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Domestic Response Plan
Afghanistan: COVID-19 outbreak

International Federation of Red Cross and Red Crescent Societies

Emergency Appeal n°	MDR00005	**Glide n°:**	EP-2020-000012-CHN
Emergency Appeal date of launch:	31/01/2020	**Expected timeframe:**	12 months
Emergency Appeal revised:	26/03/2020	**Expected end date:**	31 March 2021
Domestic Response Plan launched:	24/04/2020		
Category allocated to the disaster or crisis: Red			
Domestic Response Plan budget: CHF 16,863,000			
DREF allocated: CHF 1 million to global appeal (DREF has been reimbursed)			
Total number of people affected:	As of 24 April 2020, 1,226 confirmed cases of COVID-19 in Afghanistan	**Number of people to be assisted: 2,687,500 people (direct or indirect)**	2,687,500[1]
Provinces affected (as of 5 April):	Total 30 Provinces with 1,226 confirmed cases; country-wide	**Provinces/Regions targeted:**	All 34 provinces and 7 regions
Red Cross and Red Crescent Movement partners actively involved in the operation: Afghan Red Crescent Society (lead), IFRC, ICRC, Norwegian Red Cross, Canadian Red Cross, Qatar Red Crescent, Turkish Red Crescent, Finnish Red Cross, Red Cross Society of China.			
Other partner organizations actively involved in the operation: Afghan Ministry of Public Health, WHO, OCHA, IOM, UNICEF, BPHS implementers (INGOs and Local NGOs).			

A. Situation analysis

Description of the disaster

On 31 December 2019, Wuhan city in China reported cases of pneumonia of unknown origin, which was later confirmed to be caused by a new coronavirus now known as SARS-CoV-02 which causes the disease COVID-19. Since then, COVID-19 has since been declared by WHO as global pandemic on 11 March, currently affecting 206 countries and territories around the world.

As of 20 April 2020, more than 2.4 million cases of COVID-19 have been reported globally. While more than 629,000 people have recovered, the death toll keeps growing with up to 165,000 deaths reported, predominantly in the USA (40,565), Italy (23,660), Spain (20,453), France (19,718), United-Kingdom (16,060) and Iran (5,118).China and South Korea, initially two of the most affected countries, seem to have controlled the spread of the virus, concerns are growing as the pandemic is expanding in fragile contexts where health and socio-economic systems are not equipped to capture or absorb a massive pandemic shock.

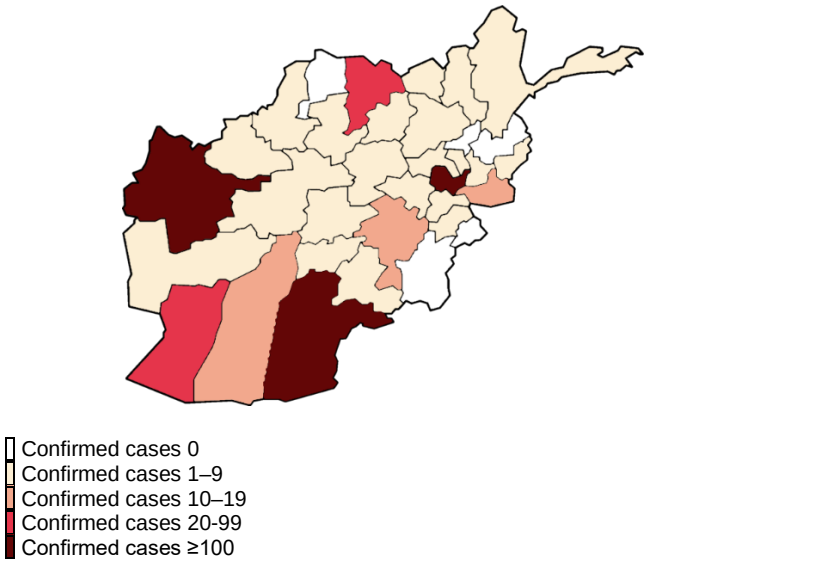
In Afghanistan, the Ministry of Public Health (MoPH) reported the first confirmed case on 24 February 2020 located in the western province of Herat, at the border with Iran. Herat has become since then the hotspot of the country due to its proximity with the Iranian border which has been crossed by more than 200,000 Afghan returnees since February 2020 and became the main vectors of COVID-19 imported cases across the country.

[1] Total 70 per cent coverage of 138 health facilities in 34 Provinces, with 455,000 people supported with food and/or cash interventions.

As of 20 April, MoPH data shows that 996 people across 30 provinces were confirmed to have the virus, for 33 reported deaths while 131 people had recovered from the virus. The case fatality rate was 3.4 per cent. More people had acquired the virus inside Afghanistan than had brought it from other affected countries**.** Men between the ages of 40-69 represent 60 per cent of all COVID-19 related deaths. Cases were expected to increase rapidly over the weeks ahead as community transmission escalates, creating grave implications for Afghanistan's economy and people's well-being. Herat was still the most affected part of the country.

COVID-19 outbreak situation as of 24 April 2020 (based on WHO)

Number of cases	1,226 confirmed
Number of deaths	40
Recovered[2]	188
Response phase	Containment and mitigation
Mode of transmission	Imported cases from Iran, Saudi Arabia, UK and increasing local spreading
Number of provinces affected	25 (out of 34) – See map below



Map of affected provinces, Afghanistan. (***Source: Afghan Ministry of Public Health***)

A pandemic of potential disastrous proportions in the Afghan context

It is acknowledged that the COVID-19 caseload in Afghanistan only captures a fraction of the real impact of the pandemic in the country. Until 20 April, the Afghan Ministry of Public Health (MoPH) reported that only 6,422 tests had been conducted. In war-torn Afghanistan, the overall health system is not equipped to absorb the shocks of a major pandemic as suffering from systemic weaknesses in terms of human resources, financial resources and infrastructures. On 20 April, the testing capacity for the coronavirus had been slowly increased up to 1,000 tests a day through eight laboratories. This remains largely insufficient compared to required standards and imperative to systematically track, test and treat.

Towards the end of March, the Afghan Ministry of Public Health estimated that 25.6 million Afghans (approximately 80 per cent of the population) could be infected and 110,000 Afghans might die from COVID-19. If that estimate is borne out, the casualties from the virus would be much higher than the total civilian casualties of the more than 18-year war.

The Emergency Response Plan adopted by the Afghan Ministry of Public Health (MoPH) on 24 March 2020 envisions three possible scenarios for the country:

1. Low-transmission scenario (based on the model analyzed in Hubei, China) would envision already a caseload of 40,000 people early April for a total fatality of 1,383 people and more than 9,000 hospitalized. This would however require massive mobilization and availability of protective equipment and medical materials as well as aggressive measures to find, test, isolate and treat cases, and trace contacts – a capacity which is not in Afghanistan's immediate reach due to multiple shortages and fragile systems across the country. However, ARCS have the capacity to mobilize more than 600 staff through its health facilities as well as between 4,000 to 6,000 volunteers. The blocking factor for scalable mobilization is the lack of PPEs and the systemic weaknesses of the local market for meeting the needs along acceptable quality standards.

[2] Based on the Johns Hopkins University dashboard here.

2. Moderate-transmission scenario which forecasts more than 190,000 cases, mortality at 5,716 and 38,205 persons to be hospitalized. This scenario supposes full compliance to social distancing and preventive measures as well as strengthened health systems and capacities over a period of eight months.
3. High-transmission scenario look into a grimmer picture of more than 16 million people infected, a total fatality 110,000 persons, and 738,000 persons in need of hospitalization. This scenario is developed based on global studies of the pattern of disease in other countries. In this scenario, 80 per cent of the total population would be affected, out of which 66 per cent of the infected people would be symptomatic. From the total symptomatic cases 4.4 per cent of the patients require hospitalization from which 30 per cent will be in the critical stage.
4. The COVID-19 outbreak will make the already worse situation of the country more deteriorating. The shocks and stresses of this pandemic will have a much broader impact on the socio-economic of the vulnerable households and will not only diminished the well-being and livelihoods of people, but also has undermined the markets and food security on which life depends. The shocks of COVID-19 will also have impacts on labour markets, purchasing power and lost productivity – all of which are significant factors for Afghanistan, not least because few Afghans have access to productive or sustainable remunerative employment.

While the moderate transmission scenario has been considered as the most likely and the one to prepare for, the high-transmission scenario is not excluded. More fine-tuned scenarios are being worked out by MoPH for planning purposes that contemplate at least 40,000 hospitalizations until June.

An expected widespread humanitarian impact due to pre-existing high vulnerabilities

The pandemic takes place against the backdrop of already deeply deteriorated socio-economic conditions while the ability of millions of people to cope with the crisis has been eroded from past shocks:

- More than 50 per cent of the population are living with less than USD 1 a day, or even a week.
- In 2020, 8.21 million vulnerable people are in need of urgent food and livelihoods assistance to reduce food consumption gaps, protect livelihoods and reduce malnutrition (Humanitarian Response Plan (HRP) 2020).
- Around 14.28 million people are estimated to be in crisis or emergency levels of food insecurity in the first months of 2020.
- More than 2.5 million people are internally displaced across Afghanistan due to both disasters and protracted conflict. Many millions more are living as refugees in neighbouring countries, and across the globe.
- A recent survey on nutrition conducted across Afghanistan indicated that 22 out of 34 provinces are currently above the emergency level threshold for acute malnutrition. The impacts of 2018-2019 drought further aggravating an already poor nutritional situation in the country (HRP 2020).
- 62.7 per cent of the urban population in Afghanistan are living in informal settlements according to data collected by the World Bank in 2014[3].

The restrictions and lockdown measures adopted in Afghanistan and neighbouring countries are expected to result in steady increase of food prices. Spikes in prices have already been observed on some key food items such as wheat, wheat flour, and cooking oil relative to COVID-19 impacts. For example, the price of wheat has increased by 15 per cent between 14 March – 2 April 2020. Potential supply disruptions of key food commodities (such as wheat flour and wheat grains) from Kazakhstan could further aggravate the possible negative economic impacts. The poorest households will suffer disproportionally from potential food price spikes with urban areas hit the hardest.

Numerous reports also indicate that patients suspected or even confirmed cases were escaping from health facilities to continue supporting their family with income generated on a daily basis. Between hunger and infection, impoverished communities will tend to prioritize surviving strategies based on income rather than health protection.

In a fragile context like Afghanistan, the pandemic may have a significant and widespread humanitarian impact on the poorest of the poor, especially in **urban and remote areas and IDP sites**. It will also affect the whole population and further weaken coping mechanisms and social safety nets while **unemployment** is expected to rise from 40 per cent to 70 per cent as a direct consequence of the pandemic (Afghan Ministry of Finance).

Key concerns and aggravating factors

Cross-border concerns

- As of 20 April, there were more than 82,000 confirmed cases in **Iran** where the first imported cases in Afghanistan were originated from. More than 150,000 Afghan migrants (and refugees) living in Iran returned crossed the border to Afghanistan between 1 and 28 March (IOM). The total number of Afghan migrants (and refugees) returning is estimated to 215,000 people. Although significantly reduced since 21 March, the returns still continue despite lockdown measures while all flights to and from Iran were suspended. This influx is

[3] While there are challenges in going beyond Cash and Voucher Assistance (CVA) and the distribution of NFIs and emergency shelters at this time, there is a plan to partially address these through disaster readiness proposals currently being reviewed.

considered having been the highway of the virus across the country and the porosity of the border between Iran and Afghanistan remains a high concern.

- In **Pakistan**, where 8,418 cases were confirmed as of 10 April, the country's border with Afghanistan has been officially closed. Despite several brief openings during which a limited number of commercial trucks have been allowed to cross to ensure continued supplies of goods, the humanitarian community has expressed concerns about the impact of repeated border interruptions on supplies of commercial goods which could drive up domestic prices in Afghanistan, as well as the impact on pipelines for humanitarian goods (i.e. food supplies). There are nearly 3 million documented and undocumented Afghan refugees living in Pakistan. The country's Torkham and Chaman-Spin Boldak border crossings with Afghanistan were re-opened on 6 April to allow citizens of Afghanistan who have been stuck in Pakistan to return. More than 70,000 people travelled across the borders from 6 to 10 April, which caused overwhelming COVID-19 screening measures according to IOM. Initially people returning to Afghanistan were likely to be placed under quarantine immediately after crossing at Torkham, irrespective of whether they had any symptoms. However, local authorities later changed their position due to the volume of the cross-border movement and instructed people to self-quarantine in their respective homes (OCHA/IOM).
- In early March, Afghanistan's neighbors – **Tajikistan, Turkmenistan and Uzbekistan** – have closed their borders for civilian movement and suspended flights to and from Afghanistan. However, several commercial transports are still in service.

Insecurity and violence

- Despite progress of the peace talks with the signing of a peace agreement between the US and the Taliban at the end of February followed by initial intra-Afghan discussion on prisoners, violence and insecurity remain a daily reality in the country. In March, the number of attacks has significantly increased, mostly targeting Afghan National Security Forces but also affecting civilians. In this context, and despite the pandemics, the risk of a 'Spring offensive' is not excluded.
- The level of criminality is also expected to rise while security forces focus on COVID-19 related measures and potentially fed by the worsening of socio-economic conditions and access to affordable food.
- With the further enforcement of lockdown measures, concerns are also growing with regards to heightened risk of sexual and gender-based violence against women and children (SGBV) and the rise of protection needs.

Disease, disaster, displacement: combined risks of cumulated shocks

- **Disease**: As observed in other countries, COVID-19 will have an impact on the capacity to address existing health challenges, including non-communicable diseases or mother-and-child health. Owing to weak health systems and infrastructures, it is expected that health facilities will be overwhelmed by the priority given on people affected by the pandemic to the expense of people suffering from chronic and other communicable diseases. Among vaccine preventable diseases, polio is not yet eradicated in the country, measles and whooping cough outbreak are still prevalent in different areas and there are cases of hepatitis A especially among children. Currently, main challenges with regards to vaccine preventable diseases in Afghanistan are:
  - Poor utilization of immunization services due to low coverage of basic health care implementer.
  - Disparity in distribution of healthcare services between rural and urban areas; health services are unavailable in many areas.
  - Ongoing security issues limiting access to health services.
  - Overall systemic weaknesses of the health system (human and technical resources, infrastructures and etc.) after 40 years of war.
- **Disasters**: Severe rainfall have been experienced across many provinces in March and April, with an estimated caseload of more than 34,000 people affected by floods, landslides and avalanches. Preliminary analysis suggests that nearly 60,000 hectares of cropland would be at risk of flooding across 10 provinces. This represents approximately 7 per cent of overall cropland across these provinces (Food Security Cluster). Efforts to contain and control the pandemics will have to be coupled with preparedness for disaster response and risk reduction.
- **Displacement**: In addition to Afghan returnees from Iran (215,000) and Pakistan (65,000), there are around 55,700 people have been displaced by conflicts in first quarter of 2020 according to OCHA. Internally displaced people (IDP) sites in various parts of the country are also bound to be potential pandemic hotspots due to limited capacities to contain the propagation.

Summary of the current response

Afghanistan has been in a state of protracted crises and political instability for more than 40 years while the country is exposed to recurring natural disasters, diseases, displacements, and disruption of livelihood due to overall high vulnerability and reduced coping mechanisms. Poor access to health care, limited access to water and sanitation, widespread food insecurity and high rates of malnutrition are all additional complicating factors for Afghanistan. The

ongoing propagation of COVID-19 is threatening to have overwhelming consequences on a fragile context like Afghanistan. Recognizing the rapid propagation of the virus as well as the limited capacities of the health system to respond, there is an urgent need to enhance multi-sectoral preparedness, operational readiness and response capacities to prevent and rapidly respond to pandemic, in line with International Health Regulations (IHR 2005), while addressing its humanitarian consequences.

Official data shows that, as of 20 April, 996 people across 30 provinces were confirmed to have the virus (for 6,422 tests conducted to date) and 15 people have died. Importantly, more people have now acquired the virus inside Afghanistan than have brought it from other affected countries.

Afghan public authorities
Aware of facing a crisis of potential nation-wide disastrous proportions, an Afghan High-Level Committee has been established directly under the Afghan President, with a pivotal role given to the Afghan Ministry of Public Health (MoPH) in driving the preparedness and response process.

Following initial measures in February focusing on risk communication and preparedness for response, the MoPH has equipped itself with an *Emergency Response Plan for Corona Virus 2020* which focus on six objectives across short and medium terms:

- Early case finding through active surveillance, which includes strict screening at the points of entry, referral system, contact tracing and community surveillance.
- Early isolation of confirmed cases and effective management of infected persons, with a focus on hospitalizing only those patients with severe symptoms (20 per cent of all cases) and those with critical conditions (5 per cent of cases) by increasing the number of beds from 10,400 to 40,000.
- Infection prevention and control as vital measures for controlling the pandemic in health facilities and communities.
- Health education, community mobilization, awareness raising and risk communication to enhance public awareness by disseminating a package of key messages and communication materials regarding COVID-19 using different communication channels[4].
- Effective coordination and resource mobilization.
- Effective and timely logistics support for emergency response.

At the end of March, the budget projections only for health, has been increased from USD 123 million for a low-transmission scenario to USD 891 million for high-transmission scenario.

Afghanistan relies heavily on **imports for medical materials and equipment** and foreign support at large. Stronger capacities have been built over the years with a network of 3,500 public health facilities and 1,000 private hospitals and clinics, 30,000 publicly employed health and around 30,000 community health volunteers, The surveillance system has 530 sentinel sites in all the 34 provinces, in both public and private health facilities. In response to the COVID-19, active surveillance sites have been established in all airports and zero-point borders of the country with trained staff and screening equipment.

The **health system** would however need to be actively strengthened to enable the public authorities to detect, test, treat and trace in a systematic manner. In March, only one central health laboratory was doing diagnostic tests, with maximum capacity of 50 tests per day, costing USD 1,600 per diagnostic kit. The absence of local laboratories to do diagnostic tests for COVID-19 created considerable delays in treating and isolating patients in hospitals in distant parts of the country. The government announced in early April that around 50,000 tests to be made available and efforts to scale-up testing were underway with additional eight testing facilities (Kabul, Herat, Mazar-e-Sharif, Kandahar, Kapisa and Nangarhar provinces). Altogether, the government plans to expand to 15 testing facilities across the country within the month.

Several provinces have instituted measures to limit the exposure of residents to COVID-19. International airports have been closed since end of March for commercial flights. Early April, **lockdown measures** were being enforced in the main cities (Kabul, Herat, Mazar, Kandahar, Jalalabad) where stricter measures have been progressively put in place, including through the mobilization of military and police forces and reported arrests, fines and/or placement into quarantine for people who did not comply. Movement restrictions should however not affect essential public services nor humanitarian organizations.

[4] ARCS will look into ensuring that all risk communication and community engagement (RCCE) activities are adapted and accessible to all people, especially marginalized groups.

Afghan Red Crescent Society (ARCS)
As auxiliary to public authorities, ARCS leadership has been involved from the onset into the high-level committee established under the President of the country, as well as through the Emergency Committee under the MoPH while participating to the Health cluster meetings focused on COVID-19.

In February-April, ARCS teams have been mobilized in various fronts to support prevention and containment activities, especially in Herat and the overall western region sharing a border with Iran. In support to early detection and surveillance efforts, ARCS has contributed to the screening of returnees from China and, more crucially, from Iran. During the first phase of COVID-19 preparedness and response (February-March), ARCS contributed as follows:

- Awareness raising on COVID-19 as part of preventive measures for ARCS own staff in all seven regional offices and 34 branches as well as through widespread network of health facilities (hospitals, clinics, Mobile Health Teams, etc.).
- ARCS MHT and health centers conducted awareness raising sessions /risk communication in 31 provinces.
- 12 MHT members, trained in IPC, engaged in early detection and surveillance efforts – more than 142,000 people screened (as of 20 April) for more than 93 presumptive cases identified and referred to dedicated governmental health facilities.
- At the community level, ARCS CBHFA volunteers have conducted awareness raising and risk communication regarding COVID-19 in 31 provinces – 470,000 people (287,000 males; 183,000 females) reached by 4,066 volunteers (3,388 males; 678 females), where more than 200,000 printed IEC materials have been distributed to targeted communities.
- ARCS has provided 184 family tents and tarpaulins for temporary screening and shelters in the cross border between Afghanistan and Pakistan (Torkham, Spin – Boldak and Zherai district of Kandahar Province).

ARCS priorities in responding to the pandemics

1. **Duty of Care**: To mobilize collective efforts in tackling the pandemics but also focusing on the safety of ARCS personnel and volunteers. As of 10 April: Measures have been taken to reduce the presence in ARCS offices (HQ and branch) to essential staff while Infection prevention and control routine activities are being carried out. There is still a crucial need of personal protection materials required.
2. **Health in emergencies**: For the emergency phase, ARCS Domestic Response Plan in health, aligned to MoPH emergency plan, is meant to mobilize all ARCS capacities in health including:

Number of staff	736 medical, 45 administrative and 150 supportive staffs
Number of volunteers	3,400 CBHFA and 3,000 Youth Volunteers[5]
Health services managed by ARCS	1 comprehensive health clinic, 45 basic health clinics (BHC), 22 health sub centers (HSC), 39 mobile health clinics, 31 Mobile health teams (immunization), 1 district hospital (Kabul), 2 ambulances

Upon the request of the MoPH and highest level of Afghan authorities, **ARCS developed a comprehensive Emergency Response plan** which was submitted to and approved by Afghan MoPH. Aligned with MoPH emergency plan, ARCS contribution aims at mobilizing ARCS 138 health facilities as well as community volunteers to support detection, surveillance, infection prevention and control activities and continued efforts in awareness raising and risk communication. One of the priorities for ARCS is to transform their central hospital in Kabul into a COVID-19 isolation centre (50 beds) which requires urgent procurement of equipment and medical materials. In March, only one hospital was officially assigned to treat COVID-19 patients with a capacity of 100 beds for a population of 6 million people in Kabul.

3. **Livelihoods** support: Increasing mobilization will also be required to address the humanitarian consequences of COVID-19 with a focus on livelihoods support (food and unconditional cash transfers).

Key challenges

- ARCS nation-wide engagement has been impeded and limited by the **lack of personnel protection equipment** (PPEs) and medical material. This shortage has been a huge challenge for Afghan authorities as well as international organizations operating in the country.
- In the face of a pandemic that has become global, resources (financial, skills, infrastructures) are also missing in the country to rapidly and effectively bring response capacities at scale.
- **Combining duty of care and operational effectiveness to respond to this emergency** will remain a constant challenge that will requires constant focus and evaluation. As of 10 April, ARCS had one confirmed case of COVID-19 and confirmed the loss of one associated member to ARCS mobile health team in Balkh.

[5] Staff and volunteers will be oriented on gender and diversity sensitivity, protection, and exclusion risks.

Overview of Red Cross and Red Crescent Movement actions

IFRC has been supporting ARCS from the onset at country and regional levels through targeted inputs including:

- Technical support in producing ARCS emergency response plan.
- Joint participation to the Health Cluster meetings co-led by MoPH Vice-Minister and WHO.
- Initial financial support under the DREF for immediate action focused on procurement of medical items and printing of IEC materials in support of prevention and preparedness efforts across ARCS offices, facilities and volunteers and as contribution to MoPH emergency plan.
- Provision of guidance materials produced at global or regional level to enhance ARCS readiness and technical support for response.
- Support to procurement and resource mobilization.
- Facilitation of Movement operational coordination and coordination with external actors, including through UN clusters.
- Development of IFRC Domestic Response Plan for ARCS emergency operations.
- Support to ARCS business continuity plan in collaboration with Movement partners.

ICRC has revised its activities to include COVID-19 preparedness and response with preliminary overview of the costing amounting CHF 11,200,000. Ongoing activities will continue through its structure of 10 offices and 7 physical rehabilitation centres. In support of patients and health care staff, the ICRC continues to work with Kandahar Mirwais hospital to develop a preparedness plan in case of an outbreak. Hygiene material and personal protective equipment (PPE) have been provided. Additional materials have been provided to MoPH identified structures that will be tasked with COVID 19 case management, when available, including in the areas which are under the control of non-state armed groups. For the detainees and detentions facilities, the ICRC has scaled up its support to authorities including donation of more quantities of hygiene material and PPE to their staff. Support will be provided to the Afghan Red Crescent to ensure protection of staff and volunteers while performing their Human Remains Transfer Program (including dead bodies due to COVID 19) and also restoring family links within the normal ongoing activities. The ICRC keeps close coordination with Movement partners to support the ARCS emergency response plan with specific focus on hard to reach areas. The support is focused on the 140 health structures to continue normal activities and respond to COVID 19 needs. The ICRC continues to provide major part of the ARCS Logistic supply chain for these health structures in collaboration with Norwegian Red Cross including supplies for PPE and medical items.

Norwegian Red Cross and **Canadian Red Cross** have made financial contribution to support ARCS prevention and preparedness activities while China Red Cross have expressed intention to enhance their support as well. **Turkish RC** announced its bilateral support of USD 10,000 with in-kind support of 300 hygiene kits. **QRCS** supported the NS with CHF 3,000 for PPEs and announced its CHF 15,000 more support to ARCS.

Movement coordination and cooperation

- A COVID-19 task force has been established, led by ARCS leadership and health team, convening on a weekly basis together with Movement partners.
- In rising to the challenge posed by the pandemic, Movement partners are committed to work together in providing technical support by leveraging synergies and expertise. A Movement Emergency Support Group had to be formally established early April along the following distribution of roles:

Movement - One coordinated approach for technical and funding support to ARCS through available resources (appeals)					
Clinics lead	**Mobile health teams lead**	**Community mobilization / risk communication**	**Livelihood support**	**Case management**	**Duty of care / BCP**
Norwegian RC in liaison with Qatar RC and ICRC (supplies)	Canadian RC in liaison with Norwegian RC, Swedish RC and IFRC	IFRC in liaison with Canadian RC and Norwegian RC	IFRC in liaison with Turkish RC	ICRC (technical support, forensic)	ICRC and IFRC

Technical support on health is being co-facilitated by Norwegian Red Cross and IFRC, including to find emergency stop-gap solutions to the shortage of protective supplies.

- Other Movement Coordination mechanisms (Operational Coordination meetings, Tripartite Strategic meetings) remain actionable in agreement with or upon request from ARCS leadership.

Overview of non-Red Cross and Red Crescent actors in country

Afghan Public Authorities
National Disaster Commission (NDC) is established is established in case of huge outbreak of diseases to coordinate multisectoral efforts with a view to mitigate and control the outbreak. The President of the country appointed one Vice-President to lead COVID-19 response efforts through the NDC which has been meeting several times a week. ARCS is a member of this Commission. The NDC has also established provincial disaster commissions.

The Emergency Inter-sectoral Committee was established by the decree of the President of the Islamic Republic of Afghanistan and chaired by the Minister of Public Health, it includes key Ministries (Foreign Affairs, Haj and Awqaf, Transport, Aviation, Information and Culture, Trade, Agriculture and Livestock, Rural Development) the security agencies and the ARCS are member of this Committee.

MoPH Emergency Committee (national and provincial) is the leading committee within MoPH responsible for ensuring effective and efficient coordinated response by the health sector to any disaster in the country. MoPH operational arms are comprised of the Department of Emergency preparedness and Response (EPR) and Centre for Command and Control (CCC), a structure which is under the direct supervision of MOPH leadership. Provincial health emergency committees have been established to ensure provincial coordination of surveillance, health care services and risk communication in liaison with the central committee. The provincial health directorate acts as the secretariat.

Basic Package of Health Services (BPHS) implementers, comprised of both local and international NGOs, are supporting MoPH in undertaking daily surveillance of COVID-19 in all Health facilities and carrying out preventive measures, especially awareness raising for communities.

United Nations Response and Coordination
Afghan public authorities are also supported by UN agencies. WHO has been active in supporting the MoPH plan, COVID-19 related guidelines, health capacity strengthening (including testing capacities) and the mobilization of 'polio-eradication' volunteers. IOM has been involved in border crossing site to support the crossing of returnees.

A COVID-19 Multi-Sector Humanitarian Country Plan for Afghanistan, coordinated by OCHA, has been finalized requiring USD 108.1 million to reach 6.1 million people with life-saving assistance across all clusters. The plan outlines initial preparedness and response efforts for the next three months but is expected to be updated as the situation changes. This cost plan will form the basis of a Humanitarian Response Plan revision in the near future. The multisector plan also aims to highlight the potential effects of the outbreak on ongoing humanitarian response and spell out mitigation measures being employed to reduce interruptions to life-saving services. Priority activities in the plan include the strengthening of health capacities in expanding preparedness, containment and mitigation activities, the scaling-up of WASH especially in IDP sites, risk communication and awareness raising, food security and malnutrition, population movement monitoring, support to people with specific needs as well as advocacy and flight services (including an going initiative to establish an international air-bridge. Meanwhile, on 2 April, the World Bank approved a US$100 million grant to support Afghanistan to slow and limit the spread of COVID-19 through enhanced detection, surveillance, and laboratory systems, as well as strengthening essential health care delivery and intensive care.

In term of Inter-agency coordination, the Humanitarian Country Team (HCT) is the main inter-agency coordination body in liaison with the Inter-Cluster Coordination Group.

ARCS and IFRC have consistently engaged in critical inter-agency coordination mechanisms including:
- The inter-cluster coordination group – IFRC.
- Health cluster (co-led by MoPH and WHO).
- Food security and Agriculture cluster.
- Protection cluster.
- Cash and voucher working group.
- Risk communication working group.

Needs analysis, targeting, scenario planning and risk assessment

Needs analysis
Health: ARCS has carried out a baseline assessment to identify the risks and challenges associated to COVID outbreak which are to be addressed in its health emergency response plan's implementation. These risks or challenges are summarized as follows:
- Protection and safety of frontline responders: The accelerating transmission of the virus makes frontline responders highly exposed to infection, especially for health personnel in Kabul and Herat where infection

cases have already been confirmed. The risk is heightened by the shortage or lack of protective equipment for health responders.
- Volatile and fragile security situation,
- Food insecurity and poor immunity of mothers, children and elderly.
- Inadequate capacities or potential; capability deficit in terms of adequate Human Resources and availability of Medical and Non-medical Resources in the country's health clinics.
- Lack of comprehensive assessment report to provide needed supply for health interventions.
- Budget limitation for the response.

Hard-to-reach areas / White zones: Due to the current conflict and insecurity, part of country is out of control of Afghanistan government. Through its principled humanitarian action, ARCS is in capacity to ensure access and acceptance in all part of the countries, including hard-to-reach areas, to carry out critical activities including awareness raising, risk communication and referral of suspected cases to dedicated health facilities. MoPH also delegates the provision of primary health services to the community through BPHS (Basic Package of Health Services) through NGOs which are not always in capacity to fill in gaps in 'white areas' where health services are missing. As per its MoU with the MoPH, ARCS is one or the rare organizations able to operate in white zones and hard-to reach areas across the whole country, through a pool of trained volunteers, MHTs, fixed clinics and one district hospital at the capital level. ARCS provided free health services to vulnerable people who cannot afford to pay for it building on the deployment of MHTs covering almost the full country.

Critical needs in health
• Critical stocks of PPEs, such as masks and gowns, to equip first responders as the number of confirmed cases of COVID-19 in Afghanistan rises. • Medicines and medical equipment for isolation centers (including ARCS hospital in Kabul), transit facilities and health mobile capacities (including ARCS two ambulances). • Training materials for ARCS health responder (clinics, MHTs and volunteers) for using PPEs, infection and prevention control, identification of presumptive cases and referral to the dedicated hospitals in the country. • Non-medical equipment to support detection efforts (rub halls, etc.) • Awareness raising and prevention materials including speakers, IECs, etc. for community engagement and risk communication.

Food and livelihoods support: During COVID-19 pandemic is not a threat that stands separate from the sectors i.e. health, WASH, family wellbeing, means of income and their livelihoods. This pandemic may have severe impact on each pillar of food security, that need to be examined the protection of food security which must be integrated into other sectors in the COVID1-19 emergency operation. In the context of the COVID-19 outbreak, country may suffer from various market disruptions, producers, suppliers and financial service providers, and retailers can be affected by movement restrictions and fluctuations in the availability and prices of various goods, while concerns by the general public may cause a spike in demand for basic items – stockpiling. This is particularly likely to occur following the confirmation of new imported cases and/or human-to-human transmission in the country. If the situation worsens, there might be broader impacts on livelihoods due to border closures, restrictions of movement and economic slowdown. As a consequence, both markets and the food security of the most vulnerable populations should be monitored. Market indicators should be closely monitored to anticipate disruptions and contingency plans should be developed for the most likely scenarios (e.g. market assessments, assessment of key supply chains, alternative strategies for procurement and logistics of food and non-food items for ARCS. A wide range of actions can support and protect food security in a pandemic. COVID-19 response depends on early planning, that is why preparedness is so important. After considering the serious impact of outbreak, the NS leadership determined that food assistance is a suitable option for the operation.

Cash assistance: Those financially poor populations who are either affected and quarantined or who have lost their income due to the COVID-19 will also be required immediate financial supports to cope with the situation.

Critical needs in livelihood support
• As part of the broader COVID-19 response, and considering the fact that this pandemic is having radical negative impact on the livelihoods and financial resilience of the poor and most vulnerable population, critical needs include o Food assistance (food baskets) to poor, in urban and rural areas, including quarantined households, o Multi-purpose cash assistance to the poor households that are either quarantined or have lost their incomes due to the COVID-19

Targeting

Health interventions will be carried out through ARCS 46 basic health centres, 63 Mobile Health teams and 10 Health Sub-Centres. The main targeting populations will be the health facilities catchment area population which have already set up per health facility. If we consider the average population of each health facility, 4,000 people will be covered per each which indicates a total of 400,000 population while such a figure will be a higher for the central hospital that maybe

within 60,000-120,000 total population. Fixed clinics are functional in 34 provinces including the capital. They have own catchment population which has been already coded by the Ministry of Public Health GIS system. It's worth mentionable at the moment; ARCS will focus mainly on the provinces that are most vulnerable and prone to COVID-19 outbreak and bordering neighbouring countries such as Iran and Pakistan. According to statistic report from the World Health Organization, the highest attention will be on provinces such as: Kabul, Herat, Farah, Nimroz, Kandahar, Helmand, Balkh, Samangan and other provinces where suspected cases are recorded.

Targets for revised Domestic Response Plan

Areas		Male	Female	Total
Health Services	MHTs	288,750	236,250	525,000
	Clinics	284,625	232,875	517,500
Total MHTs &Clinics		**573,375**	**469,125**	**1,042,500**
Community & Volunteers	CBHFA	550,000	450,000	1,000,000
	WASH	104,500	85,500	190,000
Total CBHFA & WASH		**654,500**	**535,500**	**1,190,000**
Livelihoods support	Food	-	-	350,000 (50,000 households)
	Cash	-	-	154,000 (22,000 households)
Grand Total		**1,227,875**	**1,004,625**	**2,687,500**

Target group	Rationale
General population	In routine basis ARCS clinics have to provide primary health care services to the targeted population while in the emergency situation the loading of work and services will be high and require more specific intervention in accordance with the need for outbreak management. Ensure frontline medical personnel are gender-balanced and health facilities are culturally and gender sensitive.
Women and children	In the remote areas of the country, access and insecurity are the main challenges against the health service quality and equity. Meanwhile, Cultural factors may restrict women's access to information on outbreaks and availability of health services: gender roles may dictate women cannot obtain health services independently or from male service providers - even in an emergency. So, it will be considered to provide house to house care in these kinds of communities.
IDPS and returning migrants/refugees in camp settings	Established camp settlements for IDPs and returning migrants/refugees in Herat and Nangarhar province will be targeted, alongside new settlements for returning migrants/refugees in Nimroz and Herat as well as other at-risk provinces.
Quarantined Individuals / Households	The financially poor quarantined households, in addition to health care supports, will also require immediate food and livelihoods supports as a result of having no more incomes.
Households that have lost their incomes due to COVID-19	The poor and economically vulnerable households – that are not quarantined but have lost their incomes due to the greater result of COVID-19 – must also receive immediate relief and humanitarian supports, so that they should cope with the situation as well as the risk of greater humanitarian disasters be reduced.

In support to ARCS case management activities (COVID-19 hospital/isolation Center in Kabul), target group will also include people infected and hospitalized (50 beds).

Scenario planning

Scenario	Humanitarian impact
A small number of imported and isolated cases, managed effectively by the health system.	Low
Long-term spread of the virus, with outbreaks in certain parts of the community, putting stress on the health system.	Medium
Rapid spread of the virus, leading to breakdown of the health system and other essential services.	High

Currently Afghanistan is in *"Long-term spread of the virus, with outbreaks in certain parts of the community, putting stress on the health system."* scenario:

MHTs and fixed clinics are now facing the cases almost everywhere and doing case identification and referrals to dedicated governmental hospitals. At the same time in continuation of health promotion, risk communication for COVID-19 is part of awareness raising activities through health facilities.

The necessary scaling-up of the response under this Domestic Response Plan is based on MoPH projection for a **moderate-transmission scenario** that foresees: Total cases 190,549; the peak [estimated at] 31,446 cases detected in one week; total fatality with a 3 per cent of Case Fatality Rate, will be 5,716 persons, and 38,205 persons will need hospitalization; during the peak two weeks 6,291 cases will need hospitalization at the same time from which 1,574 cases (5 per cent of total cases) will be in critical phase – need ventilators. It is also taking into account the humanitarian impact of the pandemic and the longer term needs to be addressed.

However, in case of worst-case scenario (high transmission, see above), which would have consequences of disastrous proportions in a fragile context like Afghanistan, this plan would need to be reviewed and expanded.

Operational Risk Assessment

Risk area	Controls
Staff and volunteer health: risk of contracting COVID-19 through clinical or community-based activities	• Information and training for staff and volunteers • PPE for all frontline staff and volunteers in high-risk affected areas • Enhanced efforts to localize the supply chain to the maximum in liaison with regional logistics and Movement partners • Minimize non-essential travel
Services disrupted due to restrictions to movement or illness of personnel	• Business Continuity Plan including tasks for finance, admin, IT, HR • Set up flexible working arrangements • Identify essential and non-essential services that could be prioritized during period of hibernation or withdrawal
Negative media coverage related to handling of the response operation	• Proactive communication with media and stakeholders • Community Engagement and Accountability (CEA) • Thorough needs analysis, planning, prioritization and reporting
HR - Low technical and operational capacity of staff.	• Staff development training is supported to expand its trained human resources base.
Coordination and Communication - Delays in implementation of planned activities with delay processing of documents required from other departments. Weak field level coordination with humanitarian agencies; less participation to health coordination and cluster meetings by RHOs.	• Set up regular ARCS IFRC health management meetings at HQ level. • ARCS Internal communication and coordinated mechanism in place between program departments and different level. • Continued activation of the Movement Emergency Support Group on a daily basis. • Regular Movement Coordination meeting at HQ, regional and branch level. • Continued participation to national and local level UN clusters and working groups.
Logistics - Weak logistical and control system. Delayed the implementation of the planned activities due to delayed procurement approval. Non-compliance to procurement and logistics requirements.	• Monitor and supervise implementation of procurement procedures at regional level. • Orientation of ARCS Health program staff on ARCS and IFRC procurement/logistic framework, guidelines and requirements for compliance.
Security - Worsened conflict situation. Risks and threats for staff and volunteers. Abduction of staff for interrogation. Volatile security situation can compromise community access without notice resulting in cancellation or postponement of planned activities.	• ARCS coordinate with district authorities and community Shuras where ARCS programs will be implemented for recognition and protection of staff and volunteers in the areas. • Safe access and security awareness sessions provided to ARCS staff and volunteers in coordination with ICRC based on Movement Security Framework. • IFRC coordinates with ARCS and ICRC on a daily basis in monitoring of security factors across the country • Orientation of ARCS Health staff on stay safe training • Support to establish ARCS security framework and training of ARCS Security focal point • IFRC coordinates with ARCS and ICRC on a daily basis in monitoring of security factors across the country. • Having regular phone contacts with field officers.
External - Closure of main roads for logistical supply.	• Plan for earlier delivery/prepositioning of commodities to the regions and provincial branches. • Disasters may temporarily interrupt project schedules but will be used as opportunities to

Risk area	Controls
Delay/suspension of project activities.	enhance the experience of ARCS in the application of response skills in assessment, coordination and integrated programming opportunities in emergencies with the DM, health, OD, Gender, PMER and other related departments. • Re-prioritization of activities as needed.

The planned coverage areas are large and security situation need to be carefully monitored. This will be factored into the detailed planning and budgeting for the operation and will include security and safety considerations, especially for frontline responders (staff and volunteers) to be provided with protective equipment and additional trainings in liaison with MoPH.

B. Operational strategy

The overall operational objective is to contribute to reducing morbidity, mortality as well as the humanitarian impact of the pandemic, in urban and rural areas, by preventing or slowing transmission and helping affected communities to access basic social services enabling them to cope with the situation in a dignified way.

The ARCS deliver humanitarian services across Afghanistan through its branch network including the provision of community and primary health care services through CBHFA volunteers, Mobile Health teams, Health Sub Centres, Basic Health Centres, Comprehensive Health clinics and a district Hospital. The ARCS is uniquely placed to provide essential services in hard to reach areas where ongoing hostilities have resulted in increased vulnerabilities of communities living in these areas. The operational strategy under IFRC emergency appeal focuses on ARCS health facilities and livelihood support to affected households and communities. Across the response continuum, priority will be given to staff and volunteers' duty of care and protection, gender and inclusion at large.

Strengthening ARCS coordination with public health authorities and other stakeholders in emergency health will facilitate building synergies while avoiding duplication of efforts resulting in an effective national and sub-national response capacity.

Protection concerns are exacerbated by pre-existing conflicts. Considering this volatile security environment, it is vital that ARCS take preventative measures in its awareness raising and mobilization of communities. These include implementing IFRC Minimum Standard Commitments on Protection, Gender and Inclusion during Emergencies. Specifically, these minimum standards should be utilized during assessments of the ARCS response. The response should include a gender and diversity analysis in all actions and adapt activities as required to ensure to ensure protection and inclusion for all.

Proposed strategy

The proposed strategy for this Domestic Response Plan will seek to reduce the vulnerability of 2,687,500 people. The operational strategy is articulated around four pillars:

1. **Duty of care for 1,000 staff and 4,000 volunteers during the emergency response**
   COVID 19 transmission is expected to significantly increase over the coming weeks exposing the frontline health care workers and volunteers to high risk of infection and heavy workloads. Priority will be given to the safety and protection the frontline workers (staff and volunteers involved in the response) who are critical in the containment of the pandemic.
   - Provision of Personnel Protective Equipment (PPEs) for frontline staff in ARCS health facilities, including in the district hospital in Kabul to be turned into a COVID-19 isolation centre (around 1,000 staff) as well as volunteers engaged in community engagement and risk communication (4,000 volunteers). This is a condition for ARCS teams to operate within minimum safety conditions.
   - The provision of 220,000 hygienic items – sanitizers, hand washing soap, disinfectant, etc.
   - Health risk allowance for staff involved in the response (clinics, MHTs, immunization teams, hospital).
   - Insurance for 4,000 volunteers.

2. **Health in emergencies**
   IFRC Domestic Response Plan for Afghanistan will support ARCS health emergency plan that has been approved by Afghan MoPH. Coordinated technical support with RCRC movement partners - including with {Norwegian Red Cross (emergency health), Canadian Red Cross (Mobile Health teams) and ICRC (case management) - will harness the technical support capacity that can be mobilized in the country in implementing the Domestic Response Plan.

- Support to establishing ARCS district hospital as COVID-19 isolation centre (50 beds) in Kabul in the current District Hospital.
- Infection, prevention and control (IPC) in health facilities and communities, including in white zones and hard-to-reach areas.
- Surveillance and detection: Early case finding through screening, referral, contact tracing (when possible) and community surveillance, including establishment of rub hall screening centres.
- Community engagement, risk communication and hygiene promotion.
- Psychosocial support including supporting the frontline health workers and volunteers to build resilience and cope with the stresses of responding to the pandemic in frontlines where some of the health workers are casualties of the pandemic. Build the capacity of the Frontline workers on Psychosocial support for patients and clients who find it challenging to cope with the emotions and realities of the pandemic.

3. **Emergency food security assistance**

ARCS will be supported in providing emergency food security assistance to the poor and most vulnerable households (including displacement affected people) that are / will directly be affected by COVID-19 outbreak. The planned activities under this component will be operationalized as per the following operational strategy and procedures.

- The poor and most vulnerable households in quarantine, households with a member(s) under treatment, or households who have lost their main income sources will be prioritized.
- The poor and most vulnerable households (around 22,000) that are still having access to local markets will be provided with unconditional cash assistance to address their food needs.

The poor and most vulnerable households that are in quarantine and cannot leave their residences to purchase food will be included:

- Food packages or multipurpose cash assistance to be provided with in-kind to most impoverished communities, including in urban informal settlements and IDP and returnee sites,
- Food packages or multipurpose cash assistance (raw or cooked food baskets).
- The displacement affected households (IDPs or returnees) and households with handicapped member(s) in need of emergency food assistance will be amongst prioritized beneficiaries under this component.
- All the target households, under this component, will be eligible to receive complete food baskets for one month.

4. **Capacities and systems strengthening**

The operational response will go together with efforts to enhance ARCS capacities and systems in a sustainable manner. Activities will aim at strengthening the organization effectiveness and readiness to respond in priority areas (health and livelihoods support) as well as existing systems. Under this priority will be included:

- Youth and volunteer engagement and management.
- Data readiness and ARCS Information management in liaison with HMIS.
- Support to ARCS logistical capacities (purchasing of 2 trucks and strengthened warehousing capacity).
- Protection, gender and inclusion.
- Support to ARCS Business continuity.
- ARCS operational frameworks and procedures for preparedness and response to pandemics.

While it is anticipated that some ongoing ARCS supported programmes will be postponed or delayed, this operational strategy will also aim to integrate COVID-19 response components in relevant ongoing programmes and operations while keeping aa response capacity in case of other emergencies. This will require to repurpose, partially or integrally, some activities in liaison and agreement with funding partners.

They include but are not limited to:

- Immunization programme and health teams in hard-to-reach areas and associated mobile immunization and health teams (31).
- Community-based health programme, which includes the mobilization of community health volunteers.
- Women empowerment programme, including through the involvement of ARCS Marastoons (social welfare centres hosting widows and under-privileged women) in the effort of producing locally protective equipment as income-generating activities.
- Youth-led health projects.
- Health and Cash remaining activities under IFRC emergency appeal on drought and floods.
- Response readiness to other emergencies, especially natural disasters.

Proposed interventions

Overall, this operation seeks to assist the following within each sector:

- **Procurement and distribution of critical items** which include Personal Protective Equipment (PPE) kits, medicines, medical equipment, WASH-related items, food supplies and household items (rub halls, blankets, etc.). These procurements will prioritize PPEs for frontline responders as well as operationalization of the ARCS Isolation Centre for case management. Although the market in Afghanistan make the provision of these items heavily dependent on external support and international procurements, all efforts will be made to source and procure local items in line with acceptable quality standards in compliance to the laid down procurement procedures and guidelines.

- **Infection, prevention and control (IPC) and triage:** IPC is crucial in containing the spread of COVID-19. Robust IPC measures and practices through development and operationalization of Standard operating procedures in all the ARCS health facilities. IPC aims to stop the spread of infectious diseases to other patients as well as health care workers by rapid isolation of suspected cases; creation of isolation areas that ensure correct patient flow and keep suspect patient away from others seeking usual care; and availability of appropriate facilities and materials for hand washing, waste management, cleaning and disinfection as well as PPE for health workers. It is also important that facilities have trained staff in triage and early detection of suspected Coronavirus cases. ARCS will extend the support through existing health facilities countrywide for improving IPC measures and the training of health personnel in the target provinces. These activities will be implemented through ARCS MHTs and existing health structures focusing on IPC/triage at the facility level. With active support from Movement partners, IPC needs will be assessed and met, taking into consideration the Movement capacities, geographical evolution of the pandemic as well as access constraints. With the support of ICRC and MoPH health staff will be trained on IPC as part of critical preventive measures in all health facilities. This will protect health staff and prevent from spreading of infection to the clients and through them to the community members.

- **Surveillance and detection:** Health staff and volunteers will be equipped with personal protective equipment and trained on case identification (line listing), diagnosis and management where appropriate, in coordination with MoPH. In ARCS health facilities, this will include screening, referral system and possible contact tracing. ARCS community volunteers (100 per province) will reinforce, the surveillance programme in target provinces. Joint surveillance trainings would be supplemented by Red Crescent-specific training, i.e. community engagement and epidemic control for volunteers (ECV) for those who do not already have this training.

- **Risk communication and community engagement (RCCE):** Community engagement will be mainstreamed of pandemic preparedness and response and will be integrated across all aspects of the operations in affected provinces across the country. Trusted, clear and effective communication and engagement approaches are critical to ensure that fear, panic, and rumours do not undermine the response efforts and lead to COVID-19 spreading even more quickly. Effective community engagement will also support the operation to gain an insight into the perceptions and behaviours of different groups, and to develop effective and targeted messaging. ARCS will adopt diversified approaches to implement the operation activities in targeted areas, including adapting sensitization tools to local realities and needs, using key informants to reach people and influence their ways and practices. These approaches put communities at the centre of all actions through community leaders, men, women and youth groups. IFRC will ensure national RCCE plans are informed by gender analysis and sex, age, pregnancy status, and disability disaggregated data where available.

- **Mental Health and psychosocial support:** COVID-19 pandemic needs are identified in various populations facing the outbreak. SGBV prevalence has complicated the emergency response in Afghanistan where the coping mechanisms of most individuals deficient and stressful. Frontline health workers and volunteers who are supporting the response encounter challenging problems daily and would need PSS in order to continue to function optimally. In addition, SGBV increases in contexts of emergencies, with additional strain being put on already weak health structures in the country, a training component on responding to the mental health and psychosocial needs of SGBV survivors will also be integrated into the PSS pillar of the response. Alongside the training of volunteers, the coordination with other actors able to provide services for survivors will be strengthened to ensure the availability of referral pathways. Volunteers working in COVID-19 response and especially in high risk activities are under extreme stress and carry out some of the most dangerous tasks related to the outbreak. MHPSS services should be made available to them as well, including, workshops and actual practice of roster and work shifts to assist volunteers and staff on stress management and peer support, and setting up support systems to help them deal with their situation without engaging in risk taking behaviour. A team of trainers in psychosocial support will be set up within ARCS and will be able to carry out awareness activities and trainings for both the staff and volunteers involved in pandemic response. Referral mechanisms should be made available in handling various mental health clinical conditions due to pre-existing and outbreak-

related disorders.

- **Maintenance (continuance) of and access to health care services:** While focusing on the response to the pandemics, ARCS will also aim at ensuring continuity in the delivery of primary health services in the catchment areas of its 138 health facilities.

- **Hygiene promotion:** Hygiene promotion begins by identifying key messages through appropriate communication channels and then focusing on the most effective interventions, including handwashing with soap, excreta disposal, household water treatment and safe storage. Messages will aim to address local health risks and behaviour change in most at-risk communities. In this operation ARCS will support communities through its trained volunteers to communicate and disseminate the information to households on WASH issues.

- **Food assistance:** The proper functioning of market chains and flow of agricultural products are key elements for food and nutrition security. The deadly COVID-19 outbreak knock-on and may have huge effects – loss of lives, stifled growth rates, reverse socio-economic gains, aggravate poverty and food insecurity and destroy livelihoods and particularly affecting women and children. Beyond physical effects of the pandemic, people will suffer reversals in economic empowerment, because of reduction of the economic activities related to COVID-19 control measures that restrict the movement of people and goods. In their role as economic providers for their families, people will experience sharper negative economic impacts. If the situation worsens, there might be broader impacts on livelihoods due to border closures, restrictions of movement and economic slowdown. Consequently, both markets and the food security of the most vulnerable populations should be monitored. Under specific circumstances during COVID-19 outbreak, ARCS will provide food assistance to households affected by movement restrictions and loss of their livelihoods. Food assistance brings a clear contribution to the disease containment efforts and/or food security outcomes. ARCS will ensure to access equally and to impartial assistance according to need and without discrimination. This includes identifying people in need of food assistance if they are marginalized or fear marginalization due to the virus and preserving sensitive information on affected persons or communities.

- **Cash and Voucher Assistance to support affected people needs and livelihoods:** ARCS will be supported in providing emergency food assistance to the poor and most vulnerable households that are affected by COVID-19. This will include households in quarantine, households with a member under treatment, and poor households that lost their main income source due to movement restrictions. Depending on the local context and accessibility of target households to markets, the type of food assistance will either be unconditional cash assistance (cash for food), or in-kind assistance (raw or cooked food baskets). As of development of this Domestic Response Plan, ARCS intend to provide unconditional cash assistance to 22,000 households and food baskets to additional 50,000 households across all 34 provinces of Afghanistan. The distribution of targets to provinces will be finalized at the start-up phase of the implementation. All the households, within this component, will be eligible to receive complete food basket for one month.

- **Protection, gender and inclusion:** The operation will apply an integrated approach and the IFRC Minimum Standard to Protection, Gender and Inclusion in Emergency Programming will be mainstreamed in sector specific interventions. Briefings will be held on IFRC/ARCS commitments through the Code of Conduct and Child protection Policy, as well as obligations of volunteers, staff and management to ensure a zero tolerance to sexual exploitation and abuse (PSEA). Community based protection approaches will be designed by communities and this will be enhanced during the operation to ensure social inclusion and community cohesiveness, as well as to mitigate tensions. Based on the community structures in the villages, a need to focus on women's participation and decision making in the community is essential, promoting grandmothers as active agents in all activities including longer term social inclusion initiatives. Outreach teams and mobile health teams will be equipped with referral information and will have received training on Protection, gender and inclusion to be able to support with house to house visits when difficulties in access may be increased.

Operational support services

Human resources

As part of the implementation of this Domestic Response Plan, Movement partners and ARCS will mobilize the following resources:

In-country resources

- IFRC country team covering operation management, health, Cash and livelihoods, coordination, security, National Society development (including youth and volunteers), logistics, human resources and finance. The IFRC Head of Country Office will be ultimately accountable for timely implementation, compliance, financial management and reporting of the operation.

- Norwegian Red Cross country team (co-lead on emergency health operation) covering support to fixed clinics and MHTs, risk communication and procurement of essential and medical items.
- Canadian Red Cross country team will lead on technical support for MHTs
- Qatar Red Crescent team (clinics) and Turkish Red Crescent (hygiene and livelihoods)
- ICRC will integrate COVID 19 in its operations (health and detention) with technical support capacities for case management, forensic and ARCS business continuity.

Surge support
Due to the closure of airports and access to and from Kabul, surge capacities will be sourced locally, at least during the first phase of the response, and will include:

- An operations support coordinator, responsible for coordinating the emergency response with a focus on monitoring, evaluation and reporting functions, in support to ARCS and in compliance with IFRC procedures.
- Health officer to support ARCS health-related activities with a focus on health communication.
- PGI officer to ensure the mainstreaming of protection and gender related activities and monitoring.
- A PMER senior officer.
- A livelihoods senior officer.
- Communication coordinator to support awareness raising activities, facilitate content generation and produce regular information materials for partners and media.
- Disaster risk management coordinator to support ARCS emergency readiness and systems and prepare for disaster response.

ARCS

- At the provincial level, the National Society will hire a project staff designated for the implementation of ARCS emergency plan. Besides health, livelihoods & cash, and youth & volunteer focal points, administration and finance persons will also be appointed.
- At the level of the implementation areas, the National Society will commit DRUs/NDRTs for operation and for the supervision of volunteers.

Logistics and supply chain management
Logistics activities aim to effectively manage the supply chain, including mobilization, procurement, customs clearance, fleet, storage and transport to distribution sites in accordance with the operation's requirements and aligned to IFRC's logistics standards, processes and procedures.

Personal protective equipment (PPE) kit are needed for this operation. Except medicine and water filter, most of the relief items will be replenished subject to funding availability. PPE kits will be sourced internationally through Operational Logistics, Procurement & Supply Chain Management Unit, Asia Pacific (OLPSCM). IFRC CO will source out some items/equipment based on the availability in Afghanistan in accordance with IFRC procurement procedures and processes.

One surge specialized in logistics will be deployed to Kabul in review the logistics and procurement processes and introduce improvements, coach and train IFRC logistics officer, and, coordinate logistics of the Emergency Appeal operation.

Communication strategy
ARCS and IFRC will collaborate to implement a two-fold communication approach:

- Support awareness raising and risk communication strategy through the provision of communication materials, messages and recommendations on appropriate communication channels to ensure wide outreach on prevention activities.
- Movement and external communication, in liaison with and support to ARCS communication team, through context analysis, content generation, media/social media materials and outreach, potential field visits as well as weekly updates and information materials on the emergency response targeting partners and external stakeholders.

Security
Generally, the security situation in the country remains unpredictable and volatile, and in some areas the security risks are extreme. The overall response in COVID-19 outbreak may affect the activities and communities due to access restriction or security concerns. Civilians living in the provinces of Nangarhar, Kabul, Helmand, Ghazni, and Faryab were most impacted by the conflict. The increase in the number of civilian casualties from suicide and complex attacks by anti-government elements, more than half of which are attributed to a non-state armed group, continued to offset decreases in civilian casualties from other incidents. The majority resulted from suicide and complex attacks, which increased both in frequency and in lethality to civilians, driving the overall rise in civilian deaths. Ground engagements

were the second leading cause of civilian casualties, followed by targeted and deliberate killings, aerial operations, and explosive remnants of war. confinement measures initially led to a decrease in traditional criminality in many places, as movement restrictions and curfew made it difficult for criminals to move around. The fact that people are staying at home means less victims in the street and less empty houses to break into. However, in the medium term this might lead to an increase in crime of opportunity

The IFRC Afghanistan country office will continue to provide regular analytical updates on security to inform emergency operations and facilitate anticipation and adaptability in planning and delivery.

Planning, monitoring, evaluation, and reporting (PMER)
Continuous monitoring will be carried out through the ARCS staff members in the areas of implementation to support the COVID-19 interventions and will ensure that there is compliance with the minimum international humanitarian standards and IFRC Fundamental Principles, as well as beneficiary satisfaction, and the management of the available resources. The IFRC Afghanistan Country Office will also carry out monitoring missions in collaboration with the ARCS to support the effective implementation of the revised Emergency Appeal and Domestic Response Plan and budget will be conducted based on the results of the monitoring report. Trained staff and volunteers will be mobilized for data collection and basic analysis in all target provincial branches. Data collections include registration of people to be assisted, baseline data on Cash and Voucher Assistance (CVA), post-distribution monitoring (PDM) data, end line survey, market analysis and price monitoring data. Steps are being taken to strengthen the National Society approaches to PMER.

Through this Domestic Response Plan, IFRC Afghanistan country office as part of PMER development efforts of the National Society will extend its PMER support, the plans will be developed with PMER unit at the National Society that will be responsible for implementing a monitoring, evaluation and reporting system. Monitoring and reporting will be done according to the agreed monitoring framework. Whereby the provincial branch staff and volunteers will submit reports to respective branch focal person weekly and monthly. The branch weekly and monthly report will then be submitted to national PMER unit for consolidation. A mid-term and an (independent) end-term evaluation will be carried out, mainly for impact assessment.

Administration and Finance
A Project Agreement will be signed between the IFRC Afghanistan country office and the ARCS, which will outline the parties' responsibilities to implement the activities planned within the Emergency Appeal and ensure that the appropriate guidelines are complied with in terms of the use of the funding allocations. The ARCS have a permanent administrative and financial department, which will ensure the proper use of financial resources in accordance with terms of the Project Grant Agreement for COVID-19 Emergency Appeal. Monthly field returns will be sent to the IFRC Afghanistan county office for verification and booking to ensure that the activities are reported in accordance with the IFRC Standard Financial Management procedures.

C. Detailed Operational Plan

Livelihoods and basic needs

People targeted: 504,000
Male: 252,000
Female: 252,000
Requirements (CHF): 7,185,679

Needs analysis: First, in general, poverty rates in Afghanistan continue to rise as a result of continued conflict, climate change, and the added challenges created by cross border arrivals on already stretched economies and systems. Based on the 2020 Humanitarian Needs Overview, in 2020, 8.21 million vulnerable people are in need of urgent food and livelihoods assistance in the country. A recent nutrition survey across Afghanistan indicated that 22 out of 34 provinces are currently above the emergency level threshold for acute malnutrition.

The ongoing COVID-19 outbreak has made the already worse situation of the country more deteriorating. The shocks and stresses of the COVID-19 pandemic is having a much broader impact on the socio- economic of the vulnerable households and will not only diminished the well-being and livelihoods of people, but also undermined the markets and food security on which life depends. In Afghanistan, the COVID-19 outbreak comes against the backdrop of the Spring flood season. Each year, floods affect large swathes of the country as heavy snow melts and rivers swell, inundating communities. Heavy rainfall also contributes to flash flooding. The typical flood season runs from March to June each year. In 2020, some 200,000 people are expected to be affected only by floods.

The shocks of COVID-19 will also have impacts on labour markets, purchasing power and lost productivity – all of which are significant factors for Afghanistan, not least because few Afghans have access to productive or sustainable remunerative employment. A quarter of the labour force is unemployed, and 80 percent of employment is 'vulnerable' and insecure, comprising self-employment, day labour, or unpaid work. There are also growing concerns that due to price increases and future movement restrictions, farmers' and herders' access to farming inputs may be hampered, reducing their ability to successfully grow summer crops (mostly vegetables and pulses), sell produce and vaccinate/treat their livestock.

It is also important to note that Afghanistan's economy and millions of families have grown reliant on remittances from Iran. Currency devaluations over the past year have resulted in a drop in the value of such remittances but the surge in returns and COVID-19 interruptions to work opportunities in Iran will further diminish the purchasing power of many communities who have been heavily reliant on remittance payments over recent years. This will have a severe impact on vulnerable families.

Within this broader context, and considering the direct impact of COVID-19 on food, nutrition, and livelihoods security of especially the poor and most vulnerable households (households in IPC phase 3 and 4, and IDP and returnee households both in urban and rural areas), IFRC intends to support the ARCS provide food assistance and multi-purpose cash assistance to the households that will be quarantined, households that will be under treatments, or households that will lose their incomes due to the COVID-19. In addition, ARCS will also be supported in recruiting the food suppliers, so that the food suppliers should supply food directly to the homes of the households that will be quarantined and that cannot access market to purchase food.

Risk analysis: The following risks are anticipated with implementing the activities planned under the livelihoods and basic needs component of this Domestic Response Plan.

Quarantined groups have difficulty accessing distribution site and/or local markets: the quarantined individuals and households and other vulnerable groups (persons with disabilities, elderly, etc.), who face problems accessing the distribution sites or local markets will receive their cash in their locations. Furthermore, the local food vendors willing to transport food items to local areas will also be contracted and used.

Diversion of assistance to non-eligible or non-beneficiaries: IFRC will support the ARCS in conducting verification of beneficiary lists before finalization to ensure the households are eligible. Beneficiaries will be verified during cash distributions (i.e. ID check to verify they are the intended recipient) and ARCS will seek to ensure that there is a context-specific identity verification process at the distribution site. The engagement of community elders and other community-based networks will reduce the risk of fake beneficiary inclusion. Furthermore, IFRC will also support ARCS in establishing community-based feedback and complaint mechanism that will allow the beneficiaries and non-beneficiaries share their voices / feedback / complaints with ARCS.

Transfer value is insufficient to cover food or other basic needs due to market price fluctuations: IFRC will support ARCS to regularly monitor the market prices especially the prices of food items. In addition, close and systematic coordination with relevant clusters such as the Food Security and Agriculture Cluster and the Cash and Voucher Working Group will also enable IFRC and ARCS receive up to date market related information from these sources. In case of significant increase in food other basic need market prices, IFRC and ARCS will remain flexible in changing the transfer value.

Population to be assisted: under this Emergency Appeal, IFRC and ARCS intend to provide emergency food assistance and multiple cash grants to the financially most vulnerable households that will lose their incomes due to being quarantined or the broader impact of the COVID-19.

Programme standards/benchmarks: IFRC and ARCS, to implement the planned livelihoods and basic needs assistance activities under this Emergency Appeal, will consider and apply the programming standards of the relevant clusters (i.e. Afghanistan Food Security Cluster and Cash and Voucher Working Group), and the Ministry of Public Health of Afghanistan.

P&B Output Code	**Livelihoods and basic needs Outcome 1: Communities, especially in disaster and crisis affected areas, restore and strengthen their livelihoods**						*# of people will have enough food, cash or income to meet their survival threshold (Target: 455,000)*			
	Livelihoods and basic needs Output 1.2: Basic needs assistance for livelihoods security including food is provided to the most affected communities						*# of households reached with food assistance (Target: 50,000)*			
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP008	Identification, registration and verification of people to be assisted	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	
AP008	Procurement of food package	*x*	*x*	*x*	*x*	*x*				
AP008	Distribution of food packages to 50,000 households		*x*	*x*	*x*	*x*	*x*	*x*		
AP008	Post distribution monitoring, including regular measurement of Food Security indicators and reporting		*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
P&B Output Code	**Livelihoods and basic needs Output 1.5: Households are provided with unconditional/ multipurpose cash grants to address their basic needs**			*# of households reached with multipurpose cash grants to meet livelihoods and basic needs. (Target: 15,000 HHs)*						
	Activities planned Month	1	2	3	4	5	6	7	8	9

AP081	Modification and extension of Memorandum of Understanding (MoU) with previously selected financial service provider (FSP)	*x*	*x*							
AP081	Beneficiary selection and verification, including targeting and registration committees formed from the target communities	*x*	*x*	*x*	*x*	*x*				
AP081	Distribution of unconditional cash assistance to 22,000 households those who lose their income due to the COVID-19			*x*	*x*	*x*	*x*			
AP081	Recruitment of food supplier and distribution of complete food baskets to the affected households that are quarantined and that cannot access to market to purchase foods	*x*	*x*	*x*	*x*					
AP081	Conduct post distribution monitoring							*x*	*x*	*x*
AP081	Monitoring and evaluation activities to document response achievements, lessons learned, and the best practices.		*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

Health

People targeted: 2,042,500
Male: 1,035,547
Female: 1,006,953
Requirements (CHF): 4,500,001

Needs analysis: The overall operational objective is to contribute to reduce the morbidity and mortality of COVID-19 outbreak by preventing or slowing transmission of the virus across Afghanistan's 34 provinces. Adjusted to a moderate-transmission scenario (40,000 confirmed cases), response strategies must however be adaptable to a changing epidemiology. Given the different challenges faced in urban and non-urban settings including access and security, the response must be continuously adapted to fit the evolution of the outbreak and of the new areas affected including increasing the use of mobile health teams, decentralizing and localizing response activities and use of rapid response teams while taking into account the psychosocial dimension on vulnerable communities.

In support of ARCS priorities and commitments under the MoPH, IFRC Domestic Response Plan will focus its efforts on equipping and supporting ARCS health facilities and outreach in communities with a focus on:

- Procuring and providing protective equipment for staff and volunteers as absolute priority.
- Supporting the supply chain to operationalize ARCS hospital/isolation capacities for case management.
- Providing medical and non-medical materials to ARCS health teams (clinics, mobile teams, etc.) to support screening, contact tracing and community outreach as part of the nation-wide surveillance efforts.
- Risk communication activities to share timely and trustworthy information, address misinformation and build knowledge, acceptance and intention about signs and symptoms, transmission modes, preventive actions (handwashing and social distancing).
- Community engagement approaches with focus on targeted public engagement (through media), community feedback systems, volunteers dialogue and community level activities (through/ with key influencers) to address fear, enhance trust and promote community-led solutions to prevent and control the outbreak (closely linking health and PSSMH activities).
- Ensuring the mainstreaming of PGI in emergencies across health response, including for Sexual and gender-based violence prevention and child protection.
- Facilitating care for people who cannot access health and other essential services due to social exclusion, other barriers to access, or during shutdown of public services, public transportation, etc.

Risk analysis: In case of accelerated and uncontrolled transmission of the virus affecting frontline responders could result in proportionally reduced response capacities. The risk is particularly high for large populations concentrated in cities, especially in informal urban settlements without adequate water and waste management and deficiencies in public health infrastructures. Security risks and impeded access remain permanent as the response takes place in a protracted crisis context marked by more than 18 years of conflict.

Population to be assisted:

- Preparedness and containment activities will focus on enhanced engagement of ARCS health facilities and engagement of communities at risk of transmission, in urban settings and hard-to-reach areas.
- Mitigation and risk reduction activities will be focused on ensuring the most vulnerable and excluded groups have access to essential services
- Priority communities across all phases of the outbreak will include:

- Internal Displaced Population (IDPs).
- Refugees/ returnees.
- HTR, white and insecure areas.
- Remote and isolated community.

Programme standards/benchmarks: SPHERE standards and WHO guidelines.

P&B Output Code	Health Outcome 1: Communities and National Societies can quickly and effectively respond to an outbreak of COVID-19 Health Output 1.1: Increase understanding of risk and safe activities, including risk communication and health promotion based on community feedback										*NS together with MoPH completed capacity and risk mapping and response planning. (Target: Yes)* *# of people reached through risk communication and community engagement activities. (Target: 200,000)* *# of people reached with community-based epidemic prevention and control activities. (Target: 200,000)*
	Activities planned Month	1	2	3	4	5	6	7	8	9	
AP084	Mobilize NS volunteers' networks and key influencers (i.e. religious and community leaders) to encourage promotion of general health behaviours and address mistrust, misinformation and rumours with actionable and verified information	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	
AP084	Carry out risk communication activities based on community information needs, concerns and perceptions, share timely and trustworthy information, address misinformation and build knowledge, acceptance and intention about signs and symptoms, transmission modes, preventive actions (handwashing, social distancing) and care-seeking behaviours by people experiencing respiratory symptoms. Participate in and contribute to risk communication and community engagement coordination structures	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	
AP084	Preposition community engagement and communication material for rapid use by volunteers in at risk/affected areas (i.e. FAQ documents)		*x*	*x*	*x*						
AP084	Promote local dialogue and social cohesion with focus on addressing stigma and xenophobia and promote acceptance and trust	*x*	*x*	*x*	*x*	*x*	*x*	*x*			
AP084	Set up a community feedback system (including rumours tracking) to monitor, address and answer information gaps, believes and misconceptions, questions and rumours and inform health approaches			*x*	*x*						
P&B Output Code	**Health Output 1.2: ARCS is prepared to maintain life-saving humanitarian and development activities during an outbreak of COVID-19 and can adapt their approaches to the evolving outbreak.**										*# of people reached with community-based epidemic prevention and control activities. (Target: 200,000)* *# of risk communication and community engagement plan developed (Target: Yes)*
	Activities planned Month	1	2	3	4	5	6	7	8	9	
AP011	Develop and review pandemic emergency response plan	*x*	*x*			*x*	*x*		*x*	*x*	
AP040	Conduct training for new staff and volunteers on Infection prevention and control and case detection, risk communication and CEA	*x*	*x*	*x*							
AP040	Training and sensitization of the appropriate, safe and effective use of PPE to staff and volunteers	*x*	*x*	*x*	*x*	*x*	*x*				
AP011	Localize, contextualize and/or translate COVID-19 materials and tools for community-level use	*x*	*x*	*x*							

P&B Output Code										
	Health Outcome 2: National Societies support rapid containment of localized outbreaks when they occur in new communities or countries				*NS supported outbreak response at the request of the respective government. (Target: Yes)*					
	Health Output 2.1: Support public confidence in the health system and outbreak response measures, and promote effective community engagement, risk communication, behaviour change and hygiene promotion approach to motivate action and promote participation. Reduce stigma and violence				*NS working in clinical setting following IPC guidance. (Target: Yes)*					
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP011	Implement a risk communication and community engagement plan, in line with MoPH plan, with focus on vulnerable groups: the elderly, women, migrants, persons with disability)	*x*	*x*	*x*	*x*	*x*	*x*			
AP084	Communicate about relevant available services (i.e. mental health and psychosocial support, etc.), based on community questions and concerns	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP084	Enhance understanding and acceptance of key containment actions (e.g. IPC, community-based surveillance, quarantine, point of control screening, isolation and treatment)	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP021	Influence government and partner approaches to quarantine, isolation, treatment and other response approaches based on community feedback.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
P&B Output Code	**Health Output 2.2: Reduce risk of secondary transmission of the virus to prevent an outbreak or once local transmission has begun, reduce risk of more generalized transmission of the virus to contain the outbreak.**				*# of cases screened and detected related to surveillance (Target: Yes)* *# of people reached by psychosocial support. (Target: 10% of population)*					
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP050	Equip staff and volunteers with PPEs	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP050	Support the supply of ARCS isolation centre and case management (PPE, medical and non-medical materials	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP011	Provide medical and non-medical items (rub halls, blankets) in support to ARCS hospital, clinics and health teams	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP011	Screening, contact tracing and other services related to surveillance and case detection, in support of government activities	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP023	Psychosocial support to responders, including RCRC volunteers and staff	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
P&B Output Code	**Health Outcome 3: People living under disease containment measures have access to MHPSS services to maintain their wellbeing and dignity.**				*% of target population who agree their priority needs are being met. (Target: at least 80%)*					
	Health Output 3.1: Psychosocial support provided to the target populations as well as to Red Cross Red Crescent volunteers and staff				*# of people reached by mental health and psychosocial support. (Target: 10% of target population)*					
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP023	Emergency social services and related psychosocial support. If applicable, MHPSS activities, including psychological first aid and psychoeducation, are provided to quarantined or movement-restricted communities, including elderly and people with chronic conditions, disability, health workers, as well as NS staff and volunteers	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

AP023	PSS trainings for targeted volunteers and establishing a PSS national hotline		*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP023	Conduct PSS trainings/refreshers for staff and volunteers		*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP023	Establish referral pathway for cases needing of other MHPSS services		*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

P&B Output Code	**Health Outcome 7: National Society has increased capacity to manage and respond to health risks**				*NS requested by MoH to support COVID-19 preparedness and response. (Target: Yes)*					
	Health Output 7.1: The National Society and its volunteers are able to provide better, more appropriate, and higher quality emergency health services				*NS having epidemic preparedness and response plan. (Target: Yes)*					
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP021	Support health and social service maintenance (e.g. support to scale up services required, direct service provision as appropriate)	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP021	Engage with inter-governmental bodies and stakeholders to provide regional frameworks and leadership to facilitate information exchange, surveillance and coordination	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

Water, sanitation and hygiene

People targeted: 190,000
Male: 96,330
Female: 93,670
Requirements (CHF): 529,724

Needs analysis: Community people are unaware on water purification methods for safe drinking while sanitation management systems and hygiene practices remain weak and sub-standard across the country, including on handwashing. Gaps in WASH need to be addressed as critical part of the emergency response to the pandemic.

Risk analysis: One of the key risks of spreading of COVID-19 is due to poor hygiene especially hand washing. In Afghanistan this risk is very high due to lack of health knowledge, poor economic status and water supply.

Population to be assisted: Preparedness and containment activities will focus on hygiene promotion in most at-risk communities, while building the capacity and relationships needed for ARCS and volunteers to effectively respond. Priority communities across all phases of the outbreak will include:

- Internal Displaced Population (IDPs).
- Refugees/ returnees.
- Hard-to-reach, white and insecure areas.
- Remote and isolated communities.

Programme standards/benchmarks: The aim of WASH interventions under this sectoral component is to promote good personal and environmental hygiene as barriers to virus transmission. WASH activities in targeted provinces will be conducted in collaboration with MoPH and other humanitarian actors in accordance with the Sphere Standards as well as IFRC WASH for hygiene promotion in emergency operations and IFRC MHM guide and tools.

P&B Output Code	**WASH Outcome1: Immediate reduction in risk of waterborne and water related diseases in targeted communities**				*% of targeted population increased knowledge of personal hygiene (Target: 80%)*					
	WASH Output 1.4: Hygiene promotion activities which meet Sphere standards in terms of the identification and use of hygiene items provided to target population				*% of people provided with hygiene promotion education (Target: 80%)* *# of handwashing facilities constructed (Target: 17)*					
	Activities planned / Month	1	2	3	4	5	6	7	8	9
AP030	Conduct needs assessment, define hygiene issues and assess capacity to address the problem	*x*	*x*	*x*	*x*					
AP030	Select target groups, key messages, and methods of communicating with beneficiaries (mass media and interpersonal communication)	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP030	Develop a hygiene communication plan and train volunteers to implement activities from communication plan	*x*	*x*	*x*	*x*					
AP030	Design/print and distribution of IEC materials	*x*	*x*	*x*						
AP030	Construct or encourage construction and maintenance of handwashing facilities and water points in targeted communities	*x*	*x*	*x*	*x*	*x*				

P&B Output Code	WASH Output 1.5: Hygiene-related goods (NFIs) which meet Sphere standards and training on how to use those goods is provided to the target population				% of targeted population increased knowledge on how to use hygiene related items (NFIs) (Target: 80%)					
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP030	Determine the needs for hygiene NFIs, including soap, water storage, and menstrual hygiene for each community based on health risks and user preference in targeted communities in coordination with the WASH group or cluster	*x*	*x*	*x*						
AP030	Distribute of hygiene kits to target population		*x*	*x*	*x*					
AP030	Train population of targeted communities in use of distributed hygiene items.			*x*	*x*	*x*	*x*			
AP030	Determine whether additional distributions are required and whether changes should be made				*x*	*x*	*x*	*x*	*x*	
AP030	Monitor use of hygiene items and water treatment products and user's satisfaction through household surveys and household water quality tests						*x*	*x*	*x*	
P&B Output Code	**WASH Outcome 2: Sustainable reduction in risk of waterborne and water related diseases in targeted communities in the recovery phase**				*% of targeted population have a knowledge of waterborne and water related diseases (Target: 80%)*					
	WASH Output 2.1: Continuous monitoring and evaluation of water, sanitation, and hygiene situation is carried out in targeted communities				*Visits conducted to evaluate the water, sanitation, and hygiene situation in targeted communities (Target: Yes)* *Trainings conducted for ARCS volunteers in target areas (Target: Yes)* *% of the targeted population reached for hygiene promotion activities (Target: 80%)*					
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP026	Conduct baseline survey to define hygiene issues and assess capacity to address the problem	*x*	*x*							
AP026	Conduct training for ARCS volunteers on carrying out water, sanitation and hygiene monitoring and evaluation	*x*	*x*	*x*						
AP026	Continuously monitor the water, sanitation and hygiene situation in targeted communities	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP026	Coordinate with other WASH actors on target group needs and appropriate response	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

Protection, Gender and Inclusion

People targeted: 150,000
Male: 76,050
Female: 73,950
Requirements (CHF): 298,200

Protection needs: This response is taking place across the country with a high rate of gender-based violence, marginalization of a number of populations and presence of extremely vulnerable groups. The major needs in this sector include ensuring all populations the most vulnerable people are reached by COVID-19 response and preparedness activities; training of ARCS volunteers and staff on key areas including prevention and response to sexual and gender-based violence as well as protection against sexual exploitation and abuse. The PGI activities will be implemented for both COVID-19 response and preparedness in all provinces across the country. Vulnerable population in Afghanistan such as women, children, elderly, persons with disabilities and the sick are at higher risk of exploitation. There is a need to protect this population and incorporate their different needs into the programming. Protection needs in the complex emergency in Afghanistan are mainly related to the deteriorating security situation and forced population movements. Children are at particular risk of abuse, neglect, marginalization, and exploitation. Holistic approaches aimed at improving the resilience and self-reliance of affected households, as well as enhancing positive engagement of governance structures to reduce vulnerabilities and to mitigate short and longer-term protection risks. Timely identification of protection risks through systematic and coordinated protection monitoring and analysis will inform preventative, responsive, and remedial interventions, as well as enhance accountability. This includes evidence-based advocacy, protection specific service delivery, and community-based mobilization, mitigation, and prevention activities creating a protection-conducive environment.

ARCS and IFRC will coordinate with protection and gender-based violence clusters in western, central, northern and eastern regions. Stronger linkages with protection clusters are also sought on relevant issues of common interest, such as the development of a comprehensive disability and assistance survivor support strategy and response; enhanced operational and planning integration of PGI across the emergency response.

Risk analysis: The PGI risks are cross cutting in nature. The programme staff often overlook the softer issues in relation to inclusiveness, protection and gender sensitivity while undertaking community-based livelihoods activities in affected areas.

Population to be assisted: All the people involved/assisted in either relief phase and through any sectoral interventions, must include PGI lenses, especially in beneficiary selection, delivery of interventions, monitoring and reporting. As an essential crosscutting theme for all RCRC emergency operations, the operation targets all beneficiaries with a PGI driven approach.

Program standards/benchmarks: PGI approaches will be aligned with the IFRC Minimum Standard to Protection, Gender and Inclusion in Emergency Programming, the IASC Gender-Based Violence Guidelines. The IFRC MSs have been developed based on (but not limited to) the Sphere handbook and the Minimum Standards for Child Protection in Humanitarian Action. The Protection, Gender and Inclusion Area of Focus of the emergency appeal is complimentary to the Response Priority 1 of the One Window Framework.

P&B Output	Protection, Gender & Inclusion Outcome 1: Communities become more peaceful, safe and inclusive through meeting the needs and rights of the most vulnerable.	*Operation demonstrates evidence of addressing the specific needs and rights are met and PGI are included in all stages. (Target: Yes)*

Code	Protection, Gender & Inclusion Output 1.1: Programmes and operations ensure safe and equitable provision of basic services, considering different needs based on gender and other diversity factors.									*Initial assessments include key PGI areas. (Target: Yes)* *Sex, age and disability disaggregated data is collected. (Target: Yes)* *# of staff and volunteers trained on minimum standards. (Target: 150)*
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP031	Gender-balanced staff and volunteer mobilization to the extent possible in Afghan context	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP031	Collection, analysis, and dissemination of sex- and age-disaggregated data	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP031	Collection, analysis, and dissemination of sex- and age and disability-disaggregated data	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP031	Support sectoral teams to include measures to address vulnerabilities specific to gender and diversity factors (including people with disabilities) in their planning and aim for gender parity in volunteers	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP031	Training of volunteers on protection, gender and inclusion, including gender analysis, basic prevention of sexual and Gender Based Violence, Sexual Exploitation and Abuse and Child Protection	*x*	*x*	*x*						
AP031	Incorporate key PGI messaging together with RCEC for integrated delivery to National Societies and communities.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP031	During community consultations and awareness sessions, special effort is made to ensure women and people with disabilities are also included and feel comfortable to share their concerns and feedback. This includes gender-segregated group discussions to enable women to speak freely	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
P&B Output Code	**Protection, Gender & Inclusion Output 1.2: Programmes and operations prevent and respond to sexual- and gender-based violence and other forms of violence especially against children.**									*% of staff and volunteers signed the Code of Conduct. (Target: 100%)*
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP033	Use Minimum Standards as a guide to support sectoral teams to include child protection and measures to mitigate the risk of SGBV	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP033	Establish a system to ensure IFRC and NS staff and volunteers have signed the Code of Conduct and have received a briefing in this regard	*x*	*x*	*x*						
AP033	Appoint a Prevention of Sexual Exploitation and Abuse (PSEA) and Code of Conduct focal person	*x*	*x*	*x*						
AP033	Volunteers, staff and contractors sign, are screened for, and are briefed on child protection policy/guidelines	*x*	*x*	*x*						

Strategies for Implementation

Requirements (CHF): 4,349,305

Based on the demand for the technical and coordination support required for this operation, the following programme support functions will be put in place or maintained to ensure an effective and efficient technical coordination: human resources, logistics and supply chain; information technology support (IT); communications; security; planning, monitoring, evaluation and reporting (PMER); partnerships and resource development; finance and administration; and information management (IM). A core emphasis of the strategy is to strengthen the National Society in the above-mentioned areas. The regional coordination strategy and plans, in addition to providing technical and strategic guidance, further allows for the coordination and overview needed for monitoring, reviews and a final evaluation of the operation. Core assumptions, the context and impact, operational constraints, and priority needs continuous assessments will be carried out by the ARCS staff and volunteers as well as IFRC operational staff in the targeted area.

Several related guidance and additional tools are or have been adapted, revised or updated, in particular for **business continuity planning**, which establishes the basis for National Societies to ensure the continuous functioning of key services during the crisis in all relevant locations. It includes also a plan to recover and resume business processes when programmes have been disrupted unexpectedly. Beside activities ensuring the duty of care for staff and volunteers, special focus is also put on back-up measures for defined services of the National Societies.

P&B Output Code	**Outcome S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical and financial foundations, systems and structures, competences and capacities to plan and perform**				*# of volunteers mobilized (Target: 4,400)*					
	Output S1.1.4: National Societies have effective and motivated volunteers who are protected				*# of volunteers insured. (Target: 500)* *% of staff and volunteers are provided with necessary PPE. (Target: 100%)*					
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP039	Ensure that volunteers working with NS have insurance coverage for accidents and death	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP039	A volunteer management platform is established to support community engagement activities			*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP039	Youth and volunteers have appropriate trainings and support to perform their tasks	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
P&B Output Code	**Output S1.1.6: National Societies have the necessary corporate infrastructure and systems in place**				*# situation reports. (Target: TBC)* *# operational and financial report. (Target: TBC)* *# ARCS essential staff enabled to perform its work despite lockdown and reduced movements to office. (Target: TBC)* *NS developed Business Continuity Plans finalized. (Target: Yes)* *# staff and volunteers signed ARCS Code of Conduction and Fraud and Corruption prevention policy. (Target: TBC)*					
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP040	ARCS data readiness, PMER and information management capacities are strengthened	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP021	Ensure an effective emergency response with reduced resources, including a mapping of the minimum structures needed to keep core business going as part of the business continuity plan	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP040	ARCS business continuity is supported including for IT equipment and connectivity, in close liaison with the regional/global BCP helpdesk operated by GDPC and IFRC as appropriate	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

AP040	ARCS financial management is strengthened	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP040	ARCS is equipped with a proper SOP for preparedness and response to pandemics enabling effective emergency management at HQ and branch level, and will review the impact from COVID-19 pandemic on other disaster and crisis scenarios and develop/revise contingency plan with multi-hazards approach for these other disaster and crisis situations	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP040	ARCS Code of Conduct and zero tolerance for fraud and corruption are enforced	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
P&B Output Code	**Outcome S2.1: Effective and coordinated international disaster response is ensured**				*Effective and coordinated international disaster response ensured (Target: Yes)*					
	Output S2.1.1: Effective response preparedness and NS surge capacity mechanism is maintained				*# of NS surge capacity deployed for the operation (Target: TBC)* *# of people deployed using global response tools (Target: 3)*					
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP046	Effective emergency management capacities are established	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP046	Localized surge support is mobilized in PMER, health, logistics, communication, PGI and disaster risk management	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP046	ARCS surge capabilities are supported and mobilized	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
P&B Output Code	**Outcome S3.1: The IFRC secretariat, together with National Societies uses their unique position to influence decisions at local, national and international levels that affect the most vulnerable.**				*# people reached through awareness raising and risk communication (Target: TBC)* *# News stories and media materials on ARCS emergency response (Target: TBC)*					
	Output S3.1.1: IFRC and NS are visible, trusted and effective advocates on humanitarian issues				*Communications materials produced/published. (Target: Yes)*					
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP053	ARCS, supported by IFRC, has enhanced visibility amongst its key public audiences and maintains active online media engagement throughout the emergency	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP053	Implement awareness raising and risk communication campaigns	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP053	Enable visibility and positive ARCS profiling through high quality photos, video clips, and news stories for use across ARCS and IFRC cross media platforms	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP053	Support the positioning of ARCS as a credible and leading humanitarian responder	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
P&B Output Code	**Output S3.1.2: IFRC produces high-quality research and evaluation that informs advocacy, resource mobilization and programming.**				*# of Lessons learned workshop is conducted. (Target: 1)* *# of evaluations conducted (Target: 2)* *# of paper/report published (for RCRC) (Target: 2)*					
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP055	Mid-term review and end term evaluations are carried out			*x*		*x*				*x*
AP055	Recommendations and learnings from evaluations are shared for improved preparedness for both IFRC and National Societies in epidemic/pandemic responses in the future			*x*		*x*				*x*
AP055	Support to ARCS auxiliary role across the response	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
AP055	Production of context analysis, positions and opinion pieces			*x*		*x*				*x*
AP055	Participation to external/cluster coordination meetings at national and provincial levels	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

AP055	Partnership meetings/briefings (Movement and external)	*x*		*x*		*x*				*x*
P&B Output Code	**Outcome S4.1: The IFRC enhances its effectiveness, credibility and accountability**				*# of staff participated in Fraud and Corruption training. (Target: TBC)*					
	Output S4.1.2: IFRC staff shows good level of engagement and performance									
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP069	Staff awareness training on Fraud and Corruption Prevention	*x*	*x*	*x*						
AP069	IFRC staff insurance is ensured	*x*	*x*	*x*						
AP069	Office cost for BCP activation	*x*	*x*	*x*						
P&B Output Code	**Output S4.1.3: Financial resources are safeguarded; quality financial and administrative support is provided contributing to efficient operations and ensuring effective use of assets; timely quality financial reporting to stakeholders**				*# of staff recruited to support the implementation of the COVID-19 operation. (Target: 10)*					
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP065	Essential staff recruited to ensure effective implementation of COVID-19 operation	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
P&B Output Code	**Output S4.1.4: Staff security is prioritized in all IFRC activities**			*Regular monitoring of safety and security of staff members (Target: Yes)*						
	Activities planned Month	1	2	3	4	5	6	7	8	9
AP066	Security Risk Assessment (SRA) and continuous security updates	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

Funding Requirements

Refer to below for revised budget details.

International Federation of Red Cross and Red Crescent Societies

all amounts in Swiss Francs (CHF)

DOMESTIC RESPONSE PLAN

MDR00005 - AFGHANISTAN - COVID-19 OUTBREAK

24/4/2020

Budget by Resource

Budget Group	Budget
Clothing & Textiles	3,400
Food	4,327,532
Water, Sanitation & Hygiene	495,273
Medical & First Aid	2,368,816
Other Supplies & Services	6,329
Cash Disbursement	1,813,924
Relief items, Construction, Supplies	**9,015,274**
Computers & Telecom	25,316
Medical Equipment	507,202
Other Machinery & Equipment	400,000
Land, vehicles & equipment	**932,518**
Distribution & Monitoring	233,021
Transport & Vehicles Costs	70,004
Logistics Services	950,000
Logistics, Transport & Storage	**1,253,025**
International Staff	108,000
National Staff	245,980
National Society Staff	1,502,595
Volunteers	683,595
Personnel	**2,540,170**
Consultants	37,975
Professional Fees	133,291
Consultants & Professional Fees	**171,266**
Workshops & Training	560,146
Workshops & Training	**560,146**
Travel	549,661
Information & Public Relations	385,990
Office Costs	39,000
Communications	80,759
Financial Charges	50,593
Other General Expenses	18,987
Shared Office and Services Costs	236,328
General Expenditure	**1,361,319**
DIRECT COSTS	15,833,717
INDIRECT COSTS	1,029,192
TOTAL BUDGET	**16,862,909**

Reference documents ↘

Click here for:

- Information bulletin
- Revised EA

For further information, specifically related to this operation please contact:

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For Performance and Accountability support (planning, monitoring, evaluation and reporti enquiries)

- Liew Siew Hui, PMER manager; email: siewhui.liew@ifrc.org
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How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable. The IFRC's vision is to inspire**, encourage, facilitate and promote at all times all forms of humanitarian activities** by National Societies, with a view to **preventing and alleviating human suffering**, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.