for collective PSS, mainly for women and children (especially in case of major protection risks being identified – gender and age disaggregated). Where PSFA is on the spot and mostly one time, PSS is part of a follow-up process. However psychological counseling (PC) will only be done by dedicated psychologists – 1 referral psychologist per mobile team will be included in the team. For the qualifications of these psychologists please find in annex the relevant TOR/job descriptions as will be published for staff recruitment. INTERSOS protection team will be trained on case management steps and tools in line with SOPs, which will be shared by the Clusters. These include: identification, case assessment, designing of a case plan for each single individual (agreed in case meetings between trained Social Worker and Protection Officer), regular follow-ups, review of the case plan and closure in accordance with pre-established conditions. Upon identification of vulnerable women, men, girls and boys, the social workers will closely follow up, review and monitor the psychosocial progress of each individual. INTERSOS will also seek to identify and activate a network of community outreach volunteers (20 COVs per district) to ensure identification and referral of individual cases to the social workers. COVs will also work on organizing community awareness sessions, community groups & collective PSS sessions: total of 60 COVs will be trained and actively contributing to the implementation of the protection activities, in particular ensuring community mobilization, engagement and acceptance, in addition to case identification, internal referral for assessment and case management and support case follow-up. Also protection concepts will be approached and explained (where possible) through Afghan Islamic interpretations to ensure a greater by-in. It will be made clear that protection principles are not contradicting with Islam but rather are in line with each other.	2017										X	X	X
	2018	X	X	X	X	X	X						
Activity 1.1.1: INTERSOS will conduct small rehabilitations for 4 HFs in Arghistan (2) and Khakrez (2) per needs established and assessed with DoPH/BARAN. Please, find attached estimated BoQ for WASH rehabilitation works (latrines and bath facilities,waste management). Please note that based on consultation with WHO in Kandahar, HFs in Shah Wali Kot won't be targeted with WASH rehabilitation since WHO has already committed funds for this intervention. The infrastructure rehabilitation of health facilities will also ensure that safe water is available (water pumping, storing and treatment). For waste management at health facilities, the rehabilitation/maintenance of infrastructure will seek to include segregation of waste (solid waste, hazardous waste (needles, knives, glass) and biological waste) (possibility to color code for segregation will be explored), including specific training about waste management system, and infections preventions. Infrastructural works include the rehabilitation or construction of incinerator and placenta pit. Please find attached the proposed design. The rehabilitation works will be delivered by private contractors, hired locally, per bid analysis procurement process. The financial contribution will on average not be more than 5.000 US$ for these rehabilitations.	2017												
	2018		X	X	X								
Activity 1.1.1: The project will procure and preposition emergency trauma and health kits for 1 FATP and 6 basic trauma points in 6 CHCs in Arghistan, Maywand , Khakrez and Shah Wali Kot districts: - Procure and preposition medical supplies and equipment for integrated FATP in 6 CHDs; - Procure and distribute first aid kits for CHWs (total of 222 CHWs > 192 already present + 30 new) & replenish regularly these kits (222 kits & 222 replenishment); - Procure and distribute first aid kits for community trained in First Aid & replenish regularly these kits (992 kits & 992 replenishment).	2017										X	X	
	2018												

Activity 1.1.2: 6 Hygiene Promoters (HPs) (2 per district) will work in pairs with CHWs or COVs (there will always be 1 men and 1 women) and each team will conduct each: 8 months x 4 weeks/month x 3 days/week x 3 teams = 288 sessions each with 20 participants for a total of 5.760 beneficiaries Please note that in the total beneficiary calculation these beneficiaries will not be double counted. The teams will use IEC materials for hygiene promotion (leaflet, posters, and demonstration kits for hand washing) that will be adapted to the context and literacy level of the target groups. This activity will be starting by month 2 of the project, when all other activities and staff have been recruited, ensuring a good complementarity and integration of HP with the other sectors/activities, continuing for 8 months. Hygiene promotion session will aim to provide information on hygiene-related risks and preventive actions, such as promoting hand-washing, awareness on waterborne disease and water boiling and safe water storage and handling and hygiene behavioral change. Awareness sessions will be conducted for different target groups. Education and communication are important components of hygiene promotion. All people have a right to know about the relationship between water, sanitation, hygiene, health and nutrition of themselves and their families. However, education alone does not necessarily result in improved practices. Knowing about the causes of disease may help, but new hygiene practices may be too unfamiliar, too difficult, or conditional on other aspect (such as access to water), especially for poor people, including displaced. Promoting behavioral change is a gradual process that involves working closely with communities, studying existing beliefs, defining motivation strategies, designing appropriate communication tools (pictograms, posters, and practical sessions) and finally encouraging practical steps towards positive practices (establishment of WASH committees is one of these steps). Communities will be fully engaged in the process at all stages using participatory processes, and special attention should be given to building on local knowledge and promoting existing positive traditional practices. As such the hygiene promotion will combine info sharing and community mobilization, linked to the provision of essential services. Topics will include among others: hand-washing, personal hygiene (including for mother and child for Pregnant and Lactating Women), general session on relation WASH and health (clean water, water boiling and safe water storage and handling and clean sanitation facilities), environmental health and waste management. A KAP survey will be conducted at the beginning of the awareness sessions to draw the baseline and the final survey at the end of the campaign to measure behaviour change.	2017												X
	2018	X	X	X	X	X	X							

Activity 1.1.2: Health facility staff, CHWs and community members are trained in BLS and management of trauma patients: The existing network of CHWs will be strengthened to meet the emergency needs of the communities and HFs' capacity/attention for trauma care services will be enhanced through cascade training by trained emergency medical doctors and nurses for outreach services and HFs: HFs level: i. Training in BLS, ALS, ATLS and ToT for 18 MD, 30 MWs and 21 Nurses: 3 days for BLS, 3 days each for ALS, ATLS and ToT courses for a total 12 days of 3 hours theory plus 3 hours practice daily i.e. 6x12= 108 hours of training. Basic PSFA training will be included in the training package for HFs medical staff by INTERSOS psychologists. Outreach level: ii. Cascade training from already trained emergency medical doctors and nurses (see above) to 10 CHSs (7 already present + 3 new). Training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days) plus Training of Trainers (ToT) (3 days) courses. Total 9 days of training, 6 hours daily (3 theory + 3 practice) i.e. 54 hours of training; iii. Cascade training from the already trained 10 CHS (see above) to 222 CHWs. The training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days). Total 3 days of training, 6 hours daily i.e. 18 hours of training. During the project the health kits will be replenished of what was used; iv. Follow up with monitoring, evaluation and counseling of the activity of the CHWs, CHSs and HFs medical staff. Please note that PSFA training for CHSs and CHWs and GBV prevention and response training for both medical staff and outreach personnel is included in below outcome. Certified health professionals (INTERSOS and MoH/BARAN) will conduct the relevant training.	2017												X
	2018	X											

Activity 1.1.2: Provision of case management services for individual protection cases (GBV and PwSN). Individual protection cases will be identified by different means: internal referral from mainly health activities, external referral by community outreach volunteers, community groups and local organizations, self-referral by cases, from other humanitarian actors. The social workers will ensure to dedicate time for PSFA and PSS and suggest the cases for internal (including for further psychological counseling by dedicated psychologist and legal counselling by dedicated lawyer) or external referrals. For all cases full consent and confidentiality will be guaranteed by the teams: basic sessions on how to ensure confidentiality, including of data, will be provided to all INTERSOS team at inception phase. INTERSOS will contract per district 1 legal counselor to provide for legal counselling mainly on information sharing/legal awareness/advice, and mediation mainly for GBV and PwSN cases. Moreover, per district, INTERSOS will seek to identify the availability of a psychologist in case of more complex cases in need of further counseling and follow-up. The focus for these roles and positions will be on female staff, as it is expected that female beneficiaries will make the majority of cases. Upon identification of vulnerable women, men, girls and boys, all the cases will have initial one-time assessment and will be provided with PSFA. Case Managers and Social Workers will closely follow up, review and monitor the psychosocial progress of each individual. PSS approach will include both individual and group activities, according to the single person's needs and case plan. An established mechanism of internal and external referral will be put in place and used whenever it is needed, with a consequent follow up in order to guarantee the provision of the service required and to monitor the impact of the service on the well-being of the person. Regular review of case plan, in case meetings within Social Workers, Case Managers and Protection Officer and evaluation of psychosocial well-being of beneficiaries receiving PSS services will be conducted in order to monitor progress on the psycho-social conditions of the cases. Upon positive results, the protection staff involved can proceed with the case closure. Identified GBV cases, as part of case management, will receive dignity kit in-kind from UNFPA (agreement with UNFPA to be developed upon approval of the present project), while the most vulnerable cases, according to given criteria, will also be provided with material assistance to cover basic needs. Referral to HFs and legal aid will be part of the package. The cases in need of follow-up will be provided with schedule as per the rotation of the mobile team (each location will be visited about every month for 2 to 3 time max). If the case also requires psychological counseling, s/he will be referred to the psychologist for sessions as per need. The social workers and psychologists can meet the cases in their homes but will also identify safe spaces where they could meet in a more confidential manner – in collaboration with local associations – where needed. Cases will receive individual follow-up till closure. The well-being and safety of the case will always be prioritized. It is estimated that each social worker will have no more than 30 open cases at the same time. It is important to have ASAP clear referral maps in place and ensure these referrals are conducted well and appropriately. Gender perspective is ensured by trained female Staff, in order to guarantee free and protected access of vulnerable women and girls to the services available. Female Staff will be mainstreamed in all services available, including PSS consultations and information dissemination on health services. Male members from the staff will also be trained on basic principles of gender equality. Internal and external referrals will be organized per developed service mapping.	2017											X	X
	2018	X	X	X	X	X	X						

Activity 1.1.3: Collective PSS activities organized for most vulnerable population groups at community level (CP, GBV and PwSN) In addition to general awareness sessions on protection (see output below) the community outreach volunteers supported by the social workers will also organize more focused collective PSS sessions – i.e. support groups – for particular target groups, e.g. children engaged in child labour, widows, women at risk, unemployed men and youth, permitting them to share experiences and to discuss with the guidance of social workers on coping mechanisms and strategies (negative and positive): - CP: child marriage, children recruited in armed groups, child labour, violence against children versus education, skill training, recreational activities, parents groups, role of school shura at community level, access to and information about available services, etc. - GBV: child/forced marriage, deprivation of resources, domestic violence, sexual violence and exploitation versus gender equality, livelihoods and education opportunities, ensure engagement of men and women, access to and information about available services, etc. - PwSN: disability, PLW, women at risk, chronically ill, mental health, elderly at risk and extreme poverty versus rights based approach, providing these disadvantaged groups with a platform to voice their concerns/needs/issues and provide for greater community support and acceptance, access to and information about available services, etc. Such collective PSS session will provide a safe space for persons of concern to meet – gender and age disaggregated, exchange and also learn. In order to avoid stigmatization, the sessions will be organized as social gatherings with refreshments provided by INTERSOS: club model. So the topics and approaches in the sessions can vary depending on the target group (also age and gender considered) but the model will always be the same. It is estimated that per month 4 such sessions will be organized per team, or in total 96 sessions (4 session x 3 teams x 8 months), for about 20 persons per session, reaching about 1.920 persons (30% children, 50% women and 20% men). Community outreach volunteers are to be living within 500m from the targeted communities. 50% women and 50% IDPs, 20% returnees/30% host community - they support the INTERSOS protection team during the interventions, provide mobilization messages, protection promotion awareness, counselling and identify/refer the most vulnerable persons/HHs in need to the INTERSOS protection team. Selection of COVs will be conducted at village level with the consultation of shura members and village leaders to identify the most active and already engaged individuals within the community. COVs will participate to the training as per activity 1.1.4. Based on literacy level COVs will be provided with culturally-sensitive awareness material. COVs are provided with small monthly transportation allowance and phone credits, to incentivized their commitment, and are coordinated and supervised by the protection officer. There will be 60 Community Outreach Volunteers in total, in addition to community member and members of local civil society per district that will be encouraged to establish Community Based Protection Networks and regularly meet to discuss on protection and undertake coordinated action for prevention and response activities.	2017											X	X
	2018	X	X	X	X	X	X						
Activity 1.1.3: Community Based First Aid training for community members. 992 members of the target community, corresponding to the 10% of the individuals receiving health awareness sessions, will be selected for the CBFA training and will receive First Aid Kit. The activity will follow the model of CBHFA training of ARCS: the community approach applied for this activity is deemed extremely relevant given the remoteness of the area and the lack of First Aid Point. Training will be provided by trained medical staff and strict follow up by CHWs will ensure efficiency of the selected methodology.	2017												
	2018		X	X	X	X	X						

Activity 1.1.4: Training on PSS-related concepts and approaches to community leaders, urban committees and community members INTERSOS Protection Officer will provide training sessions to key community members within the targeted urban areas on definition of PSS, identification of vulnerable individuals, PSS approaches, sensitive communication techniques and community-based protection mechanisms, with the aim of increasing the capacity of the community to develop their own protective measures and establish mechanisms of self-reliance. Please find attached training CV. CHWs and CHSs will be as well trained in GBV protection and response and Protection concerns identification as mentioned in Activity 2.1.1 under Health sector. 171 persons (50% men & 50% women) > 6 social workers, 9 mobile health team staff, 3 psychologists, 3 legal counsellors, min. 30 local community leaders per targeted district (90), and 60 community outreach volunteers. These trainings will be conducted per district. The trainings will be conducted in Pashto by qualified trainers, taking 4 days per training. Further on job-training and coaching will also be provided for INTERSOS staff with the support of the protection activity coordinator dedicated on the project. Training will start from month 2 of the project.	2017										X		
	2018												
Activity 1.1.5: Awareness sessions for community members on protection related issues (CP, GBV and PwSN) Awareness sessions on protection related issues will aim to enhance community understanding on right based approaches related to CP, GBV and PwSN, aimed at community protection (foremost protection but also response), contributing to better identification, prevention and response of protection concerns and violations. The outreach activities will target community leaders to promote and advocate rights. COVs will be organizing the session at community level, supported by social workers to facilitate the awareness sessions. Understanding the traditional nature of the communities that will be targeted and to ensure community acceptance and facilitation, these sessions will be integrated where possible with the health-nutrition-WASH awareness sessions (see above). Also protection concepts will be approached and explained (where possible) through Afghan Islamic interpretations to ensure a greater by-in. It will be made clear that protection principles are not contradicting with Islam but rather are in line with each other. Therefor it will be important to also work with key stakeholders such as Islamic teachers and religious leaders from those targeted communities. Considering the delicate nature of GBV issues, these will be tackled as part of overall protection and also linked to reproductive health issues (for example child marriage) & CP issues will be tackled by looking into the importance of education, access to knowledge and overall health of the child. For PwSN (incl. PLW, women at risk, disabled, elderly persons at risk, extremely poor, mental health case and chronically ill cases), INTERSOS will spend sufficient time on the situation of disabled as this is a particular vulnerable group that is in need for recognition of their rights and for improved services and adapted assistance (as individual but also for their families). 192 sessions will be conducted for 3.840 (30% children, 35% women and 35% men): 2 sessions x week x 4 weeks x 8 months x 20 persons per session x 3 teams = 3.840 individuals. Only 30% will be considered as NEW/ADDITIONAL beneficiaries on top of the already reached people by other awareness session – so in the total beneficiary calculation, there will be no double counting.	2017												
	2018	X	X	X									

Activity 2.1.1: Training and deployment of medical staff and health workers for community mobilization, health education and PHC outreach services: Outreach level: Assure OUTREACH through support for already existing CHW teams linked to 8 HFs in Arghistan, Khakrez and Shah Wali Kot districts. CHWs (in/from targeted communities) are normally already put in place by BARAN but there are gaps, therefore, INTERSOS will identify, and support additional new 30 CHWs (15 men and 15 women) and 3 new CHSs, in addition to the 94 CHWs and the 3 CHSs already operating in the three districts. Average of 62 teams of 2 CHWs (Mahram system) for a total of 124 CHWs (94 already present + 30 new). All Trainings will be conducted in line with the guidelines of the BPHS, in cooperation with DoPH: 3 days of new training and 2 days of refresher training. CHWs and CHS (50% females) in the targeted districts are trained on community mobilization, basics of post-traumatic counselling, GBV prevention and response, ensuring relevant and timely identification of survivors and appropriate referral to relevant service providers per referral pathways and PSFA., receiving sensitization tools and CHWs health kits at the end of the training. For health education messaging special attention will be given for PLW, pre and post-natal care, including the importance of ANC and PNC, breastfeeding, and tetanus vaccination and safe delivery. HFs level: Also training for health staff in HFs is provided in IMCI (integrate management of childhood Illness) and Emergency obstetric and newborn care (EmONC), family planning (FP). Staff already trained will only do refreshment training, permitting immediate start-up and new staff will receive full training. Health professions (INTERSOS and PHD – and other actor relevant and interested) will benefit from training and coaching on health, protection and SGBV related topics, and PSFA.	2017												X
	2018													
Activity 2.1.2: Compose/hire/operate 3 mobile teams to support the outreach capacity of the HFs for provision of RH services in Arghistan, Khakrez and Shah Wali Kot districts, mainly focusing on white areas where no other humanitarian organizations are present. Mobile teams will complement the RH services at HF level (ANC/PNC/family planning). 9 trained dedicated health professionals in total – per team 1 GP, 1 midwife and 1 female nurse will be supported by the network of CHWs. Additionally, 2 social workers and 1 case manager will be part of each mobile team in charge of case management and protection monitoring. BARAN/DoH are not able to provide drugs or medical equipment for the mobile teams which will, therefore, procured directly by INTERSOS. The training for the mobile team staff will be comprehensive on EPHC – Emergency Primary Health Care and the curriculum will include clinical management of childhood diseases (IMCI), maternal health, basic internal medicine and minor surgery, TRIAGE/BLS and emergency care. Protection integration is ensured by the presence of two social workers for each team for the identification of PWSN and case management of GBV survivors. Moreover as part of protection mainstreaming the health professionals will also benefit from trainings and coaching on health, protection and SGBV related topics and psychosocial first aid (PSFA) for health professionals. The training will be conducted over a span of 9 days immediately after recruitment during the first month of the project. The car of the mobile team will be a mini-bus or 4X4 that could be converted to BLS in case of emergency (delivery, casualty or critical SAM case) for immediate referral to the nearby HF or referral hospital, depending on the severity. Each CHC has an ambulance available but due to geographical coverage, distance and considering emergency, these ambulances are often not timely available or able to assist the case. The mobile teams will be organized in coordination with BARAN/DOPH to ensure the best possible coverage of the gaps. The Mobile Team will rove 5 days per week visiting 1 or 2 locations per day, covering about 50 consultations per day. Total number of consultancies (PHC – with focus on RH) is expected to be: 50 consultancies per day per team x 3 teams x 5 days per week x 4 weeks x 9 months = 27.000 consultations during the project duration. The mobile team itself will have mostly attention for Mother and Child Health (MCH) (ANC/PNC/BEmONC) as such the bulk of the patients will be women and children > estimation of 70% women (WCBA – PLW), 20% children and about 10% men. It is expected that the team also makes referrals to the HFs for further follow-up and for identified protection cases referrals to the social workers. The mobile teams will be operating from the village health posts (village health rooms).	2017											X	X
	2018	X	X	X	X	X	X							

Activity 2.2.1: Strengthened functional capacities of targeted HFs for the provision of maternity care and emergency obstetric care services (establish BEmONC at district level and strengthen CEmONC at referral level) For all facilities (8): (Performance based) Incentives for night shift midwifes available on call. 8 midwives will be trained at BEmONC standard level to staff the 8 HFs, in addition of the midwife already deployed by BARAN, when any. Additionally, activation of trusted taxis to be activated as BLS and to ensure safe travels a night for female midwifes is foreseen. - Training by an experienced midwife to the CHSs incl. the following: Pregnancy Control and Safe Motherhood, Antenatal and Post Natal Care practices, GBV prevention and identification and referral procedures, Early recognition of pregnancy at risk and referral procedures, Triage and Stabilization / Referral of Obstetric Emergencies (5 days of training 6 hours daily 50/50% theory and practice). - Cascade training from the already trained CHSs (see above) to CHWs. The training will include the same components as above i.e. Pregnancy Control and Safe Motherhood, Antenatal and Pre Natal Care practices, GBV prevention identification and referral procedures, Early recognition of pregnancy at risk and referral procedures, Triage and Stabilization / Referral of Obstetric Emergencies.	2017												X
	2018	X	X	X	X	X								
Activity 2.2.2: Community health awareness sessions Women in Childbearing age (WCBA) and Pregnant or Lactating Women (PLW) will receive health messages to improve the safety of their pregnancies and motherhood. CHWs at village level will contribute to the early recognition of pregnancy at risks giving appropriate counseling (e.g. just preventive move to temporary stay nearer to the HF BEmONC services – or CmONC in case of complications). The health awareness sessions will also provide information on the services available at HF and MC level and on the risk of late (self) referral for complications and negative long term consequences. Other topics will include: -sensitization about the importance of ANC and PNC; -sensitization about the importance of tetanus vaccination during and after pregnancy for mother and child to prevent neonatal tetanus. Awareness sessions will also include basic protection principles, gender related issues and services to refer to in case of survivors as victim of SGBV. Men will also be encouraged to participate to the awareness sessions on GBV prevention. Sessions will be conducted at the level of the health post when patients come to visit, but the CHWs will also be encouraged to conduct home visits and more general awareness sessions. In addition to individual (one on one) counseling, each team of CHWs will be expected to conduct a minimum of 1 awareness sessions for PLW/WCBA, including also for men/(future) fathers per month with a focus on Mother and Child Health (ANC/PNC and safe delivery). 62 teams (total of 124 CHW > 94 already present + 30 new) x 1 sessions per team per month X 8 months X 20 persons per session = 9.920 individuals to be reached (75% women and 25% men). High attention will be placed on prevention with the sessions by the CHWs to the women at community level.	2017												X
	2018	X	X	X	X	X								
Activity 2.2.3: Procurement for BEmONC and CEmONC: Procurement of RH and safe delivery kits - upon availability of UNFPA and UNICEF. HE material procurement and distribution: HE material in form of illustrated pamphlets containing the Health RH messages relevant for CBAWs and PLWs as explained in the HE sessions will be procured and distributed. Expected production # 10,000 pamphlets. Procurement of baby kits for most vulnerable cases (500): Such kits include: diapers, wipes, hand sanitizer, blanket, baby lotion, soap and shampoo, tower and bag.	2017											X	X
	2018													

OTHER INFO

Accountability to Affected Populations

INTERSOS is committed to strengthening positive community coping mechanism and to investing in training of the community as a long lasting investment. During the needs assessment, effort will be made to identify and recognize local CBOs, women and youth groups that will be empowered to monitor the project at the community level. This approach has proved to be more effective than establishing beneficiary committees with the only purpose of a project. As much as possible, the staffing for the project would be selected from the community so to nurture community ownership over the project. Community based approach and active involvement of men, women, boys and girls have been considered during project design phase, considering that INTERSOS is already implementing similar activities to the ones here proposed in 3 other districts of Kandahar Province and especially also taking into considerations the outcomes of INTERSOS multi sector needs assessment for the area. During implementation, beneficiaries continue to be regularly heard: in fact community meetings will be the main means of receiving feedback from the beneficiaries in order to adjust activities accordingly. Additionally, questionnaires and interviews to key actors will be carried out during the activities. Finally, compliant mechanisms will be put in place in order to channel clearly every issue and prepare a consistent response in line with beneficiaries needs. INTERSOS will communicate during project implementation an emergency number for filing complaints and asking questions. The phone number will be held by one staff of INTERSOS Monitoring and Evaluation team, independent from the project, who will record the complaint and activate an independent investigation on complaints and any negative feedback. Positive feedback will be recorded also. Confidentiality will be guaranteed. For beneficiaries that do not hold a phone or cannot read the phone number (illiterate): INTERSOS will conduct regular FGD for beneficiary/community feedback on quality of services provided (see up). These FGDs will be conducted by the M&E team and individuals not feeling comfortable with commenting in group (requesting confidentiality) will be granted time, after the FGDs, to formulate their individual complaint/feedback to the M&E team in person. FGDs/meetings will be organised ensuring specific moments of feedback for specific population/beneficiary groups; these will be organised as collective PSS and staff (social workers) will be trained/coached in the facilitation in such session: do no harm, no personlization, indirect information/feedback collection while permitting participants ventilation and raising concerns and stimulate group reflection and awareness. Considering the context men and women will not be joining same sessions and also age groups will be regrouped in order to avoid pressure from elderly on the youth for example. Cultural sensitivity will be assured by pulling information (input and feedback) from protection monitoring reports, engagement with local actors (organisations and leaders) - the community outreach volunteers will play a crucial role in this, as they come from the community, know what can and what cannot be done and why; how to push for new topics and where are the red lines. For what is concerning engaging the community to GBV programming, this will be done through a community based participatory approach to create an enabling and supportive environment towards combating GBV while empowering women and girls. Activities for this: sensitization and awareness raising (using culturally appropriate tools and language and by targeting women and men alike); participatory community mobilizations and action groups (with youth-led initiatives and selection of topics to be prioritized by community members themselves); advocacy towards governmental stakeholders, if feasible, involving representative from communities, especially community leaders, women and men ali

Implementation Plan

Project will be implemented in close collaboration with BARAN. Where BARAN is already BHSP implementer for Kandahar, there are challenges in delivery and gaps. Also not all services are included in the BHSP package, such as trauma care. INTERSOS will support/complement BARAN's service package in Arghistan, Maywand, Khakrez and Shah Wali Kot, through the following activities: procurement of kits and equipment, trainings/capacity building at HF and outreach level, strengthen/support CHWs network in order to reach communities and get communities to come to HFs for services. Focus is on First Aid/Trauma Care Services, Mother and Child health care and Emergency obstetrics. At HF level, INTERSOS will seek to support BARAN/DoPH with improvement/upgrading of the facility in terms of sanitation and waste management facilities. Already residing staff will also be trained (refresher or specialized). This will improved the quality and availability of the services to be provided in the HFs per BPHS guidelines, encourage patient health-seeking behavior and patient-satisfaction. For outreach services, INTERSOS will hire staff to run mobile teams providing for reproductive health services for the most isolated and vulnerable communities/population groups, mainly white areas. Meanwhile these mobile teams will strengthen the referral mechanism to the HF of cases identified by the CHWs. There will be 1 Mobile Team activated per district (not Maywand though already covered by INTERSOS through other funds), closely cooperating with a set of CHWs and CHSs, roving per monthly planned & coordinated schedule within the targeted district. Moreover, INTERSOS will be working intensively with the community on health and hygiene promotion, community mobilization and raising awareness for different target groups on safe water use and storage, hand-washing, sanitation/toilet use, health and communicable diseases, mother and child health for PLW, and also on the importance of cleaning/maintenance of public facilities and promote public solid waste management. Community mobilization will be done by CHWs for health and nutrition issues and the WASH related issues will be covered by trained hygiene promoters. Furthermore INTERSOS will have social workers linked to the mobile teams that will be providing PSFA & PSC to identified protection cases (CP, GBV, PwSN) in need of case management services and conduct collective PSS sessions for most vulnerable groups (life skills and coping mechanisms – age and gender segregated), in addition to protection awareness to could contribute to enhanced protection and actual prevention from protection issues. The use of mobile teams will allow for high flexibility to redirect life-saving services to those communities most in need, ensuring coverage and provision of health and protection services enabling families who would otherwise not be able to access treatment - either because of the prohibitive costs of travel or insecurity - to get their children the life-saving assistance they need. The project will start with kick off meeting between BARAN and INTERSOS, signing and MoU on the partnership relation for the implementation of this project. CHWs are already active and where there are gaps, BARAN will be requested to identify CHWs from the targeted communities. Procurement will be kick-started from the beginning there is approval on the project, starting with the revision and verification of BoQ for different drugs and equipment. Kits will be requested immediately to UNICEF and UNFPA to ensure timely delivery. The start-up phase will take max 1 month and from the 2nd months all activities will be running in the field. Monthly reports will be submitted/collected starting from month 1, and this first month will also function as baseline, to follow the evaluation in services provided and services attended following training, capacity building and strengthening, equipping and major community mobilization and awar

Coordination with other Organizations in project area

Name of the organization	Areas/activities of collaboration and rationale
Ministry of Public Health (MoPH) and Department of Public Health (DoPH)	They will be the main institutional counterpart for the implementation of the present action. DoPH has already been, and will continue to be, involved in the assessment and planning phase and will play a relevant role also in the implementation phase, supporting INTERSOS staff through the organization of coordination meetings with other stakeholders. Approval for the present action has been already obtained by DoPH.

BARAN	Project will be implemented in close collaboration with BARAN. Where BARAN is already BHSP implementer - responsible for 7 components of national guidelines for public health - for Kandahar there are challenges in delivery and gaps. Also not all services are included in the BHSP package. INTERSOS will support/complement BARAN's service package through the following activities: procurement of goods, kits and equipment, trainings/capacity building at HF and outreach level, strengthen/support CHWs network in order to reach communities and get communities to come to HFs for services. Focus is on First Aid/Trauma Care Services, Mother and Child health care and Emergency obstetrics. BARAN and INTERSOS will be signing and MoU on the partnership relation for the implementation of this project as per signed contract with OCHA.
Health Cluster	INTERSOS will coordinate with the Health Cluster at country and regional level and ensure that INTERSOS programs are in line with the cluster strategy and are filling an identified gap in emergency response.
Any other international and national actor providing health care services in the geographical targeted area	Coordination with actors providing health care services in the target locations will continue throughout the project implementation timeframe in order to enhance referral system and avoid duplication in term of services or locations targeted by the provision of essential health services.
Local authorities - Non-State Actors	Humanitarian space and access coordination > work towards acceptance and facilitation, in line with international humanitarian law and per humanitarian principles
Local authorities/ Community Leaders	INTERSOS will work with the local authorities, respected members of the target communities, and other non-state actors, in order to increase the awareness and utilization of existing power structures that facilitate activity implementation in the target communities. The local administration in each targeted community and districts, will be mobilized and sensitized on the proposed intervention and their full support sought. They will assist in ensuring that the community has access to program services. They will also share vital information, including information on security issues, and encourage community participation in program implementation to help strengthen the responsiveness of service delivery.
UNHCR	For all IDP related issues and for documented returnees; and for overall protection sector coordination
IOM	For all undocumented returnees related issues
Different service providers	Following referral mapping – all relevant organizations active in the target districts: referral in and out. INTERSOS will seek to hold Case Management Meetings if needed to assure the best possible response for the most critical cases. INTERSOS will also closely work together with BARAN for referral but also for support with the identification and selection of community outreach volunteers. The GBV sub-cluster partners have agreed to refer to each other/and other relevant service providers Health Net TPO and YHDO are also working in the south in PSS, NRC are working in civil documentation, HLP and access to essential services, HI in disability. INTERSOS will seek to refer each case per need and available services, in coordination with different service providers and within each sector per cluster mapping and coordination.
Ministry of Women's Affairs (MOWA)	For all gender related issues - specifically for women and girls
WASH cluster and UNICEF	INTERSOS will coordinate with the WASH Cluster at country level and ensure that INTERSOS programs are in line with the cluster strategy and are filling an identified gap in emergency response.
OCHA, APC and sub-clusters, working groups and task forces	At regional and national level, where relevant to the project for protection cluster, GBV SC and CPiE SC, Cash WG, IAWG, MA SC and HLP TF clusters > coordination and referrals, sharing or referral maps. Coordination with GBV SC will be enhanced particularly at Provincial level.

Environment Marker Of The Project

A: Neutral Impact on environment with No mitigation

Gender Marker Of The Project

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

Justify Chosen Gender Marker Code

The proposed intervention aims at contributing in some limited way to gender equality. Women and girls are among the projects' beneficiaries as they are particularly affected by lack of access to health services, in particular for RH service.
Medical staff will benefit from training and coaching on health, protection and SGBV related topics.
The training for medical staff and CHWs on protection and gender/GBV related topics will help to ensuring the quick, proper and confidential referral of survivor and persons at risk; foremost for women and girls but overall for all protection survivors and persons at risk.
The project will ensure the delivery of essential health services, including Reproductive Health that will target particularly the needs of women and children, with particular regards to pregnant and lactating women. ANC and PNC services will be an essential component of the services offered by INTERSOS medical teams. All health teams will have female staff presence to facilitate the delivery of health services to women. The trained staff, with particular regard to CHWs and COVs will be, as much as possible, composed by 50% women, to facilitate the delivery of health promotion messages in a way that may be more effective to establish a behaviour change. It has been observed that messages received by CHWs of the same gender of the beneficiary are more effective to establish a behaviour change. In this regard, messages delivered by male CHWs will ensure the engagement of male family members in ensuring that female family members can have regular access to preventive (e.g. ANC/ PNC services) and outpatients or emergency health services.
Moreover, the protection component of the intervention aims at directly targeting women at risk and GBV survivors through comprehensive case management, including PSS and material assistance.
Lastly the project aims to contribute to the maternal and child mortality and will therefore have special attention to safe delivery and the well-being of mother and child. RH and safe delivery provides immediately also an opportunity to address concerns on child/early marriage, but addressing this from the angle of pregnancy and health risks for young girls in case of child marriage.

Protection Mainstreaming

INTERSOS has a long experience in delivering protection services globally. Protection mainstreaming is also the backbone of INTERSOS programming: INTERSOS strives for a full mainstreaming of protection throughout its program at country level: protection mainstreaming in health-nutrition programming and WASH activities. This also allows INTERSOS to access ‘white areas’, working with community members for their communities. This is also why the project opts for community outreach strengthening via the already existing network of CHWs and COVs, working on its short falls (females, capacities in first aid and reproductive health/mother child health and quality of health and protection education/awareness).
The proposed intervention has been designed in a way to enable beneficiaries to fully access and enjoy their rights; safety and dignity, while at the same time avoid harm. All project activities will be carried out in accordance with AGDM principles. INTERSOS will ensure that key cross-cutting issues are mainstreamed into the proposed intervention including age, gender, diversity, equal participation/opportunity, environment and human rights. Gender will remain a key focus, guaranteeing consultation with female beneficiaries when undertaking assessments through female staff accessing them and identifying their needs.
The focus of the present intervention will be on reaching as well vulnerable groups of individuals, such as trauma victims, extremely vulnerable women, women and children at risk, disabled, etc. Access to women and children with special needs will be pursued to identify, support and strengthen the coping mechanisms that beneficiaries often create to protect themselves against threats to their safety and dignity, and also foster beneficiaries' self-esteem and development of skills. Participation of beneficiaries will also ensure that the proposed intervention is appropriate and effective.
INTERSOS staff will receive extensive training in code of conduct, protection, CP, GBV, PSS/PFA to ensure they acquire extensive technical skills and knowledge. The project staff will be encouraged to provide beneficiaries with the opportunity to raise any concerns, also through the establishment and implementation of a complaint mechanism. Since the project includes individual case management, confidentiality and safety of the survivor/individual case will at all times be prioritized. Especially for the GBV survivors the context is complex and reporting will not immediately lead to prosecution of the perpetrators. Meaningful access will be granted through community outreach and volunteers accessing the community and referring the case to the mobile protection teams, further combined with identification and mapping of local actors and sensitizing communities on services and options available at community level, while capacitating community based organizations to have better known, accessible and qualitative services available.
CHWs and COVs will be working in strategic locations to facilitate and guarantee appropriate support also for those beneficiaries hard to reach, ensuring access and referral to essential protection services, PSS and ad hoc emergency assistance based on the different needs and vulnerabilities.
Training includes also attention for protection and GBV/VAW/CP mainstreaming, ensuring relevant and timely identification of survivors and appropriate referral to relevant service providers per referral pathways and PSFA.
Moreover the project provides for GBV and protection mainstreaming, BARAN medical teams (staff and volunteers) will be trained in PSS/PSFA as critical elements in the package of essential life-saving health-care services, also trained in case identification, referral and confidentiality and consent as core protection principles, and provided with information on available referral pathways.

Country Specific Information

Safety and Security

Regardless of the extremely complex situation and environment, INTERSOS has maintained its presence in Afghanistan since 2001, including expats, and managed to implement projects in response to the growing humanitarian needs of IDPs, refugees and returnees and host communities. Based on an understanding of Duty of Care, INTERSOS policy requires that all operations demonstrate an appreciation of the threats, vulnerabilities and risks faced by the organization/mission. Furthermore INTERSOS is required, in meeting its Duty of Care responsibilities, to be able to demonstrate how identified threats are mitigated and where required contingency plans are in place, tested and rehearsed. For the above, INTERSOS has developed a standard format called Contingency Planning Process (CPP) which contains an analysis of the risk management processes INTERSOS is undertaking for Afghanistan. Kandahar Province presents several constraints in term of security: the security situation within the surrounding districts of Kandahar city is volatile, with various power brokers vying for control and dominance. The key actors operating within these districts are the Afghan National Security Forces (ANSF), the International Military Forces (IMF), Armed Opposition Groups (AOG), specifically the IEA, and Armed Criminal Groups (ACG) largely involved with opium drug trade. INTERSOS evaluates that working in the selected districts is permissible, despite being currently disputed and with limited ANSF/GoA control in the rural areas: gaining local community acceptance and engaging with local interlocutors/power brokers have been the preliminary mitigation measures INTERSOS has put in place since mid-2016 when it decided to re-establish its operation in the Province and thank to the partnership with a national NGO with proven enhanced access to remote and white areas in the Province. Arghistan is 2-hour drive from Kandahar city: the road until the district HQ is good, but in other areas roads are bad and winter becomes muddy to travel. About 75% of the district is considered white areas. Khakrez is 2 and half hour drive. Currently the main road is blocked, by detour and it takes 4 hours. 80% white. Shah Wali Kot is one and half hour drive from Kandahar. 80% white. Currently 50% of all incidents reported in this province in the last month are from Shah Wali Kot and Khakrez.
A strong and always updated country security analysis together with INTERSOS standard mission's security tools (CPPs, Security Plans, Communication Trees, Evacuation Plans) will always be provided to any staff who will be deployed in the country (both national and international). INTERSOS premises are always to be furnished and equipped with adequate security minimum standard structures (adequate fenced perimeters walls, safety rooms, pedestrian entry check rooms, etc.). Basic security and safety training for new staff and refreshment on security management for all expat staff deployed in Afghanistan will be regularly undertaken and in any case foreseen prior to deployment in the country. During selection process for expat staff to be deployed in the country, previous experience in fragile and volatile contexts should be assessed and considered as a pre-condition together with solid knowledge on basic security rules and regulations. With the use of mobile phone and satellite phone technology, staff movement can be tracked from the call centre currently contracted out to '24/7'. INTERSOS is also exploring GPS tracking devices for staff and vehicles (which can be carefully concealed while traveling through sensitive regions) which would give real time locations to the Kabul office. INTERSOS plans as well to establish an early warning system through key informants located in the target districts, particularly white areas, who will remain in constant contact with INTERSOS security adviser based in Kandahar in order to obtain first-hand information on displacement movement.

Access

There are certain procedures organizations can employ to improve access. Building strong relationships with key government ministries, beneficiary communities and anti-government AOGs operating in the beneficiary-catchment areas will improve access, promote mutual understanding and reinforce INTERSOS's neutrality. INTERSOS is currently implementing a similar program in some other hard to reach districts of the Province: strategy to gain humanitarian access to the target areas of the present project will follow a similar pattern INTERSOS has used for other programs in Kandahar: introduction to the local authorities at district level by BARAN, so that access to HFs is ensured. Strong initial community mobilization by INTERSOS senior staff is then conducted prior to any staff deployment or activity implementation in order to meet community leaders, shuras, NSAs in target villages and properly present the organization's profile, mandate, objective and go deeper in the specific project activities to avoid false expectations and misunderstanding. The present project is also to be implemented in white areas under full control of AOGs and INTERSOS has already initiated dialogue and discussion over access with the relevant key informal military leaders. Consistency with humanitarian principle, impartiality in particular, is ensured by the fact that the mobile teams comprising health and protection activities will be able to serve villages not under government control where humanitarian needs are deemed to exceed those identified in areas under government control.
Access will be sought in different ways, namely:
• Strong profile management will be implemented in order to establish active engagement with local partners for assessment, collection of up-to-date information, and analysis;
• Selective staff will be deployed to the areas of operation, thus taking into account ethnic, communal, and local considerations in the areas where the intervention will be implemented;
• Coordination and liaison with relevant stakeholders, including OCHA, networks and mechanisms will be pursued and maintained in order to ensure principled humanitarian action and provision of basic services to conflict-affected populations in the areas of operation.
During the past months INTERSOS has already started accessing the target districts in Kandahar in the framework of the multi-sector program which is currently carried out and sensitization with the local communities and other stakeholders has been initiated over INTERSOS profile, mandate and objectives and activities to be carried out therefore INTERSOS is positive in having gained acceptance from the local community. A key component for good access in the southern region is the quality of delivery and NGO's who fail to deliver or clearly demonstrate the benefits of the programme could potentially run into problems with access. NGO's that produce high quality programming with clear benefits and have strong messaging of neutrality will likely find it easier to expand into further areas based on a strong reputation and a clear perceived benefit to communities. INTERSOS will also work closely with other humanitarian actors who have gained positive reputations in the region to help achieve access through endorsement. Priority of access will be the main focus in the early stages of project implementation to ensure programme delivery throughout the project period and potential for expansion in to other districts over the next year.

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	Project Manager	D	1	5,500.00	9	100.00	49,500.00
	1 international staff, based in Kandahar, with full managerial and technical responsibility, charged of the implementation of the project, including procurement, selection of staff, performance monitoring and financial supervision of expenditures against target activities. He/she will support training and will supervise all the activities in the field locations. He/she is responsible of regular donor reporting and attends technical coordination meetings. The monthly cost of the PM includes the gross salary, taxes and the life and health insurance. 1 international project manager @ 5,500 USD/month for 9 months, 100% dedicated to the project.						
1.2	Contribution to Head of Mission	S	1	6,000.00	9	11.12	6,004.80

	"The Head of Mission is an International staff based in Kabul, roving over the mission, including to Kandahar. Represents INTERSOS in the country and coordinates the entire mission, having the responsibility for the achievement of all projects objectives. Liaises with donors and all other implementation partners. S/he works closely with Project Managers and the Country Admin-Finance Officer. Guarantees a constant support in the implementation of every single project and s/he will be travelling to the fields locations, when security allow it. 1 head of mission @ 6000 USD/month for 9 months, 11% dedicated to the project. "						
1.3	Contribution to Country Finance Officer	S	1	5,500.00	9	11.12	5,504.40
	The Country Finance Officer is an International Staff based in Kabul. Senior humanitarian financing expert, will ensure supervision of the aspects of accounting of expenditures and budget reporting, with regular travel in the country. 1 CFO @ 5,500 USD/month for 9 months, 11% dedicated to the project						
1.4	Medical Coordinator	D	1	1,200.00	9	100.00	10,800.00
	National staff, Medical Doctor expert in health project coordination, supervision of activities in 4 districts. 1 coordinator @ 1.200 US$/month for 9 months - 100%.						
1.5	Pharmacist	D	1	500.00	9	100.00	4,500.00
	Pharmacist responsible for drug/medical equipment and supply stock movement, dispensing and compile the drugs consumption reports from teams and reporting to the health supervisor the forecast, utilizing drug reports. National staff, Pharmacist @ 500 US $/month for 9 months - 100%.						
1.6	Medical Doctor for Mobile Teams	D	3	600.00	8	100.00	14,400.00
	National staff, Medical Doctor for implementation of mobile team activities. 3 MDs @ 600 US$/month for 8 months - 100%.						
1.7	Midwife for Mobile Teams	D	3	450.00	8	100.00	10,800.00
	National staff, Midwife for implementation of mobile team activities. 3 MWs @ 450 US$/month for 8 months - 100%.						
1.8	Nurses for Mobile Teams	D	3	300.00	8	100.00	7,200.00
	National staff, Nurses for implementation of mobile team activities. 3 nurses @ 300 US$/month for 8 months - 100%.						
1.9	Midwife for HFs	D	8	450.00	8	100.00	28,800.00
	National staff, Midwife for implementation of RH activities in HFs. 8 MWs @ 450 US$/month for 8 months - 100%.						
1.10	Nurses for HFs	D	8	300.00	8	100.00	19,200.00
	National staff, Nurses for implementation of RH activities in HFs. 8 nurses @ 300 US$/month for 8 months - 100%.						
1.11	Nurses for FATP	D	4	300.00	8	100.00	9,600.00
	National staff, Nurses for implementation of FATP. 4 nurses @ 300 US$/month for 8 months - 100%.						
1.12	Guards for FATP	D	2	150.00	8	100.00	2,400.00
	National staff, guards for implementation of FATP. 2 guards @ 150 US$/month for 8 months - 100%.						
1.13	Protection Officer	D	1	1,200.00	9	100.00	10,800.00
	"The Protection Officer is a national staff based in Kandahar, with regular visits to the field, supervising and coaching the protection outreach teams. S/he is responsible for the field coordination, including field deployment, protection activities, community based protection networks and referral mechanism. Reports to the Project Manager and supervises directly the protection monitors, social workers, outreach volunteers. 1 Protection Officer @ 1,200 USD/month each for 9 months, 100% dedicated to the project *"*						
1.14	Social worker	D	6	600.00	8	100.00	28,800.00
	"Social workers perform individual case management services (PSFA, PSC, referral and follow-up) for identified most vulnerable cases (GBV and PwSN) and conduct awareness sessions for men, women, girls and boys, and community leaders on protection related topics. They work in teams of 2 with the mobile teams, work closely with local associations/civil society and conduct home visits, follow-up on individual cases, receive referred cases from protection monitors, other projects and other organisations/actors. 6 social workers @ 600 USD/month each for 8 months, 100% dedicated to the project. "						
1.15	PSS councelor	D	3	700.00	8	100.00	16,800.00

	"The PSS councellors are national staff based based in the targeted areas. S/he is in charge of the provision of the case management services, including psychological first aid and referral, provision of emotional support,. The PSS councellor ensures the monitoring and follow up of identified cases in need of protection and works in synergy with the social worker. 3 PSS councellors @ 700 USD/month each for 8 months, 100% dedicated to the project. *"*						
1.16	Legal cousellor	D	3	800.00	8	100.00	19,200.00
	"Legal counselors will provide legal counseling and mediation in support of the case management team. The legal counselors report to the protection officer. 3 legal counselors @ 800 USD/month each for 8 months, 100% dedicated to the project. "						
1.17	Psychologist	D	3	1,200.00	8	100.00	28,800.00
	"The Psychologists are national staff based in targeted areas. S/he assesses, identifies and provides emotional and psychological support to identified cases, including GBV. She/he assesses and facilitates emergency referral; trains and supervises case managers and front line workers in the provision of psychological first aid with special attention to safeguard the ""do no harm"" rule. 3 psychologists @1.200 USD/month each for 8 months. 100% dedicated to the project "						
1.18	Reporting officer	D	1	800.00	8	100.00	6,400.00
	"The reporting officer is based in Kandahar and receives and compiles weekly and monthly reports from the field teams/per district, submitting these reports to protection officer and project manager. 1 reporting officer @ 800 USD/months each for 8 months, 100% dedicated to the project. *"*						
1.19	Engineer for WASH activities	D	1	1,200.00	5	100.00	6,000.00
	"The engineer is responsible for the implementation of the hard WASH rehabilitation at HFs. 1 engineer @ 1,200 USD/months each for 5 months, 100% dedicated to the project. *"*						
1.20	Hygiene Promoters	D	6	400.00	5	100.00	12,000.00
	6 HPs responsible to conduct WASH awareness campaign @ 400 USD for 5 months. 100%						
1.21	Contribution to Logistician	S	1	700.00	9	11.00	693.00
	The logistician support the project team with procurement, organisation of movements, operational support to the offices, etc. For the logisitician the monthly cost includes the salary, the social insurance, the life insurance and the governmental taxes. 1 Logistician @ 700 USD/month for 9 months, 11% dedicated to the project.						
1.22	Contribution to Assistant admin/finance	S	1	1,000.00	9	11.00	990.00
	"Based in Kandahar, supports the Country Admin Finance Officer and the Project Manager by ensuring correct bookkeeping and filing of receipts and project files and other clerical duties. The salary monthly cost includes the salary, the social insurance, the life insurance and the governmental taxes. 1 Assistant Admin/Finance @ 1,000 USD/month for 9 months, 11% dedicated to the project. *"*						
1.23	Contribution to Security Officer	S	1	2,000.00	9	11.00	1,980.00
	"The security officer is a national staff in charge of collecting constant information on the security situation and facilitating safe access to the target areas. Salary monthly cost includes the salary, the social insurance, the life insurance and the governmental taxes. 1 Security Officer @ 2,000 USD/month for 9 months, 11% dedicated to the project *"*						
1.24	Contribution to Office Guards	S	4	400.00	9	11.00	1,584.00
	INTERSOS contracts per base/office 4 guards, roving and securing a 24/7 Office guards service. 6 guards @ 400 USD/month for 9 months, 11% dedicated to the project.						
1.25	Contribution to Office Cleaner	S	1	300.00	9	11.00	297.00
	INTERSOS contracts per base/office 1 clearer for cleaning and housekeeping. 1 cleaner @ 300 USD/month for 9 months, 11% dedicated to the project.						
	Section Total						**303,053.20**

2. Supplies, Commodities, Materials							
2.1	Integrated FATP in CHC	D	6	11,435.00	1	100.00	68,610.00
	Cost for Non medical supplies and medical equipment for integrated FATP in CHCs						
2.2	Equipment and supplies for FATP	D	1	1,176.00	1	100.00	1,176.00
	Cost for equipment and medical supplies for FATP						
2.3	Medical drugs for FATP	D	1	350.00	8	100.00	2,800.00
	Cost for medical drugs for FATP						
2.4	First aid kits for CHWs	D	222	30.00	1	100.00	6,660.00
	CHW kits including first aid supplies and symptomatic, palliative basic referral treatments to be provided by CHWs. The full kit comes with bag plus items non consumable. Previous bags will be replenished.						
2.5	First aid kits for community members attending CBFA training	D	992	30.00	1	100.00	29,760.00
	Kits including first aid supplies and symptomatic, palliative basic referral treatments to be provided by CHWs. The full kit comes with bag plus items non consumable. Previous bags will be replenished.						
2.6	Training in BLS, ALS, ATLS and ToT for 18 MD, 30 MWs and 21 Nurses, 15 Vaccinators	D	69	15.00	12	100.00	12,420.00
	3 days for BLS, 3 days each for ALS, ATLS and ToT courses for a total 12 days of 3 hours theory plus 3 hours practice daily i.e. 6x12= 72 hours of training. All costs included, transportation per diem teaching material, 15 USD/ day						
2.7	BLS training for CHSs	D	10	15.00	9	100.00	1,350.00
	general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days) plus Training of Trainers (ToT) (3 days) courses. Total 9 days of training, 6 hours daily (3 theory + 3 practice) i.e. 54 hours of training .						
2.8	BLS training for CHWs	D	222	10.00	6	100.00	13,320.00
	The training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days). Total 3 days of training, 6 hours daily i.e. 18 hours of training. All costs included, transportation per diem teaching material, 10USD/ day						
2.9	Training/refreshment for CHWs and CHSs of 3 districts	D	134	10.00	5	100.00	6,700.00
	Training on community mobilization, basics of post-traumatic counselling, GBV prevention and response, ensuring relevant and timely identification of survivors and appropriate referral to relevant service providers per referral pathways and PSFA. For health education messaging special attention will be given for PLW, pre and post-natal care, including the importance of ANC and PNC, breastfeeding, and tetanus vaccination and safe delivery. 94 CHWs already present + 30 new CHWs. 7 CHSs already present + 3 CHSs new.						
2.10	Training for mobile team medical staff and HFs medical staff	D	69	10.00	6	100.00	4,140.00
	IMCI (integrate management of childhood Illness) and Emergency obstetric and newborn care (EmONC), family planning (FP)						
2.11	BEmONC ToT to CHSs	D	10	10.00	5	100.00	500.00
	Pregnancy Control and Safe Motherhood, Antenatal and Post Natal Care practices, GBV prevention and identification and referral procedures, Early recognition of pregnancy at risk and referral procedures, Triage and Stabilization / Referral of Obstetric Emergencies (5 days of training 6 hours daily 50/50% theory and practice).						
2.12	Medical equipment for Mobile Teams	D	3	3,116.00	1	100.00	9,348.00
	Cost for medical equipment for Mobile Teams						
2.13	Medical drugs for Mobile Teams	D	3	850.00	8	100.00	20,400.00
	Costs for medical drugs for Mobile Teams						
2.14	Health awareness session	D	9920	0.25	1	100.00	2,480.00
	0,25 US$ per day per person for refreshments						
2.15	Health Education material	D	1	200.00	8	100.00	1,600.00

	HE material in form of illustrated pamphlets containing the Health RH messages relevant for CBAWs and PLWs as explained in the HE sessions will be procured and distributed. Expected production # 10,000 pamphlets						
2.16	Baby kits for most vulnerable cases (500)	D	500	20.00	1	100.00	10,000.00
	500 baby kits for most vulnerable women visiting HFs. Each kit include: diapers, wipes, hand sanitizer, blanket, baby lotion, soap and shampoo, tower and bag.						
2.17	Training on PSS-related concepts and approaches to community leaders, urban committees and community members	D	171	10.00	4	100.00	6,840.00
	171 persons (50% men & 50% women) > 6 social workers, 9 mobile health team staff, 3 psychologists, 3 legal counsellors, min. 30 local community leaders per targeted district (90), and 60 community outreach volunteers. These trainings will be conducted per district. The trainings will be conducted in Pashto by qualified trainers, taking 4 days per training.						
2.18	Awarnesss session on protection issues (basic material, stationary, etc.)	D	192	30.00	1	100.00	5,760.00
	"192 sessions will be conducted for 3.840 (30% children, 35% women and 35% men): 2 sessions x week x 4 weeks x 8 months x 20 persons per session x 3 teams = 3.840 individuals. Estimated 10 USD for stationary and printing and 20 USD of refreshment for participants. *"*						
2.19	Collective PSS sessions - support groups (material)	D	96	20.00	1	100.00	1,920.00
	96 sessions (4 session x 3 teams x 8 months)						
2.20	Material assistance for most vulnerable women at risk	D	200	100.00	1	100.00	20,000.00
	Ad hoc, case by case, material support will be provided to the 200 most vulnerable cases provided with individual case management services for a maximum cost of 100USD/case. The amount will be based on need assessment and could cover urgent need for NFIs or urgent transportation cost for medical treatment.						
2.21	Monthly meetings for outreach volunteers - per district	D	60	10.00	8	100.00	4,800.00
	"In order to ensure coordination/exposure/exchange/joint analysis/refreshers information on certain topics, INTERSOS will organised every month for each district a meeting that brings together all the COVs. The volunteers will be provided with an small incentive to ensure their movement and other related expenses are covered, while assuring attendance of the respective meetings. *"*						
2.22	Airtime	D	23	15.00	9	100.00	3,105.00
	"Monthly 15 USD GSM network scratch card to be given to each recipient of the mobile phones. 23 is the number of DIRECT staff eligible to receive mobile scretch cards on monthly basis based on internal Airtime policy. Communication cost for indirect staff is included under support cost - per contribution. *"*						
2.23	Stationary	D	3	100.00	8	100.00	2,400.00
	Stationary cover costs of folders, notebooks, pens, etc. and printing of training material and monthly needs of each mobile team. Each district/team is expected to require a maximum of 100 US$ per month of activities = 8 x100 USD.						
	Section Total						**236,089.00**
3. Equipment							
3.1	Office equipment (5 laptops, 1 printer, 1 projector)	D	7	530.00	1	100.00	3,710.00
	Office equipment (5 laptops, 1 printer, 1 projector)						
	Section Total						**3,710.00**
4. Contractual Services							
4.1	Vehicle rental & fuel - Supervision and Monitoring, with driver	D	1	800.00	9	100.00	7,200.00
	Monthly rental of vehicle for supervision and monitoring activities (5 doors car), including insurance, fuel, lubricants and maintenance cost.						
4.2	Van rental & fuel - Mobile health + protection teams, with driver	D	3	1,400.00	8	100.00	33,600.00

	Monthly rental of van for outreach health and protection activities, including insurance, fuel, lubricants and maintenance cost. A van is preferred to a normal vehicle considering that the van will be able to host both the medical and the protection teams which are moving to the filed together.						
4.3	Transportation of goods - kits and equipments	D	1	2,100.00	1	100.00	2,100.00
	"Lumpsum foreseen for the transportation between district centres/provincial capital for kits and equipment: use of trucks and pick-ups per service contract with transportation service providers. Estimated 3 trips to 3 districts for 700 USD each. *"*						
4.4	WASH rehabilitation works in HFs	D	4	5,000.00	1	100.00	20,000.00
	Cost for rehabilitation of WASH facilities in the target HFs including latrines and bath facilities, waste management, rehabilitation or construction of incinerator and placenta pit. The rehabilitation works will be delivered by private contractors, hired locally, per bid analysis procurement process.						
	Section Total						**62,900.00**
5. Travel							
5.1	Staff travel cost for monitoring, reporting or trainings	S	2	150.00	9	100.00	2,700.00
	Internal flight Kandahar-Kabul, round trip: 2 round trip/month at 150 USD p/trip for 9 months.						
5.2	Per diem for staff in monitoring missions	S	4	20.00	8	100.00	640.00
	*Travels Kabul-Kandahar for supervision and coordination purpose (per diem): 8 months * 2 days * 2 key staff X 20 US$ per day.*						
5.3	Transportation costs for Protection Teams	S	3	150.00	8	100.00	3,600.00
	While normally the social workers and case managers will be moving with the vehicle of the mobile teams, the will be instances where the protection personnel will be required to move with taxis in order to attend and assist urgently those protection cases not present in the span of the movement plan for the mobile teams. This will require extra transpiration cost to be covered. It is estimated that 3 teams operating over 8 months will require minimum 1 such intervention per week, further also adding the coverage of the transportation cost for referral actors to attend the cases in remote areas. The estimation is on average a cost of 150 US$ per month per team.						
5.4	Transportation allowance for community health workers (CHWs)	D	30	20.00	9	100.00	5,400.00
	CHWs work as volunteer. INTERSOS will support 30 new CHWs with reimboursement for transportation costs for 20 US$ per month per CHW.						
5.5	Transportation allowance for community health supervisor (CHSs)	D	3	20.00	9	100.00	540.00
	CHSs work as volunteer. INTERSOS will support 3 new CHSs with reimboursement for transportation costs for 20 US$ per month per CHS.						
5.6	Transportation allowance for community outreach volunteers (COVs)	D	60	20.00	8	100.00	9,600.00
	60 COVs will receive reimboursement for transportation costs for 20 US$ per month. They will be in charge of supporting identification of vulnerable individuals and protection awareness.						
	Section Total						**22,480.00**
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	Contribution to office running costs & utilities - Kandahar and Kabul	S	2	500.00	9	22.00	1,980.00
	"Represent the monthly average cost for stationary and utilities. 500 US$ per month per office: Stationary and small equipment of 150 US$ per month, 100 US$ water/electricity bills, 100 US$ cleaning materials, 100 US$ refreshments and 50US$ office maintenance. INTERSOS requests 22% contribution. "						
7.2	Contribution to office furniture/equipment & maintenance - Kandahar and Kabul	S	2	1,000.00	1	100.00	2,000.00

	Includes office desks, chairs, small furniture/equipment maintenance and replacement of parts will also be covered under this budget line: furniture is 500 US$ per office, while maintenance of office furniture or equipment/structure is 500 US$ per office - lumpsum each per office.						
7.3	Contribution to office Rental - Kandahar and Kabul	S	2	1,250.00	9	22.00	4,950.00
	Contribution to office rent in Kandahar and Kabul for 1250 US$ per month per office - cost share is 25% or contribution for 2 months for each office.						
7.4	Contribution to communication costs	S	2	500.00	9	22.00	1,980.00
	"It is the monthly average cost for the internet connection and communication costs for office support staff. INTERSOS requires22% contribution for each office or equal to 2 months for each office. *"*						
7.5	Bank & transfer fees	S	1	50.00	9	100.00	450.00
	"Bank & transfer fees - 50 US$ per month for transfer/bank cost related to project account and project payments. *"*						
7.6	Security management	S	1	3,000.00	1	100.00	3,000.00
	This budget line encompasses several risk and security management measures which include, but are not limited to, the improvement of the security set-up of the office. 3.000 US$ for office security, safety and power supply upgrades for communication.						
7.7	Generator (fuel and maintenance)	S	2	400.00	9	22.00	1,584.00
	"Fuel and lubricants and maintenance for generators for 2 offices : calculation per fuel log sheet consumption in 2016. *"*						
	Section Total						**15,944.00**
SubTotal			13,106.00				**644,176.20**
Direct							604,239.00
Support							39,937.20
PSC Cost							
PSC Cost Percent							7.00
PSC Amount							45,092.33
Total Cost							**689,268.53**

Project Locations

Location	Estimated percentage of budget for each location	Estimated number of beneficiaries for each location					Activity Name
		Men	Women	Boys	Girls	Total	
Kandahar -> Shahwalikot	30	4,038	7,382	1,254	1,254	13,928	Activity 1.1.1 : The project will procure and preposition emergency trauma and health kits for 1 FATP and 6 basic trauma points in 6 CHCs in Arghistan, Maywand , Khakrez and Shah Wali Kot districts: - Procure and preposition medical supplies and equipment for integrated FATP in 6 CHDs; - Procure and distribute first aid kits for CHWs (total of 222 CHWs > 192 already present + 30 new) & replenish regularly these kits (222 kits & 222 replenishment); - Procure and distribute first aid kits for community trained in First Aid & replenish regularly these kits (992 kits & 992

replenishment).

Activity 1.1.1 : INTERSOS will conduct small rehabilitations for 4 HFs in Arghistan (2) and Khakrez (2) per needs established and assessed with DoPH/BARAN. Please, find attached estimated BoQ for WASH rehabilitation works (latrines and bath facilities,waste management). Please note that based on consultation with WHO in Kandahar, HFs in Shah Wali Kot won't be targeted with WASH rehabilitation since WHO has already committed funds for this intervention.

The infrastructure rehabilitation of health facilities will also ensure that safe water is available (water pumping, storing and treatment). For waste management at health facilities, the rehabilitation/maintenance of infrastructure will seek to include segregation of waste (solid waste, hazardous waste (needles, knives, glass) and biological waste) (possibility to color code for segregation will be explored), including specific training about waste management system, and infections preventions. Infrastructural works include the rehabilitation or construction of incinerator and placenta pit. Please find attached the proposed design.

The rehabilitation works will be delivered by private contractors, hired locally, per bid analysis procurement process.
The financial contribution will on average not be more than 5.000 US$ for these rehabilitations.

Activity 1.1.1 : INTERSOS will activate set of 2 trained social workers (1 men and 1 women) and 1 PSS counselor per mobile team for a total of 6 social workers and 3 PSS counsellors in Arghistan, Khakrez and Shah Wali Kot districts.

For the qualifications of the social workers please find in annex the relevant TOR/job descriptions as will be published for staff recruitment.
Social workers provide for PSFA (psycho-social first aid) services and PSS (psycho-social support) – individual case management, including case referral (internal and external) and organize for collective PSS, mainly for women and children (especially in case of major protection risks being identified – gender and age disaggregated). Where PSFA is on the spot and mostly one time, PSS is part of a follow-up process.
However psychological counseling (PC) will only be done by dedicated psychologists – 1 referral psychologist per mobile team will be included in the team.
For the qualifications of these psychologists please find in annex the relevant TOR/job descriptions as will be published for staff recruitment.

INTERSOS protection team will be trained on case management steps and tools in line with SOPs, which will be shared by the Clusters. These include: identification, case assessment, designing of a case plan for each single individual (agreed in case meetings between trained Social Worker and Protection Officer), regular follow-ups, review of the case plan and closure in accordance with pre-established conditions. Upon identification of vulnerable women, men, girls and boys, the social workers will closely follow up, review and monitor the psychosocial progress of each individual.

INTERSOS will also seek to identify and activate a network of community outreach volunteers (20 COVs per district) to ensure identification and referral of individual cases to the social workers. COVs will also work on organizing community awareness sessions, community groups & collective PSS sessions: total of 60 COVs will be

trained and actively contributing to the implementation of the protection activities, in particular ensuring community mobilization, engagement and acceptance, in addition to case identification, internal referral for assessment and case management and support case follow-up. Also protection concepts will be approached and explained (where possible) through Afghan Islamic interpretations to ensure a greater by-in. It will be made clear that protection principles are not contradicting with Islam but rather are in line with each other.
Activity 1.1.2 : Provision of case management services for individual protection cases (GBV and PwSN).
Individual protection cases will be identified by different means: internal referral from mainly health activities, external referral by community outreach volunteers, community groups and local organizations, self-referral by cases, from other humanitarian actors. The social workers will ensure to dedicate time for PSFA and PSS and suggest the cases for internal (including for further psychological counseling by dedicated psychologist and legal counselling by dedicated lawyer) or external referrals. For all cases full consent and confidentiality will be guaranteed by the teams: basic sessions on how to ensure confidentiality, including of data, will be provided to all INTERSOS team at inception phase. INTERSOS will contract per district 1 legal counselor to provide for legal counselling mainly on information sharing/legal awareness/advice, and mediation mainly for GBV and PwSN cases. Moreover, per district, INTERSOS will seek to identify the availability of a psychologist in case of more complex cases in need of further counseling and follow-up. The focus for these roles and positions will be on female staff, as it is expected that female beneficiaries will make the majority of cases. Upon identification of vulnerable women, men, girls and boys, all the cases will have initial one-time assessment and will be provided with PSFA. Case Managers and Social Workers will closely follow up, review and monitor the psychosocial progress of each individual. PSS approach will include both individual and group activities, according to the single person's needs and case plan. An established mechanism of internal and external referral will be put in place and used whenever it is needed, with a consequent follow up in order to guarantee the provision of the service required and to monitor the impact of the service on the well-being of the person. Regular review of case plan, in case meetings within Social Workers, Case Managers and Protection Officer and evaluation of psychosocial well-being of beneficiaries receiving PSS services will be conducted in order to monitor progress on the psycho-social conditions of the cases. Upon positive results, the protection staff involved can proceed with the case closure. Identified GBV cases, as part of case management, will receive dignity kit in-kind from UNFPA (agreement with UNFPA to be developed upon approval of the present project), while the most vulnerable cases, according to given criteria, will also be provided with material assistance to cover basic needs. Referral to HFs and legal aid will be part of the package. The cases in need of follow-up will be provided with schedule as per the rotation of the mobile team (each location will be visited about every month for 2 to 3 time max). If the case also requires psychological counseling, s/he will be referred to the psychologist for sessions as per need. The social workers and psychologists can meet the cases in their homes but will also identify safe spaces where they could meet in a more confidential manner – in collaboration with local associations – where needed. Cases will receive individual follow-up till closure. The well-being and safety of the case

will always be prioritized. It is estimated that each social worker will have no more than 30 open cases at the same time. It is important to have ASAP clear referral maps in place and ensure these referrals are conducted well and appropriately. Gender perspective is ensured by trained female Staff, in order to guarantee free and protected access of vulnerable women and girls to the services available. Female Staff will be mainstreamed in all services available, including PSS consultations and information dissemination on health services. Male members from the staff will also be trained on basic principles of gender equality. Internal and external referrals will be organized per developed service mapping.
Activity 1.1.2 : 6 Hygiene Promoters (HPs) (2 per district) will work in pairs with CHWs or COVs (there will always be 1 men and 1 women) and each team will conduct each:
8 months x 4 weeks/month x 3 days/week x 3 teams = 288 sessions each with 20 participants for a total of 5.760 beneficiaries
Please note that in the total beneficiary calculation these beneficiaries will not be double counted.

The teams will use IEC materials for hygiene promotion (leaflet, posters, and demonstration kits for hand washing) that will be adapted to the context and literacy level of the target groups. This activity will be starting by month 2 of the project, when all other activities and staff have been recruited, ensuring a good complementarity and integration of HP with the other sectors/activities, continuing for 8 months.

Hygiene promotion session will aim to provide information on hygiene-related risks and preventive actions, such as promoting hand-washing, awareness on waterborne disease and water boiling and safe water storage and handling and hygiene behavioral change.

Awareness sessions will be conducted for different target groups. Education and communication are important components of hygiene promotion. All people have a right to know about the relationship between water, sanitation, hygiene, health and nutrition of themselves and their families. However, education alone does not necessarily result in improved practices. Knowing about the causes of disease may help, but new hygiene practices may be too unfamiliar, too difficult, or conditional on other aspect (such as access to water), especially for poor people, including displaced.

Promoting behavioral change is a gradual process that involves working closely with communities, studying existing beliefs, defining motivation strategies, designing appropriate communication tools (pictograms, posters, and practical sessions) and finally encouraging practical steps towards positive practices (establishment of WASH committees is one of these steps).
Communities will be fully engaged in the process at all stages using participatory processes, and special attention should be given to building on local knowledge and promoting existing positive traditional practices. As such the hygiene promotion will combine info sharing and community mobilization, linked to the provision of essential services.

Topics will include among others: hand-washing, personal hygiene (including for mother and child for Pregnant and Lactating Women), general session on relation WASH and health (clean water, water boiling and safe water storage and handling and clean sanitation facilities), environmental health and waste management. A

KAP survey will be conducted at the beginning of the awareness sessions to draw the baseline and the final survey at the end of the campaign to measure behaviour change.

Activity 1.1.2 : Health facility staff, CHWs and community members are trained in BLS and management of trauma patients:

The existing network of CHWs will be strengthened to meet the emergency needs of the communities and HFs' capacity/attention for trauma care services will be enhanced through cascade training by trained emergency medical doctors and nurses for outreach services and HFs:

HFs level:
i. Training in BLS, ALS, ATLS and ToT for 18 MD, 30 MWs and 21 Nurses: 3 days for BLS, 3 days each for ALS, ATLS and ToT courses for a total 12 days of 3 hours theory plus 3 hours practice daily i.e. 6x12= 108 hours of training. Basic PSFA training will be included in the training package for HFs medical staff by INTERSOS psychologists.

Outreach level:
ii. Cascade training from already trained emergency medical doctors and nurses (see above) to 10 CHSs (7 already present + 3 new). Training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days) plus Training of Trainers (ToT) (3 days) courses. Total 9 days of training, 6 hours daily (3 theory + 3 practice) i.e. 54 hours of training;
iii. Cascade training from the already trained 10 CHS (see above) to 222 CHWs. The training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days). Total 3 days of training, 6 hours daily i.e. 18 hours of training. During the project the health kits will be replenished of what was used;
iv. Follow up with monitoring, evaluation and counseling of the activity of the CHWs, CHSs and HFs medical staff.

Please note that PSFA training for CHSs and CHWs and GBV prevention and response training for both medical staff and outreach personnel is included in below outcome.

Certified health professionals (INTERSOS and MoH/BARAN) will conduct the relevant training.
Activity 1.1.3 : Community Based First Aid training for community members.

992 members of the target community, corresponding to the 10% of the individuals receiving health awareness sessions, will be selected for the CBFA training and will receive First Aid Kit. The activity will follow the model of CBHFA training of ARCS: the community approach applied for this activity is deemed extremely relevant given the remoteness of the area and the lack of First Aid Point. Training will be provided by trained medical staff and strict follow up by CHWs will ensure efficiency of the selected methodology.

Activity 1.1.3 : Collective PSS activities organized for most vulnerable population groups

at community level (CP, GBV and PwSN)

In addition to general awareness sessions on protection (see output below) the community outreach volunteers supported by the social workers will also organize more focused collective PSS sessions – i.e. support groups – for particular target groups, e.g. children engaged in child labour, widows, women at risk, unemployed men and youth, permitting them to share experiences and to discuss with the guidance of social workers on coping mechanisms and strategies (negative and positive):
- CP: child marriage, children recruited in armed groups, child labour, violence against children versus education, skill training, recreational activities, parents groups, role of school shura at community level, access to and information about available services, etc.
- GBV: child/forced marriage, deprivation of resources, domestic violence, sexual violence and exploitation versus gender equality, livelihoods and education opportunities, ensure engagement of men and women, access to and information about available services, etc.
- PwSN: disability, PLW, women at risk, chronically ill, mental health, elderly at risk and extreme poverty versus rights based approach, providing these disadvantaged groups with a platform to voice their concerns/needs/issues and provide for greater community support and acceptance, access to and information about available services, etc.

Such collective PSS session will provide a safe space for persons of concern to meet – gender and age disaggregated, exchange and also learn. In order to avoid stigmatization, the sessions will be organized as social gatherings with refreshments provided by INTERSOS: club model. So the topics and approaches in the sessions can vary depending on the target group (also age and gender considered) but the model will always be the same.
It is estimated that per month 4 such sessions will be organized per team, or in total 96 sessions (4 session x 3 teams x 8 months), for about 20 persons per session, reaching about 1.920 persons (30% children, 50% women and 20% men).

Community outreach volunteers are to be living within 500m from the targeted communities. 50% women and 50% IDPs, 20% returnees/30% host community - they support the INTERSOS protection team during the interventions, provide mobilization messages, protection promotion awareness, counselling and identify/refer the most vulnerable persons/HHs in need to the INTERSOS protection team. Selection of COVs will be conducted at village level with the consultation of shura members and village leaders to identify the most active and already engaged individuals within the community. COVs will participate to the training as per activity 1.1.4. Based on literacy level COVs will be provided with culturally-sensitive awareness material. COVs are provided with small monthly transportation allowance and phone credits, to incentivized their commitment, and are coordinated and supervised by the protection officer. There will be 60 Community Outreach Volunteers in total, in addition to community member and members of local civil society per district that will be encouraged to establish Community Based Protection Networks and regularly meet to discuss on protection and undertake coordinated action for prevention and response activities.
Activity 1.1.4 : Training on PSS-related concepts and approaches to community leaders, urban committees and community members

INTERSOS Protection Officer will provide training sessions to key community members within the targeted urban areas on definition of PSS, identification of vulnerable individuals, PSS approaches, sensitive communication techniques and community-based protection mechanisms, with the aim of increasing the capacity of the community to develop their own protective measures and establish mechanisms of self-reliance. Please find attached training CV. CHWs and CHSs will be as well trained in GBV protection and response and Protection concerns identification as mentioned in Activity 2.1.1 under Health sector.

171 persons (50% men & 50% women) > 6 social workers, 9 mobile health team staff, 3 psychologists, 3 legal counsellors, min. 30 local community leaders per targeted district (90), and 60 community outreach volunteers. These trainings will be conducted per district. The trainings will be conducted in Pashto by qualified trainers, taking 4 days per training.
Further on job-training and coaching will also be provided for INTERSOS staff with the support of the protection activity coordinator dedicated on the project.

Training will start from month 2 of the project.

Activity 1.1.5 : Awareness sessions for community members on protection related issues (CP, GBV and PwSN)

Awareness sessions on protection related issues will aim to enhance community understanding on right based approaches related to CP, GBV and PwSN, aimed at community protection (foremost protection but also response), contributing to better identification, prevention and response of protection concerns and violations. The outreach activities will target community leaders to promote and advocate rights. COVs will be organizing the session at community level, supported by social workers to facilitate the awareness sessions. Understanding the traditional nature of the communities that will be targeted and to ensure community acceptance and facilitation, these sessions will be integrated where possible with the health-nutrition-WASH awareness sessions (see above). Also protection concepts will be approached and explained (where possible) through Afghan Islamic interpretations to ensure a greater by-in. It will be made clear that protection principles are not contradicting with Islam but rather are in line with each other. Therefor it will be important to also work with key stakeholders such as Islamic teachers and religious leaders from those targeted communities. Considering the delicate nature of GBV issues, these will be tackled as part of overall protection and also linked to reproductive health issues (for example child marriage) & CP issues will be tackled by looking into the importance of education, access to knowledge and overall health of the child.
For PwSN (incl. PLW, women at risk, disabled, elderly persons at risk, extremely poor, mental health case and chronically ill cases), INTERSOS will spend sufficient time on the situation of disabled as this is a particular vulnerable group that is in need for recognition of their rights and for improved services and adapted assistance (as individual but also for their families).
192 sessions will be conducted for 3.840 (30% children, 35% women and 35% men): 2 sessions x week x 4 weeks x 8 months x 20 persons per session x 3 teams = 3.840 individuals.
Only 30% will be considered as NEW/ADDITIONAL beneficiaries on top of the

already reached people by other awareness session – so in the total beneficiary calculation, there will be no double counting.

Activity 2.1.1 : Training and deployment of medical staff and health workers for community mobilization, health education and PHC outreach services:

Outreach level:
Assure OUTREACH through support for already existing CHW teams linked to 8 HFs in Arghistan, Khakrez and Shah Wali Kot districts.
CHWs (in/from targeted communities) are normally already put in place by BARAN but there are gaps, therefore, INTERSOS will identify, and support additional new 30 CHWs (15 men and 15 women) and 3 new CHSs, in addition to the 94 CHWs and the 3 CHSs already operating in the three districts. Average of 62 teams of 2 CHWs (Mahram system) for a total of 124 CHWs (94 already present + 30 new).

All Trainings will be conducted in line with the guidelines of the BPHS, in cooperation with DoPH: 3 days of new training and 2 days of refresher training. CHWs and CHS (50% females) in the targeted districts are trained on community mobilization, basics of post-traumatic counselling, GBV prevention and response, ensuring relevant and timely identification of survivors and appropriate referral to relevant service providers per referral pathways and PSFA., receiving sensitization tools and CHWs health kits at the end of the training. For health education messaging special attention will be given for PLW, pre and post-natal care, including the importance of ANC and PNC, breastfeeding, and tetanus vaccination and safe delivery.

HFs level:
Also training for health staff in HFs is provided in IMCI (integrate management of childhood Illness) and Emergency obstetric and newborn care (EmONC), family planning (FP). Staff already trained will only do refreshment training, permitting immediate start-up and new staff will receive full training. Health professions (INTERSOS and PHD – and other actor relevant and interested) will benefit from training and coaching on health, protection and SGBV related topics, and PSFA.
Activity 2.1.2 : Compose/hire/operate 3 mobile teams to support the outreach capacity of the HFs for provision of RH services in Arghistan, Khakrez and Shah Wali Kot districts, mainly focusing on white areas where no other humanitarian organizations are present.

Mobile teams will complement the RH services at HF level (ANC/PNC/family planning).
9 trained dedicated health professionals in total – per team 1 GP, 1 midwife and 1 female nurse will be supported by the network of CHWs. Additionally, 2 social workers and 1 case manager will be part of each mobile team in charge of case management and protection monitoring. BARAN/DoH are not able to provide drugs or medical equipment for the mobile teams which will, therefore, procured directly by INTERSOS.

The training for the mobile team staff will be comprehensive on EPHC – Emergency Primary Health Care and the curriculum will include clinical management of childhood diseases (IMCI), maternal health, basic internal medicine and minor surgery, TRIAGE/BLS and emergency care.

Protection integration is ensured by the presence of two social workers for each team for the

identification of PWSN and case management of GBV survivors.
Moreover as part of protection mainstreaming the health professionals will also benefit from trainings and coaching on health, protection and SGBV related topics and psychosocial first aid (PSFA) for health professionals. The training will be conducted over a span of 9 days immediately after recruitment during the first month of the project.

The car of the mobile team will be a mini-bus or 4X4 that could be converted to BLS in case of emergency (delivery, casualty or critical SAM case) for immediate referral to the nearby HF or referral hospital, depending on the severity. Each CHC has an ambulance available but due to geographical coverage, distance and considering emergency, these ambulances are often not timely available or able to assist the case.

The mobile teams will be organized in coordination with BARAN/DOPH to ensure the best possible coverage of the gaps. The Mobile Team will rove 5 days per week visiting 1 or 2 locations per day, covering about 50 consultations per day.

Total number of consultancies (PHC – with focus on RH) is expected to be:
50 consultancies per day per team x 3 teams x 5 days per week x 4 weeks x 9 months = 27.000 consultations during the project duration.
The mobile team itself will have mostly attention for Mother and Child Health (MCH) (ANC/PNC/BEmONC) as such the bulk of the patients will be women and children > estimation of 70% women (WCBA – PLW), 20% children and about 10% men.
It is expected that the team also makes referrals to the HFs for further follow-up and for identified protection cases referrals to the social workers.
The mobile teams will be operating from the village health posts (village health rooms).
Activity 2.2.1 : Strengthened functional capacities of targeted HFs for the provision of maternity care and emergency obstetric care services (establish BEmONC at district level and strengthen CEmONC at referral level)

For all facilities (8):
(Performance based) Incentives for night shift midwifes available on call. 8 midwives will be trained at BEmONC standard level to staff the 8 HFs, in addition of the midwife already deployed by BARAN, when any. Additionally, activation of trusted taxis to be activated as BLS and to ensure safe travels a night for female midwifes is foreseen.

- Training by an experienced midwife to the CHSs incl. the following: Pregnancy Control and Safe Motherhood, Antenatal and Post Natal Care practices, GBV prevention and identification and referral procedures, Early recognition of pregnancy at risk and referral procedures, Triage and Stabilization / Referral of Obstetric Emergencies (5 days of training 6 hours daily 50/50% theory and practice).
- Cascade training from the already trained CHSs (see above) to CHWs. The training will include the same components as above i.e. Pregnancy Control and Safe Motherhood, Antenatal and Pre Natal Care practices, GBV prevention identification and referral procedures, Early recognition of pregnancy at risk and referral procedures, Triage and Stabilization / Referral of Obstetric Emergencies.
Activity 2.2.2 : Community health awareness sessions

Women in Childbearing age (WCBA) and Pregnant or Lactating Women (PLW) will receive

							health messages to improve the safety of their pregnancies and motherhood. CHWs at village level will contribute to the early recognition of pregnancy at risks giving appropriate counseling (e.g. just preventive move to temporary stay nearer to the HF BEmONC services – or CmONC in case of complications). The health awareness sessions will also provide information on the services available at HF and MC level and on the risk of late (self) referral for complications and negative long term consequences. Other topics will include: -sensitization about the importance of ANC and PNC; -sensitization about the importance of tetanus vaccination during and after pregnancy for mother and child to prevent neonatal tetanus. Awareness sessions will also include basic protection principles, gender related issues and services to refer to in case of survivors as victim of SGBV. Men will also be encouraged to participate to the awareness sessions on GBV prevention. Sessions will be conducted at the level of the health post when patients come to visit, but the CHWs will also be encouraged to conduct home visits and more general awareness sessions. In addition to individual (one on one) counseling, each team of CHWs will be expected to conduct a minimum of 1 awareness sessions for PLW/WCBA, including also for men/(future) fathers per month with a focus on Mother and Child Health (ANC/PNC and safe delivery). 62 teams (total of 124 CHW > 94 already present + 30 new) x 1 sessions per team per month X 8 months X 20 persons per session = 9.920 individuals to be reached (75% women and 25% men). High attention will be placed on prevention with the sessions by the CHWs to the women at community level. Activity 2.2.3 : Procurement for BEmONC and CEmONC: Procurement of RH and safe delivery kits - upon availability of UNFPA and UNICEF. HE material procurement and distribution: HE material in form of illustrated pamphlets containing the Health RH messages relevant for CBAWs and PLWs as explained in the HE sessions will be procured and distributed. Expected production # 10,000 pamphlets. Procurement of baby kits for most vulnerable cases (500): Such kits include: diapers, wipes, hand sanitizer, blanket, baby lotion, soap and shampoo, tower and bag.
Kandahar -> Khakrez	30	4,038	7,382	1,254	1,254	13,928	Activity 1.1.1 : The project will procure and preposition emergency trauma and health kits for 1 FATP and 6 basic trauma points in 6 CHCs in Arghistan, Maywand , Khakrez and Shah Wali Kot districts: - Procure and preposition medical supplies and equipment for integrated FATP in 6 CHDs; - Procure and distribute first aid kits for CHWs (total of 222 CHWs > 192 already present + 30 new) & replenish regularly these kits (222 kits & 222 replenishment); - Procure and distribute first aid kits for community trained in First Aid & replenish regularly these kits (992 kits & 992 replenishment). Activity 1.1.1 : INTERSOS will conduct small rehabilitations for 4 HFs in Arghistan (2) and Khakrez (2) per needs established and assessed with DoPH/BARAN. Please, find attached estimated BoQ for WASH rehabilitation works (latrines and bath facilities,waste management).

Please note that based on consultation with WHO in Kandahar, HFs in Shah Wali Kot won't be targeted with WASH rehabilitation since WHO has already committed funds for this intervention.

The infrastructure rehabilitation of health facilities will also ensure that safe water is available (water pumping, storing and treatment). For waste management at health facilities, the rehabilitation/maintenance of infrastructure will seek to include segregation of waste (solid waste, hazardous waste (needles, knives, glass) and biological waste) (possibility to color code for segregation will be explored), including specific training about waste management system, and infections preventions. Infrastructural works include the rehabilitation or construction of incinerator and placenta pit. Please find attached the proposed design.

The rehabilitation works will be delivered by private contractors, hired locally, per bid analysis procurement process.
The financial contribution will on average not be more than 5.000 US$ for these rehabilitations.

Activity 1.1.1 : INTERSOS will activate set of 2 trained social workers (1 men and 1 women) and 1 PSS counselor per mobile team for a total of 6 social workers and 3 PSS counsellors in Arghistan, Khakrez and Shah Wali Kot districts.

For the qualifications of the social workers please find in annex the relevant TOR/job descriptions as will be published for staff recruitment.
Social workers provide for PSFA (psycho-social first aid) services and PSS (psycho-social support) – individual case management, including case referral (internal and external) and organize for collective PSS, mainly for women and children (especially in case of major protection risks being identified – gender and age disaggregated). Where PSFA is on the spot and mostly one time, PSS is part of a follow-up process.
However psychological counseling (PC) will only be done by dedicated psychologists – 1 referral psychologist per mobile team will be included in the team.
For the qualifications of these psychologists please find in annex the relevant TOR/job descriptions as will be published for staff recruitment.

INTERSOS protection team will be trained on case management steps and tools in line with SOPs, which will be shared by the Clusters. These include: identification, case assessment, designing of a case plan for each single individual (agreed in case meetings between trained Social Worker and Protection Officer), regular follow-ups, review of the case plan and closure in accordance with pre-established conditions. Upon identification of vulnerable women, men, girls and boys, the social workers will closely follow up, review and monitor the psychosocial progress of each individual.

INTERSOS will also seek to identify and activate a network of community outreach volunteers (20 COVs per district) to ensure identification and referral of individual cases to the social workers. COVs will also work on organizing community awareness sessions, community groups & collective PSS sessions: total of 60 COVs will be trained and actively contributing to the implementation of the protection activities, in particular ensuring community mobilization, engagement and acceptance, in addition to case identification, internal referral for assessment and case management and support case follow-up.
Also protection concepts will be approached and explained (where possible) through Afghan

Islamic interpretations to ensure a greater by-in. It will be made clear that protection principles are not contradicting with Islam but rather are in line with each other.
Activity 1.1.2 : Provision of case management services for individual protection cases (GBV and PwSN).
Individual protection cases will be identified by different means: internal referral from mainly health activities, external referral by community outreach volunteers, community groups and local organizations, self-referral by cases, from other humanitarian actors. The social workers will ensure to dedicate time for PSFA and PSS and suggest the cases for internal (including for further psychological counseling by dedicated psychologist and legal counselling by dedicated lawyer) or external referrals. For all cases full consent and confidentiality will be guaranteed by the teams: basic sessions on how to ensure confidentiality, including of data, will be provided to all INTERSOS team at inception phase. INTERSOS will contract per district 1 legal counselor to provide for legal counselling mainly on information sharing/legal awareness/advice, and mediation mainly for GBV and PwSN cases. Moreover, per district, INTERSOS will seek to identify the availability of a psychologist in case of more complex cases in need of further counseling and follow-up. The focus for these roles and positions will be on female staff, as it is expected that female beneficiaries will make the majority of cases. Upon identification of vulnerable women, men, girls and boys, all the cases will have initial one-time assessment and will be provided with PSFA. Case Managers and Social Workers will closely follow up, review and monitor the psychosocial progress of each individual. PSS approach will include both individual and group activities, according to the single person's needs and case plan. An established mechanism of internal and external referral will be put in place and used whenever it is needed, with a consequent follow up in order to guarantee the provision of the service required and to monitor the impact of the service on the well-being of the person. Regular review of case plan, in case meetings within Social Workers, Case Managers and Protection Officer and evaluation of psychosocial well-being of beneficiaries receiving PSS services will be conducted in order to monitor progress on the psycho-social conditions of the cases. Upon positive results, the protection staff involved can proceed with the case closure. Identified GBV cases, as part of case management, will receive dignity kit in-kind from UNFPA (agreement with UNFPA to be developed upon approval of the present project), while the most vulnerable cases, according to given criteria, will also be provided with material assistance to cover basic needs. Referral to HFs and legal aid will be part of the package. The cases in need of follow-up will be provided with schedule as per the rotation of the mobile team (each location will be visited about every month for 2 to 3 time max). If the case also requires psychological counseling, s/he will be referred to the psychologist for sessions as per need. The social workers and psychologists can meet the cases in their homes but will also identify safe spaces where they could meet in a more confidential manner – in collaboration with local associations – where needed. Cases will receive individual follow-up till closure. The well-being and safety of the case will always be prioritized. It is estimated that each social worker will have no more than 30 open cases at the same time. It is important to have ASAP clear referral maps in place and ensure these referrals are conducted well and appropriately. Gender perspective is ensured by trained female Staff, in order to guarantee free and protected access of vulnerable women and

girls to the services available. Female Staff will be mainstreamed in all services available, including PSS consultations and information dissemination on health services. Male members from the staff will also be trained on basic principles of gender equality. Internal and external referrals will be organized per developed service mapping.
Activity 1.1.2 : 6 Hygiene Promoters (HPs) (2 per district) will work in pairs with CHWs or COVs (there will always be 1 men and 1 women) and each team will conduct each:
8 months x 4 weeks/month x 3 days/week x 3 teams = 288 sessions each with 20 participants for a total of 5.760 beneficiaries
Please note that in the total beneficiary calculation these beneficiaries will not be double counted.

The teams will use IEC materials for hygiene promotion (leaflet, posters, and demonstration kits for hand washing) that will be adapted to the context and literacy level of the target groups. This activity will be starting by month 2 of the project, when all other activities and staff have been recruited, ensuring a good complementarity and integration of HP with the other sectors/activities, continuing for 8 months.

Hygiene promotion session will aim to provide information on hygiene-related risks and preventive actions, such as promoting hand-washing, awareness on waterborne disease and water boiling and safe water storage and handling and hygiene behavioral change.

Awareness sessions will be conducted for different target groups. Education and communication are important components of hygiene promotion. All people have a right to know about the relationship between water, sanitation, hygiene, health and nutrition of themselves and their families. However, education alone does not necessarily result in improved practices. Knowing about the causes of disease may help, but new hygiene practices may be too unfamiliar, too difficult, or conditional on other aspect (such as access to water), especially for poor people, including displaced.

Promoting behavioral change is a gradual process that involves working closely with communities, studying existing beliefs, defining motivation strategies, designing appropriate communication tools (pictograms, posters, and practical sessions) and finally encouraging practical steps towards positive practices (establishment of WASH committees is one of these steps).
Communities will be fully engaged in the process at all stages using participatory processes, and special attention should be given to building on local knowledge and promoting existing positive traditional practices. As such the hygiene promotion will combine info sharing and community mobilization, linked to the provision of essential services.

Topics will include among others: hand-washing, personal hygiene (including for mother and child for Pregnant and Lactating Women), general session on relation WASH and health (clean water, water boiling and safe water storage and handling and clean sanitation facilities), environmental health and waste management. A KAP survey will be conducted at the beginning of the awareness sessions to draw the baseline and the final survey at the end of the campaign to measure behaviour change.

Activity 1.1.2 : Health facility staff, CHWs and community members are trained in BLS and management of trauma patients:

The existing network of CHWs will be strengthened to meet the emergency needs of the communities and HFs' capacity/attention for trauma care services will be enhanced through cascade training by trained emergency medical doctors and nurses for outreach services and HFs:

HFs level:
i. Training in BLS, ALS, ATLS and ToT for 18 MD, 30 MWs and 21 Nurses: 3 days for BLS, 3 days each for ALS, ATLS and ToT courses for a total 12 days of 3 hours theory plus 3 hours practice daily i.e. 6x12= 108 hours of training. Basic PSFA training will be included in the training package for HFs medical staff by INTERSOS psychologists.

Outreach level:
ii. Cascade training from already trained emergency medical doctors and nurses (see above) to 10 CHSs (7 already present + 3 new). Training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days) plus Training of Trainers (ToT) (3 days) courses. Total 9 days of training, 6 hours daily (3 theory + 3 practice) i.e. 54 hours of training;
iii. Cascade training from the already trained 10 CHS (see above) to 222 CHWs. The training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days). Total 3 days of training, 6 hours daily i.e. 18 hours of training. During the project the health kits will be replenished of what was used;
iv. Follow up with monitoring, evaluation and counseling of the activity of the CHWs, CHSs and HFs medical staff.

Please note that PSFA training for CHSs and CHWs and GBV prevention and response training for both medical staff and outreach personnel is included in below outcome.

Certified health professionals (INTERSOS and MoH/BARAN) will conduct the relevant training.
Activity 1.1.3 : Community Based First Aid training for community members.

992 members of the target community, corresponding to the 10% of the individuals receiving health awareness sessions, will be selected for the CBFA training and will receive First Aid Kit. The activity will follow the model of CBHFA training of ARCS: the community approach applied for this activity is deemed extremely relevant given the remoteness of the area and the lack of First Aid Point. Training will be provided by trained medical staff and strict follow up by CHWs will ensure efficiency of the selected methodology.

Activity 1.1.3 : Collective PSS activities organized for most vulnerable population groups at community level (CP, GBV and PwSN)

In addition to general awareness sessions on protection (see output below) the community outreach volunteers supported by the social workers will also organize more focused collective PSS sessions – i.e. support groups – for particular target groups, e.g. children

engaged in child labour, widows, women at risk, unemployed men and youth, permitting them to share experiences and to discuss with the guidance of social workers on coping mechanisms and strategies (negative and positive):
- CP: child marriage, children recruited in armed groups, child labour, violence against children versus education, skill training, recreational activities, parents groups, role of school shura at community level, access to and information about available services, etc.
- GBV: child/forced marriage, deprivation of resources, domestic violence, sexual violence and exploitation versus gender equality, livelihoods and education opportunities, ensure engagement of men and women, access to and information about available services, etc.
- PwSN: disability, PLW, women at risk, chronically ill, mental health, elderly at risk and extreme poverty versus rights based approach, providing these disadvantaged groups with a platform to voice their concerns/needs/issues and provide for greater community support and acceptance, access to and information about available services, etc.

Such collective PSS session will provide a safe space for persons of concern to meet – gender and age disaggregated, exchange and also learn. In order to avoid stigmatization, the sessions will be organized as social gatherings with refreshments provided by INTERSOS: club model. So the topics and approaches in the sessions can vary depending on the target group (also age and gender considered) but the model will always be the same.
It is estimated that per month 4 such sessions will be organized per team, or in total 96 sessions (4 session x 3 teams x 8 months), for about 20 persons per session, reaching about 1.920 persons (30% children, 50% women and 20% men).

Community outreach volunteers are to be living within 500m from the targeted communities. 50% women and 50% IDPs, 20% returnees/30% host community - they support the INTERSOS protection team during the interventions, provide mobilization messages, protection promotion awareness, counselling and identify/refer the most vulnerable persons/HHs in need to the INTERSOS protection team. Selection of COVs will be conducted at village level with the consultation of shura members and village leaders to identify the most active and already engaged individuals within the community. COVs will participate to the training as per activity 1.1.4. Based on literacy level COVs will be provided with culturally-sensitive awareness material. COVs are provided with small monthly transportation allowance and phone credits, to incentivized their commitment, and are coordinated and supervised by the protection officer. There will be 60 Community Outreach Volunteers in total, in addition to community member and members of local civil society per district that will be encouraged to establish Community Based Protection Networks and regularly meet to discuss on protection and undertake coordinated action for prevention and response activities.
Activity 1.1.4 : Training on PSS-related concepts and approaches to community leaders, urban committees and community members

INTERSOS Protection Officer will provide training sessions to key community members within the targeted urban areas on definition of PSS, identification of vulnerable individuals, PSS approaches, sensitive communication techniques and community-based protection mechanisms, with the aim of increasing the capacity of the

community to develop their own protective measures and establish mechanisms of self-reliance. Please find attached training CV. CHWs and CHSs will be as well trained in GBV protection and response and Protection concerns identification as mentioned in Activity 2.1.1 under Health sector.

171 persons (50% men & 50% women) > 6 social workers, 9 mobile health team staff, 3 psychologists, 3 legal counsellors, min. 30 local community leaders per targeted district (90), and 60 community outreach volunteers. These trainings will be conducted per district. The trainings will be conducted in Pashto by qualified trainers, taking 4 days per training.
Further on job-training and coaching will also be provided for INTERSOS staff with the support of the protection activity coordinator dedicated on the project.

Training will start from month 2 of the project.

Activity 1.1.5 : Awareness sessions for community members on protection related issues (CP, GBV and PwSN)

Awareness sessions on protection related issues will aim to enhance community understanding on right based approaches related to CP, GBV and PwSN, aimed at community protection (foremost protection but also response), contributing to better identification, prevention and response of protection concerns and violations. The outreach activities will target community leaders to promote and advocate rights. COVs will be organizing the session at community level, supported by social workers to facilitate the awareness sessions. Understanding the traditional nature of the communities that will be targeted and to ensure community acceptance and facilitation, these sessions will be integrated where possible with the health-nutrition-WASH awareness sessions (see above). Also protection concepts will be approached and explained (where possible) through Afghan Islamic interpretations to ensure a greater by-in. It will be made clear that protection principles are not contradicting with Islam but rather are in line with each other. Therefor it will be important to also work with key stakeholders such as Islamic teachers and religious leaders from those targeted communities. Considering the delicate nature of GBV issues, these will be tackled as part of overall protection and also linked to reproductive health issues (for example child marriage) & CP issues will be tackled by looking into the importance of education, access to knowledge and overall health of the child.
For PwSN (incl. PLW, women at risk, disabled, elderly persons at risk, extremely poor, mental health case and chronically ill cases), INTERSOS will spend sufficient time on the situation of disabled as this is a particular vulnerable group that is in need for recognition of their rights and for improved services and adapted assistance (as individual but also for their families).
192 sessions will be conducted for 3.840 (30% children, 35% women and 35% men): 2 sessions x week x 4 weeks x 8 months x 20 persons per session x 3 teams = 3.840 individuals.
Only 30% will be considered as NEW/ADDITIONAL beneficiaries on top of the already reached people by other awareness session – so in the total beneficiary calculation, there will be no double counting.

Activity 2.1.1 : Training and deployment of medical staff and health workers for community mobilization, health education and PHC outreach

services:

Outreach level:
Assure OUTREACH through support for already existing CHW teams linked to 8 HFs in Arghistan, Khakrez and Shah Wali Kot districts.
CHWs (in/from targeted communities) are normally already put in place by BARAN but there are gaps, therefore, INTERSOS will identify, and support additional new 30 CHWs (15 men and 15 women) and 3 new CHSs, in addition to the 94 CHWs and the 3 CHSs already operating in the three districts. Average of 62 teams of 2 CHWs (Mahram system) for a total of 124 CHWs (94 already present + 30 new).

All Trainings will be conducted in line with the guidelines of the BPHS, in cooperation with DoPH: 3 days of new training and 2 days of refresher training. CHWs and CHS (50% females) in the targeted districts are trained on community mobilization, basics of post-traumatic counselling, GBV prevention and response, ensuring relevant and timely identification of survivors and appropriate referral to relevant service providers per referral pathways and PSFA., receiving sensitization tools and CHWs health kits at the end of the training. For health education messaging special attention will be given for PLW, pre and post-natal care, including the importance of ANC and PNC, breastfeeding, and tetanus vaccination and safe delivery.

HFs level:
Also training for health staff in HFs is provided in IMCI (integrate management of childhood Illness) and Emergency obstetric and newborn care (EmONC), family planning (FP). Staff already trained will only do refreshment training, permitting immediate start-up and new staff will receive full training. Health professions (INTERSOS and PHD – and other actor relevant and interested) will benefit from training and coaching on health, protection and SGBV related topics, and PSFA.
Activity 2.1.2 : Compose/hire/operate 3 mobile teams to support the outreach capacity of the HFs for provision of RH services in Arghistan, Khakrez and Shah Wali Kot districts, mainly focusing on white areas where no other humanitarian organizations are present.

Mobile teams will complement the RH services at HF level (ANC/PNC/family planning).
9 trained dedicated health professionals in total – per team 1 GP, 1 midwife and 1 female nurse will be supported by the network of CHWs.
Additionally, 2 social workers and 1 case manager will be part of each mobile team in charge of case management and protection monitoring. BARAN/DoH are not able to provide drugs or medical equipment for the mobile teams which will, therefore, procured directly by INTERSOS.

The training for the mobile team staff will be comprehensive on EPHC – Emergency Primary Health Care and the curriculum will include clinical management of childhood diseases (IMCI), maternal health, basic internal medicine and minor surgery, TRIAGE/BLS and emergency care.

Protection integration is ensured by the presence of two social workers for each team for the identification of PWSN and case management of GBV survivors.
Moreover as part of protection mainstreaming the health professionals will also benefit from trainings and coaching on health, protection and SGBV related topics and psychosocial first aid (PSFA) for health professionals. The training will be conducted over a span of 9 days immediately

after recruitment during the first month of the project.

The car of the mobile team will be a mini-bus or 4X4 that could be converted to BLS in case of emergency (delivery, casualty or critical SAM case) for immediate referral to the nearby HF or referral hospital, depending on the severity. Each CHC has an ambulance available but due to geographical coverage, distance and considering emergency, these ambulances are often not timely available or able to assist the case.

The mobile teams will be organized in coordination with BARAN/DOPH to ensure the best possible coverage of the gaps. The Mobile Team will rove 5 days per week visiting 1 or 2 locations per day, covering about 50 consultations per day.

Total number of consultancies (PHC – with focus on RH) is expected to be:
50 consultancies per day per team x 3 teams x 5 days per week x 4 weeks x 9 months = 27.000 consultations during the project duration.
The mobile team itself will have mostly attention for Mother and Child Health (MCH) (ANC/PNC/BEmONC) as such the bulk of the patients will be women and children > estimation of 70% women (WCBA – PLW), 20% children and about 10% men.
It is expected that the team also makes referrals to the HFs for further follow-up and for identified protection cases referrals to the social workers.
The mobile teams will be operating from the village health posts (village health rooms).
Activity 2.2.1 : Strengthened functional capacities of targeted HFs for the provision of maternity care and emergency obstetric care services (establish BEmONC at district level and strengthen CEmONC at referral level)

For all facilities (8):
(Performance based) Incentives for night shift midwifes available on call. 8 midwives will be trained at BEmONC standard level to staff the 8 HFs, in addition of the midwife already deployed by BARAN, when any. Additionally, activation of trusted taxis to be activated as BLS and to ensure safe travels a night for female midwifes is foreseen.

- Training by an experienced midwife to the CHSs incl. the following: Pregnancy Control and Safe Motherhood, Antenatal and Post Natal Care practices, GBV prevention and identification and referral procedures, Early recognition of pregnancy at risk and referral procedures, Triage and Stabilization / Referral of Obstetric Emergencies (5 days of training 6 hours daily 50/50% theory and practice).
- Cascade training from the already trained CHSs (see above) to CHWs. The training will include the same components as above i.e. Pregnancy Control and Safe Motherhood, Antenatal and Pre Natal Care practices, GBV prevention identification and referral procedures, Early recognition of pregnancy at risk and referral procedures, Triage and Stabilization / Referral of Obstetric Emergencies.
Activity 2.2.2 : Community health awareness sessions

Women in Childbearing age (WCBA) and Pregnant or Lactating Women (PLW) will receive health messages to improve the safety of their pregnancies and motherhood. CHWs at village level will contribute to the early recognition of pregnancy at risks giving appropriate counseling (e.g. just preventive move to temporary stay nearer to the HF BEmONC services – or CmONC in case of complications).
The health awareness sessions will also provide

							information on the services available at HF and MC level and on the risk of late (self) referral for complications and negative long term consequences. Other topics will include: -sensitization about the importance of ANC and PNC; -sensitization about the importance of tetanus vaccination during and after pregnancy for mother and child to prevent neonatal tetanus. Awareness sessions will also include basic protection principles, gender related issues and services to refer to in case of survivors as victim of SGBV. Men will also be encouraged to participate to the awareness sessions on GBV prevention. Sessions will be conducted at the level of the health post when patients come to visit, but the CHWs will also be encouraged to conduct home visits and more general awareness sessions. In addition to individual (one on one) counseling, each team of CHWs will be expected to conduct a minimum of 1 awareness sessions for PLW/WCBA, including also for men/(future) fathers per month with a focus on Mother and Child Health (ANC/PNC and safe delivery). 62 teams (total of 124 CHW > 94 already present + 30 new) x 1 sessions per team per month X 8 months X 20 persons per session = 9.920 individuals to be reached (75% women and 25% men). High attention will be placed on prevention with the sessions by the CHWs to the women at community level. Activity 2.2.3 : Procurement for BEmONC and CEmONC: Procurement of RH and safe delivery kits - upon availability of UNFPA and UNICEF. HE material procurement and distribution: HE material in form of illustrated pamphlets containing the Health RH messages relevant for CBAWs and PLWs as explained in the HE sessions will be procured and distributed. Expected production # 10,000 pamphlets. Procurement of baby kits for most vulnerable cases (500): Such kits include: diapers, wipes, hand sanitizer, blanket, baby lotion, soap and shampoo, tower and bag.
Kandahar -> Maywand	10	1,345	2,461	418	418	4,642	Activity 1.1.1 : The project will procure and preposition emergency trauma and health kits for 1 FATP and 6 basic trauma points in 6 CHCs in Arghistan, Maywand , Khakrez and Shah Wali Kot districts: - Procure and preposition medical supplies and equipment for integrated FATP in 6 CHDs; - Procure and distribute first aid kits for CHWs (total of 222 CHWs > 192 already present + 30 new) & replenish regularly these kits (222 kits & 222 replenishment); - Procure and distribute first aid kits for community trained in First Aid & replenish regularly these kits (992 kits & 992 replenishment). Activity 1.1.2 : Health facility staff, CHWs and community members are trained in BLS and management of trauma patients: The existing network of CHWs will be strengthened to meet the emergency needs of the communities and HFs' capacity/attention for trauma care services will be enhanced through cascade training by trained emergency medical doctors and nurses for outreach services and HFs: HFs level: i. Training in BLS, ALS, ATLS and ToT for 18

							MD, 30 MWs and 21 Nurses: 3 days for BLS, 3 days each for ALS, ATLS and ToT courses for a total 12 days of 3 hours theory plus 3 hours practice daily i.e. 6x12= 108 hours of training. Basic PSFA training will be included in the training package for HFs medical staff by INTERSOS psychologists. Outreach level: ii. Cascade training from already trained emergency medical doctors and nurses (see above) to 10 CHSs (7 already present + 3 new). Training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days) plus Training of Trainers (ToT) (3 days) courses. Total 9 days of training, 6 hours daily (3 theory + 3 practice) i.e. 54 hours of training; iii. Cascade training from the already trained 10 CHS (see above) to 222 CHWs. The training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days). Total 3 days of training, 6 hours daily i.e. 18 hours of training. During the project the health kits will be replenished of what was used; iv. Follow up with monitoring, evaluation and counseling of the activity of the CHWs, CHSs and HFs medical staff. Please note that PSFA training for CHSs and CHWs and GBV prevention and response training for both medical staff and outreach personnel is included in below outcome. Certified health professionals (INTERSOS and MoH/BARAN) will conduct the relevant training. Activity 1.1.3 : Community Based First Aid training for community members. 992 members of the target community, corresponding to the 10% of the individuals receiving health awareness sessions, will be selected for the CBFA training and will receive First Aid Kit. The activity will follow the model of CBHFA training of ARCS: the community approach applied for this activity is deemed extremely relevant given the remoteness of the area and the lack of First Aid Point. Training will be provided by trained medical staff and strict follow up by CHWs will ensure efficiency of the selected methodology.
Kandahar -> Arghestan	30	4,038	7,382	1,254	1,254	13,928	Activity 1.1.1 : The project will procure and preposition emergency trauma and health kits for 1 FATP and 6 basic trauma points in 6 CHCs in Arghistan, Maywand , Khakrez and Shah Wali Kot districts: - Procure and preposition medical supplies and equipment for integrated FATP in 6 CHDs; - Procure and distribute first aid kits for CHWs (total of 222 CHWs > 192 already present + 30 new) & replenish regularly these kits (222 kits & 222 replenishment); - Procure and distribute first aid kits for community trained in First Aid & replenish regularly these kits (992 kits & 992 replenishment). Activity 1.1.1 : INTERSOS will conduct small rehabilitations for 4 HFs in Arghistan (2) and Khakrez (2) per needs established and assessed

with DoPH/BARAN. Please, find attached estimated BoQ for WASH rehabilitation works (latrines and bath facilities,waste management). Please note that based on consultation with WHO in Kandahar, HFs in Shah Wali Kot won't be targeted with WASH rehabilitation since WHO has already committed funds for this intervention.

The infrastructure rehabilitation of health facilities will also ensure that safe water is available (water pumping, storing and treatment). For waste management at health facilities, the rehabilitation/maintenance of infrastructure will seek to include segregation of waste (solid waste, hazardous waste (needles, knives, glass) and biological waste) (possibility to color code for segregation will be explored), including specific training about waste management system, and infections preventions. Infrastructural works include the rehabilitation or construction of incinerator and placenta pit. Please find attached the proposed design.

The rehabilitation works will be delivered by private contractors, hired locally, per bid analysis procurement process.
The financial contribution will on average not be more than 5.000 US$ for these rehabilitations.

Activity 1.1.1 : INTERSOS will activate set of 2 trained social workers (1 men and 1 women) and 1 PSS counselor per mobile team for a total of 6 social workers and 3 PSS counsellors in Arghistan, Khakrez and Shah Wali Kot districts.

For the qualifications of the social workers please find in annex the relevant TOR/job descriptions as will be published for staff recruitment.
Social workers provide for PSFA (psycho-social first aid) services and PSS (psycho-social support) – individual case management, including case referral (internal and external) and organize for collective PSS, mainly for women and children (especially in case of major protection risks being identified – gender and age disaggregated). Where PSFA is on the spot and mostly one time, PSS is part of a follow-up process.
However psychological counseling (PC) will only be done by dedicated psychologists – 1 referral psychologist per mobile team will be included in the team.
For the qualifications of these psychologists please find in annex the relevant TOR/job descriptions as will be published for staff recruitment.

INTERSOS protection team will be trained on case management steps and tools in line with SOPs, which will be shared by the Clusters. These include: identification, case assessment, designing of a case plan for each single individual (agreed in case meetings between trained Social Worker and Protection Officer), regular follow-ups, review of the case plan and closure in accordance with pre-established conditions. Upon identification of vulnerable women, men, girls and boys, the social workers will closely follow up, review and monitor the psychosocial progress of each individual.

INTERSOS will also seek to identify and activate a network of community outreach volunteers (20 COVs per district) to ensure identification and referral of individual cases to the social workers. COVs will also work on organizing community awareness sessions, community groups & collective PSS sessions: total of 60 COVs will be trained and actively contributing to the implementation of the protection activities, in particular ensuring community mobilization, engagement and acceptance, in addition to case identification, internal referral for assessment and

							case management and support case follow-up. Also protection concepts will be approached and explained (where possible) through Afghan Islamic interpretations to ensure a greater by-in. It will be made clear that protection principles are not contradicting with Islam but rather are in line with each other. Activity 1.1.2 : Provision of case management services for individual protection cases (GBV and PwSN). Individual protection cases will be identified by different means: internal referral from mainly health activities, external referral by community outreach volunteers, community groups and local organizations, self-referral by cases, from other humanitarian actors. The social workers will ensure to dedicate time for PSFA and PSS and suggest the cases for internal (including for further psychological counseling by dedicated psychologist and legal counselling by dedicated lawyer) or external referrals. For all cases full consent and confidentiality will be guaranteed by the teams: basic sessions on how to ensure confidentiality, including of data, will be provided to all INTERSOS team at inception phase. INTERSOS will contract per district 1 legal counselor to provide for legal counselling mainly on information sharing/legal awareness/advice, and mediation mainly for GBV and PwSN cases. Moreover, per district, INTERSOS will seek to identify the availability of a psychologist in case of more complex cases in need of further counseling and follow-up. The focus for these roles and positions will be on female staff, as it is expected that female beneficiaries will make the majority of cases. Upon identification of vulnerable women, men, girls and boys, all the cases will have initial one-time assessment and will be provided with PSFA. Case Managers and Social Workers will closely follow up, review and monitor the psychosocial progress of each individual. PSS approach will include both individual and group activities, according to the single person's needs and case plan. An established mechanism of internal and external referral will be put in place and used whenever it is needed, with a consequent follow up in order to guarantee the provision of the service required and to monitor the impact of the service on the well-being of the person. Regular review of case plan, in case meetings within Social Workers, Case Managers and Protection Officer and evaluation of psychosocial well-being of beneficiaries receiving PSS services will be conducted in order to monitor progress on the psycho-social conditions of the cases. Upon positive results, the protection staff involved can proceed with the case closure. Identified GBV cases, as part of case management, will receive dignity kit in-kind from UNFPA (agreement with UNFPA to be developed upon approval of the present project), while the most vulnerable cases, according to given criteria, will also be provided with material assistance to cover basic needs. Referral to HFs and legal aid will be part of the package. The cases in need of follow-up will be provided with schedule as per the rotation of the mobile team (each location will be visited about every month for 2 to 3 time max). If the case also requires psychological counseling, s/he will be referred to the psychologist for sessions as per need. The social workers and psychologists can meet the cases in their homes but will also identify safe spaces where they could meet in a more confidential manner – in collaboration with local associations – where needed. Cases will receive individual follow-up till closure. The well-being and safety of the case will always be prioritized. It is estimated that each social worker will have no more than 30 open cases at the same time. It is important to have ASAP clear referral maps in place and ensure these referrals are conducted well and

appropriately. Gender perspective is ensured by trained female Staff, in order to guarantee free and protected access of vulnerable women and girls to the services available. Female Staff will be mainstreamed in all services available, including PSS consultations and information dissemination on health services. Male members from the staff will also be trained on basic principles of gender equality. Internal and external referrals will be organized per developed service mapping.
Activity 1.1.2 : 6 Hygiene Promoters (HPs) (2 per district) will work in pairs with CHWs or COVs (there will always be 1 men and 1 women) and each team will conduct each:
8 months x 4 weeks/month x 3 days/week x 3 teams = 288 sessions each with 20 participants for a total of 5.760 beneficiaries
Please note that in the total beneficiary calculation these beneficiaries will not be double counted.

The teams will use IEC materials for hygiene promotion (leaflet, posters, and demonstration kits for hand washing) that will be adapted to the context and literacy level of the target groups. This activity will be starting by month 2 of the project, when all other activities and staff have been recruited, ensuring a good complementarity and integration of HP with the other sectors/activities, continuing for 8 months.

Hygiene promotion session will aim to provide information on hygiene-related risks and preventive actions, such as promoting hand-washing, awareness on waterborne disease and water boiling and safe water storage and handling and hygiene behavioral change.

Awareness sessions will be conducted for different target groups. Education and communication are important components of hygiene promotion. All people have a right to know about the relationship between water, sanitation, hygiene, health and nutrition of themselves and their families. However, education alone does not necessarily result in improved practices. Knowing about the causes of disease may help, but new hygiene practices may be too unfamiliar, too difficult, or conditional on other aspect (such as access to water), especially for poor people, including displaced.

Promoting behavioral change is a gradual process that involves working closely with communities, studying existing beliefs, defining motivation strategies, designing appropriate communication tools (pictograms, posters, and practical sessions) and finally encouraging practical steps towards positive practices (establishment of WASH committees is one of these steps).
Communities will be fully engaged in the process at all stages using participatory processes, and special attention should be given to building on local knowledge and promoting existing positive traditional practices. As such the hygiene promotion will combine info sharing and community mobilization, linked to the provision of essential services.

Topics will include among others: hand-washing, personal hygiene (including for mother and child for Pregnant and Lactating Women), general session on relation WASH and health (clean water, water boiling and safe water storage and handling and clean sanitation facilities), environmental health and waste management. A KAP survey will be conducted at the beginning of the awareness sessions to draw the baseline and the final survey at the end of the campaign to measure behaviour change.

Activity 1.1.2 : Health facility staff, CHWs and community members are trained in BLS and management of trauma patients:

The existing network of CHWs will be strengthened to meet the emergency needs of the communities and HFs' capacity/attention for trauma care services will be enhanced through cascade training by trained emergency medical doctors and nurses for outreach services and HFs:

HFs level:
i. Training in BLS, ALS, ATLS and ToT for 18 MD, 30 MWs and 21 Nurses: 3 days for BLS, 3 days each for ALS, ATLS and ToT courses for a total 12 days of 3 hours theory plus 3 hours practice daily i.e. 6x12= 108 hours of training. Basic PSFA training will be included in the training package for HFs medical staff by INTERSOS psychologists.

Outreach level:
ii. Cascade training from already trained emergency medical doctors and nurses (see above) to 10 CHSs (7 already present + 3 new). Training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days) plus Training of Trainers (ToT) (3 days) courses. Total 9 days of training, 6 hours daily (3 theory + 3 practice) i.e. 54 hours of training;
iii. Cascade training from the already trained 10 CHS (see above) to 222 CHWs. The training will include a) prevention and mitigation effect procedures of trauma; b) general, basic emergency medicine system organization and guidelines for telecommunication, referral and transport (1 day); c) Basic Life Support- BLS (3 days) and Basic Pre-Hospital Trauma Life Support - B-PHTLS (2 days). Total 3 days of training, 6 hours daily i.e. 18 hours of training. During the project the health kits will be replenished of what was used;
iv. Follow up with monitoring, evaluation and counseling of the activity of the CHWs, CHSs and HFs medical staff.

Please note that PSFA training for CHSs and CHWs and GBV prevention and response training for both medical staff and outreach personnel is included in below outcome.

Certified health professionals (INTERSOS and MoH/BARAN) will conduct the relevant training.
Activity 1.1.3 : Community Based First Aid training for community members.

992 members of the target community, corresponding to the 10% of the individuals receiving health awareness sessions, will be selected for the CBFA training and will receive First Aid Kit. The activity will follow the model of CBHFA training of ARCS: the community approach applied for this activity is deemed extremely relevant given the remoteness of the area and the lack of First Aid Point. Training will be provided by trained medical staff and strict follow up by CHWs will ensure efficiency of the selected methodology.

Activity 1.1.3 : Collective PSS activities organized for most vulnerable population groups at community level (CP, GBV and PwSN)

In addition to general awareness sessions on protection (see output below) the community outreach volunteers supported by the social

workers will also organize more focused collective PSS sessions – i.e. support groups – for particular target groups, e.g. children engaged in child labour, widows, women at risk, unemployed men and youth, permitting them to share experiences and to discuss with the guidance of social workers on coping mechanisms and strategies (negative and positive):
- CP: child marriage, children recruited in armed groups, child labour, violence against children versus education, skill training, recreational activities, parents groups, role of school shura at community level, access to and information about available services, etc.
- GBV: child/forced marriage, deprivation of resources, domestic violence, sexual violence and exploitation versus gender equality, livelihoods and education opportunities, ensure engagement of men and women, access to and information about available services, etc.
- PwSN: disability, PLW, women at risk, chronically ill, mental health, elderly at risk and extreme poverty versus rights based approach, providing these disadvantaged groups with a platform to voice their concerns/needs/issues and provide for greater community support and acceptance, access to and information about available services, etc.

Such collective PSS session will provide a safe space for persons of concern to meet – gender and age disaggregated, exchange and also learn. In order to avoid stigmatization, the sessions will be organized as social gatherings with refreshments provided by INTERSOS: club model. So the topics and approaches in the sessions can vary depending on the target group (also age and gender considered) but the model will always be the same.
It is estimated that per month 4 such sessions will be organized per team, or in total 96 sessions (4 session x 3 teams x 8 months), for about 20 persons per session, reaching about 1.920 persons (30% children, 50% women and 20% men).

Community outreach volunteers are to be living within 500m from the targeted communities. 50% women and 50% IDPs, 20% returnees/30% host community - they support the INTERSOS protection team during the interventions, provide mobilization messages, protection promotion awareness, counselling and identify/refer the most vulnerable persons/HHs in need to the INTERSOS protection team. Selection of COVs will be conducted at village level with the consultation of shura members and village leaders to identify the most active and already engaged individuals within the community. COVs will participate to the training as per activity 1.1.4. Based on literacy level COVs will be provided with culturally-sensitive awareness material. COVs are provided with small monthly transportation allowance and phone credits, to incentivized their commitment, and are coordinated and supervised by the protection officer. There will be 60 Community Outreach Volunteers in total, in addition to community member and members of local civil society per district that will be encouraged to establish Community Based Protection Networks and regularly meet to discuss on protection and undertake coordinated action for prevention and response activities.
Activity 1.1.4 : Training on PSS-related concepts and approaches to community leaders, urban committees and community members

INTERSOS Protection Officer will provide training sessions to key community members within the targeted urban areas on definition of PSS, identification of vulnerable individuals, PSS

approaches, sensitive communication techniques and community-based protection mechanisms, with the aim of increasing the capacity of the community to develop their own protective measures and establish mechanisms of self-reliance. Please find attached training CV. CHWs and CHSs will be as well trained in GBV protection and response and Protection concerns identification as mentioned in Activity 2.1.1 under Health sector.

171 persons (50% men & 50% women) > 6 social workers, 9 mobile health team staff, 3 psychologists, 3 legal counsellors, min. 30 local community leaders per targeted district (90), and 60 community outreach volunteers. These trainings will be conducted per district. The trainings will be conducted in Pashto by qualified trainers, taking 4 days per training.
Further on job-training and coaching will also be provided for INTERSOS staff with the support of the protection activity coordinator dedicated on the project.

Training will start from month 2 of the project.

Activity 1.1.5 : Awareness sessions for community members on protection related issues (CP, GBV and PwSN)

Awareness sessions on protection related issues will aim to enhance community understanding on right based approaches related to CP, GBV and PwSN, aimed at community protection (foremost protection but also response), contributing to better identification, prevention and response of protection concerns and violations. The outreach activities will target community leaders to promote and advocate rights. COVs will be organizing the session at community level, supported by social workers to facilitate the awareness sessions. Understanding the traditional nature of the communities that will be targeted and to ensure community acceptance and facilitation, these sessions will be integrated where possible with the health-nutrition-WASH awareness sessions (see above). Also protection concepts will be approached and explained (where possible) through Afghan Islamic interpretations to ensure a greater by-in. It will be made clear that protection principles are not contradicting with Islam but rather are in line with each other. Therefor it will be important to also work with key stakeholders such as Islamic teachers and religious leaders from those targeted communities. Considering the delicate nature of GBV issues, these will be tackled as part of overall protection and also linked to reproductive health issues (for example child marriage) & CP issues will be tackled by looking into the importance of education, access to knowledge and overall health of the child.
For PwSN (incl. PLW, women at risk, disabled, elderly persons at risk, extremely poor, mental health case and chronically ill cases), INTERSOS will spend sufficient time on the situation of disabled as this is a particular vulnerable group that is in need for recognition of their rights and for improved services and adapted assistance (as individual but also for their families).
192 sessions will be conducted for 3.840 (30% children, 35% women and 35% men): 2 sessions x week x 4 weeks x 8 months x 20 persons per session x 3 teams = 3.840 individuals.
Only 30% will be considered as NEW/ADDITIONAL beneficiaries on top of the already reached people by other awareness session – so in the total beneficiary calculation, there will be no double counting.

Activity 2.1.1 : Training and deployment of medical staff and health workers for community mobilization, health education and PHC outreach services:

Outreach level:
Assure OUTREACH through support for already existing CHW teams linked to 8 HFs in Arghistan, Khakrez and Shah Wali Kot districts.
CHWs (in/from targeted communities) are normally already put in place by BARAN but there are gaps, therefore, INTERSOS will identify, and support additional new 30 CHWs (15 men and 15 women) and 3 new CHSs, in addition to the 94 CHWs and the 3 CHSs already operating in the three districts. Average of 62 teams of 2 CHWs (Mahram system) for a total of 124 CHWs (94 already present + 30 new).

All Trainings will be conducted in line with the guidelines of the BPHS, in cooperation with DoPH: 3 days of new training and 2 days of refresher training. CHWs and CHS (50% females) in the targeted districts are trained on community mobilization, basics of post-traumatic counselling, GBV prevention and response, ensuring relevant and timely identification of survivors and appropriate referral to relevant service providers per referral pathways and PSFA., receiving sensitization tools and CHWs health kits at the end of the training. For health education messaging special attention will be given for PLW, pre and post-natal care, including the importance of ANC and PNC, breastfeeding, and tetanus vaccination and safe delivery.

HFs level:
Also training for health staff in HFs is provided in IMCI (integrate management of childhood Illness) and Emergency obstetric and newborn care (EmONC), family planning (FP). Staff already trained will only do refreshment training, permitting immediate start-up and new staff will receive full training. Health professions (INTERSOS and PHD – and other actor relevant and interested) will benefit from training and coaching on health, protection and SGBV related topics, and PSFA.
Activity 2.1.2 : Compose/hire/operate 3 mobile teams to support the outreach capacity of the HFs for provision of RH services in Arghistan, Khakrez and Shah Wali Kot districts, mainly focusing on white areas where no other humanitarian organizations are present.

Mobile teams will complement the RH services at HF level (ANC/PNC/family planning).
9 trained dedicated health professionals in total – per team 1 GP, 1 midwife and 1 female nurse will be supported by the network of CHWs.
Additionally, 2 social workers and 1 case manager will be part of each mobile team in charge of case management and protection monitoring. BARAN/DoH are not able to provide drugs or medical equipment for the mobile teams which will, therefore, procured directly by INTERSOS.

The training for the mobile team staff will be comprehensive on EPHC – Emergency Primary Health Care and the curriculum will include clinical management of childhood diseases (IMCI), maternal health, basic internal medicine and minor surgery, TRIAGE/BLS and emergency care.

Protection integration is ensured by the presence of two social workers for each team for the identification of PWSN and case management of GBV survivors.
Moreover as part of protection mainstreaming the health professionals will also benefit from trainings and coaching on health, protection and

SGBV related topics and psychosocial first aid (PSFA) for health professionals. The training will be conducted over a span of 9 days immediately after recruitment during the first month of the project.

The car of the mobile team will be a mini-bus or 4X4 that could be converted to BLS in case of emergency (delivery, casualty or critical SAM case) for immediate referral to the nearby HF or referral hospital, depending on the severity. Each CHC has an ambulance available but due to geographical coverage, distance and considering emergency, these ambulances are often not timely available or able to assist the case.

The mobile teams will be organized in coordination with BARAN/DOPH to ensure the best possible coverage of the gaps. The Mobile Team will rove 5 days per week visiting 1 or 2 locations per day, covering about 50 consultations per day.

Total number of consultancies (PHC – with focus on RH) is expected to be:
50 consultancies per day per team x 3 teams x 5 days per week x 4 weeks x 9 months = 27.000 consultations during the project duration.
The mobile team itself will have mostly attention for Mother and Child Health (MCH) (ANC/PNC/BEmONC) as such the bulk of the patients will be women and children > estimation of 70% women (WCBA – PLW), 20% children and about 10% men.
It is expected that the team also makes referrals to the HFs for further follow-up and for identified protection cases referrals to the social workers.
The mobile teams will be operating from the village health posts (village health rooms).
Activity 2.2.1 : Strengthened functional capacities of targeted HFs for the provision of maternity care and emergency obstetric care services (establish BEmONC at district level and strengthen CEmONC at referral level)

For all facilities (8):
(Performance based) Incentives for night shift midwifes available on call. 8 midwives will be trained at BEmONC standard level to staff the 8 HFs, in addition of the midwife already deployed by BARAN, when any. Additionally, activation of trusted taxis to be activated as BLS and to ensure safe travels a night for female midwifes is foreseen.

- Training by an experienced midwife to the CHSs incl. the following: Pregnancy Control and Safe Motherhood, Antenatal and Post Natal Care practices, GBV prevention and identification and referral procedures, Early recognition of pregnancy at risk and referral procedures, Triage and Stabilization / Referral of Obstetric Emergencies (5 days of training 6 hours daily 50/50% theory and practice).
- Cascade training from the already trained CHSs (see above) to CHWs. The training will include the same components as above i.e. Pregnancy Control and Safe Motherhood, Antenatal and Pre Natal Care practices, GBV prevention identification and referral procedures, Early recognition of pregnancy at risk and referral procedures, Triage and Stabilization / Referral of Obstetric Emergencies.
Activity 2.2.2 : Community health awareness sessions

Women in Childbearing age (WCBA) and Pregnant or Lactating Women (PLW) will receive health messages to improve the safety of their pregnancies and motherhood. CHWs at village level will contribute to the early recognition of pregnancy at risks giving appropriate counseling (e.g. just preventive move to temporary stay

							nearer to the HF BEmONC services – or CmONC in case of complications). The health awareness sessions will also provide information on the services available at HF and MC level and on the risk of late (self) referral for complications and negative long term consequences. Other topics will include: -sensitization about the importance of ANC and PNC; -sensitization about the importance of tetanus vaccination during and after pregnancy for mother and child to prevent neonatal tetanus. Awareness sessions will also include basic protection principles, gender related issues and services to refer to in case of survivors as victim of SGBV. Men will also be encouraged to participate to the awareness sessions on GBV prevention. Sessions will be conducted at the level of the health post when patients come to visit, but the CHWs will also be encouraged to conduct home visits and more general awareness sessions. In addition to individual (one on one) counseling, each team of CHWs will be expected to conduct a minimum of 1 awareness sessions for PLW/WCBA, including also for men/(future) fathers per month with a focus on Mother and Child Health (ANC/PNC and safe delivery). 62 teams (total of 124 CHW > 94 already present + 30 new) x 1 sessions per team per month X 8 months X 20 persons per session = 9.920 individuals to be reached (75% women and 25% men). High attention will be placed on prevention with the sessions by the CHWs to the women at community level. Activity 2.2.3 : Procurement for BEmONC and CEmONC: Procurement of RH and safe delivery kits - upon availability of UNFPA and UNICEF. HE material procurement and distribution: HE material in form of illustrated pamphlets containing the Health RH messages relevant for CBAWs and PLWs as explained in the HE sessions will be procured and distributed. Expected production # 10,000 pamphlets. Procurement of baby kits for most vulnerable cases (500): Such kits include: diapers, wipes, hand sanitizer, blanket, baby lotion, soap and shampoo, tower and bag.

Documents

Category Name	Document Description
Project Supporting Documents	INTERSOS MSA report - Kandahar - March 2017.pdf
Project Supporting Documents	APC - Endorsement Letter Intersos.pdf
Project Supporting Documents	WASH Cluster Endorsement Letter-INTERSOS.pdf
Project Supporting Documents	Health Cluster - Intersos Support Letter.pdf
Project Supporting Documents	Health Cluster - INTERSOS_Project_Logframe_CHF multi-sector - 25 08 17 -Signed.pdf
Project Supporting Documents	INTERSOS Multi-sector Kandahar - ToR social workers.pdf
Project Supporting Documents	INTERSOS Multi-sector Kandahar - ToR Psychologist.pdf
Project Supporting Documents	INTERSOS - CHF multi-sector - Beneficiary breakdown - 04 09 17.xlsx
Project Supporting Documents	INTERSOS - CHF multi-sector - Beneficiary breakdown rev. - 26 09 17.xlsx
Project Supporting Documents	Activity 4.4 - General Protection and PSS Training CV.docx
Project Supporting Documents	Support Letter DOPH Kandahar - 26 09 17.jpg

Budget Documents	2.1 - Cost for integrated FATP at CHC.xlsx
Budget Documents	2.2 - Equipment_medicine_supplies for FATP.xlsx
Budget Documents	2.3 - Medicine for FATP.xlsx
Budget Documents	2.4-2.5 - First Aid Kit.xlsx
Budget Documents	2.12 - Medical equipment mobile teams.xls
Budget Documents	2.13 - Medical drugs mobile teams.xls
Budget Documents	4.4 - WASH rehabilitation HFs.xlsx
Budget Documents	7.6 - Security Management.xlsx
Grant Agreement	INTERSOS - 6777 - GA - Signed by HC.pdf
Grant Agreement	INTERSOS - 6777 - GA - Signed by HC_signed by IP.pdf