(REACH Logo to be added after approval)

Operations Manual

Covid-19 Relief Efforts for Afghan Communities and Households Project (REACH)

Implementing Agencies:
Independent Directorate of Local Governance (IDLG)
Kabul Municipality (KM)
Ministry of Rural Rehabilitation and Development (MRRD)

Effective: 15th September 2020

Preface

This Manual will serve as a policy guideline for all the Implementing Agencies (IAs) of the REACH project, their staff, their contracted Facilitating Partners (FPs), the Municipalities of the cities covered by the urban REACH, the Rural Rehabilitation and Development Provincial Directorates (RRDs), Community Development Councils (CDCs), Gozar Assemblies (GAs), Gozar Councils (GCs), Community Participatory Monitoring (CPM) teams and their ad-hoc counterparts involved in the REACH project implementation.

This Manual is informed by the step-by-step guidelines that will form the basis for the training/ social manuals/ materials that will be prepared to train all stakeholders involved at the field level. The training materials will include detailed step-by-step guidelines to be followed closely by the FPs and the ground-level staff in the REACH implementation. In the event of any discrepancy between the Operations Manual and the Social/ Training Manuals, the Operations Manual will prevail.

This manual lays out the rules of the work to be done and references key processes, but does not lay out how the work will be done or the sequential steps that should be followed during implementation. FP and Government Field Social Organizers should follow the step-by-step guidelines that are part of the Training Manual to plan each visit and activity in the community.

In the event that the Operations Manual is translated into Dari or Pashto or both and there are discrepancies between the various translations, the English version will prevail. In the event of discrepancies between this Operations Manual and the Project Appraisal Document (PAD), the Disbursement Letter(s) and Financing and Grant Agreements for the REACH project, the Financing and Grant Agreements will prevail.

This Operations Manual ("OM") has received the World Bank's No Objection Letter (NOL) on _____ August 2020, and will be deemed effective immediately and for the whole project duration, or until revised formally before the second tranche distribution. Any future revisions will only be considered effective after the formal NOL of the World Bank is received for the same. IAs are not allowed to make any revisions to this Operations Manual, in contextual terms, until the proposed revisions are discussed with and agreed with the Bank in writing.

Note: This Operations Manual finalization is a condition for the REACH effectiveness. As such, this version is prepared with the information available as of mid-August 2020. Any changes in the policies and procedures proposed, with the lessons learned from the CCNPP Covid-19 rollouts and/or with the REACH tranche 1 rollouts, will need to be incorporated into this Manual prior to the REACH tranche 2 rollouts. This is particularly important for the mobile money transfer options currently under discussions for the tranche 2 in select urban communities/ households.

The following stand-alone manuals are also considered part of the Operations Manual:

a) Community Procurement and Accounting Manual
b) Grievance Handling and Gender Based Violence (GBV) Manual

This Manual is supported by the Training Manual and the step-by-step guidelines.

Acronyms/ Abbreviations:

AFN	Afghani
ARTF	Afghanistan Reconstruction Trust Fund
BQF	Bid Quotation Form
CASA-1000	Central Asia-South Asia Transmission Line Project
CCAP	Citizens' Charter Afghanistan Project
CDC	Community Development Council
A-CDC	Ad hoc CDC for REACH
CFA	Cities for All Project
CPM	Community Participatory Monitoring
CSP	Community Support Project (of the CASA 1000)
ENETAWF	Early Warning, Early Finance and Early Action Project
ESS	Environmental and Social Safeguards
ESCP	Environmental and Social Safeguards Commitment Plan
ESMF	Environmental and Social Safeguards Management Framework
EZ-Kar	Eshteghal Zaiee – Karmondena Project
FHH	Female-Headed Households
FP	Facilitating Partner
FM	Field Monitor
FMM	Financial Management Manual
GA	Gozar Assembly
GBV	Gender Based Violence
GC	Gozar Council
GD	General Directorate (MRRD)
GHM	Grievance Handling Mechanism
HH	Household
HQ	Headquarters
HTR	Hard-to-Reach
IA	Implementing Agency
IDA	International Development Agency of the World Bank Group
IDLG	Independent Directorate of Local Governance
IUFR	Interim Unaudited Financial Report
KM	Kabul Municipality
KMDP	Kabul Municipal Development Project
M&E	Monitoring and Evaluation
MIS	Management Information System
MoCI	Ministry of Commerce and Industry
MoF	Ministry of Finance
MRRD	Ministry of Rural Rehabilitation and Development
NGO	Non-Governmental Organization
NSIA	National Statistics and Information Agency
NPA	National Procurement Authority
NPC	National Procurement Committee
NSP	National Solidarity Program
OM	Operations Manual
PCC	Provincial Capital Cities
PDO	Project Development Objective
PIU	Project Implementation Unit (IDLG and KM)
PMU	Provincial Management Unit
PO	Purchase Order
PPE	Personal Protective Equipment

REACH	Covid-19 Relief Efforts for Afghan Communities and Households Project
RF	Results Framework
SEP	Stakeholder Engagement Plan
SO	Social Organizer
TPM/ SA	World Bank Third Party Monitors/ Supervisory Agents
USD	United States Dollars
WB	World Bank

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CHAPTER ONE: INTRODUCTION AND KEY STAKEHOLDERS

GENERAL:

Even prior to the Covid-19 outbreak in Afghanistan, the country was facing numerous socio-economic and security challenges. The poverty rate in Afghanistan has increased markedly from 38 percent in 2012 to 55 percent in 2017, when the last household survey was carried out. Female-headed households (FHHs) and households with no able-bodied male member are disproportionately represented among the poor and are particularly vulnerable. Poverty co-exists with exposure to a large number of shocks, which disproportionately affect the poor. Shocks that are inherent in a conflict affected country (e.g. forced displacement, disrupted access to markets and basic services, price volatility of consumption staples) are added to high prevalence of food insecurity due to the unique geography of Afghanistan (e.g. droughts, floods, avalanches and infestation of agricultural production). Three in four poor households are affected by at least one shock and 80 percent of them cannot recover from their shocks within one year. The official confirmed numbers for Covid-19 affected individuals in the country remains low compared to its neighbors, but the real numbers are likely much higher, given limited testing facilities. The outbreak and resulting lockdowns and subsequent income losses have further exaggerated the dire socio-economic crises in the country. As humanitarian agencies alone were unable to cope with the sheer volume and scope of the emergency relief needed, it was agreed between the World Bank and the Government of Afghanistan to restructure as many as twenty different ongoing programs and add new funding as well to finance an emergency relief project to address immediate food needs for almost universal coverage to all households in the country.

The **Covid-19 Relief Effort for Afghan Communities and Households Project (REACH)** was conceived, planned and developed in a relatively short timeframe (April to July 2020) to respond to the stated crises. Together with the CCNPP Covid-19 relief effort, REACH contributes to the Government's nationwide "Dastarkhan Milli" program (named in the national languages of Dari and Pashtu, literally meaning "national dining cloth"). The **Project Development Objective (PDO)** of REACH is to provide emergency support to selected households through communities in project areas during the Covid-19 outbreak. It is expected to be rolled out between September 2020 and December 2021.

The REACH was approved by the Afghanistan Reconstruction and Trust Fund (ARTF) Committee on 6th July 2020 and by the World Bank Board on 4thAugust 2020, and was declared effective (after having met the stated effectiveness conditions) on 15thSeptember 2020. REACH is identified in World Bank documentation as Project ID 174119.

A CDD approach to Emergency Aid

As humanitarian agencies alone are unable to cope with the sheer volume and scope of the emergency relief needed, the World Bank and the Government of Afghanistan have restructured as many as twenty different ongoing programs and added new funding to finance an emergency relief project to address immediate food needs for almost universal household coverage in the country. The REACH relief aid approach outlined below works through Community Driven Development principles that include community-driven beneficiary selection, locally planned and conducted distribution of relief aid, with sensitivity to households that require special arrangements such as women-headed or those that are headed by elderly, disabled or drug-addicted persons. Further, the REACH approach differs in that it provides relief aid to all food-insecure households, whereas Humanitarian approaches limit their beneficiaries to a relatively small percentage of the community.

Under the REACH Program, Social Organizers will work with community leaders (who will represent their respective neighborhoods) and engage them in participatory processes to enable them to conduct fair and equitable beneficiary selection, safe distribution of relief aid, and the proper documentation to receive and account for the funds. Unlike Humanitarian Emergency Relief efforts, where 'outsiders' determine

beneficiaries, distribute the aid, and fill out the paper work, the REACH approach will work with community leaders to lead the efforts in their communities and thereby ensure more efficient and effective implementation, whilst building capacity of local leaders to consider equity, transparency, and accountability in relief efforts; at the same the leaders and youth in their communities will learn, disseminate and reinforce the COVID 19 safety measures that are so important to contain the virus. To the extent feasible within the social-distancing requirements, the community leaders will consult with all households in their assigned neighborhoods.

Components:

The REACH is divided into four core components as outlined below:

- Component 1: REACH Rural: Household support in rural and peri-urban areas ($136 million) - Provision of relief support in the forms of food and hygiene products to selected households in rural and peri-urban areas, including nineteen (19) provincial capital cities and those areas outside the municipal boundaries of Kabul and the other provincial cities.
- Component 2: REACH Urban: Household support in provincial capital cities ($56 million) - Provision of relief support in the forms of food and hygiene products and/or cash to selected households, including returnees living in settlement camps inside municipal boundaries, through CDCs and/or GAs in fourteen (14) provincial capital cities.
- Component 3: REACH Kabul: Household support in Kabul Municipality ($80 million) - Provision of relief support in the forms of food and hygiene products and/or cash transfer to selected households in Kabul.
- Component 4: Project management, communication, and monitoring ($8 million) - Provision of support for Project management and capacity building; dedicated strategic communications; and monitoring, including safeguard compliance for: (a) MRRD; (b) IDLG; and (c) Kabul Municipality.

Funding Sources and Categories:

The REACH has a total funding of US$ 280 million, coming from two primary funding sources as outlined below:

- World Bank's International Development Association (IDA): The IDA has committed a total of SDR 112.7 million (i.e. approximately US$ 155 million) towards REACH, through the IDA Financing Agreement (FA) Grant # D7110-AF.
- Afghanistan Reconstruction Trust Fund (ARTF): The ARTF has committed a total of US$ 125 million towards REACH, through the ARTF Grant Agreement (GA) Grant # TF0B3447.

The Financing and Grant Agreements break down the total costs in the following core categories, and it should be noted that the cost categories are not all aligned with the Components.

- Category 1: Food grants, administrative costs for CDCs under Component 1 (MRRD)
- Category 2: Food and cash grants, administrative costs for CDCs/ GAs under Component 2 (IDLG)
- Category 3: Food and cash grants, administrative costs for CDCs/ GAs under Component 3 (KM)
- Category 4: Goods, non-consulting services, consulting services, and Incremental Operating Costs (Note: no works costs are planned and hence not included) across all four components and three Implementing Agencies (IAs)
- Category 5: Project implementation staff across all four components and three IAs, including temporary staff

The actual breakdowns by funding source and budget is as shown in the individual IA approved REACH budgets but is approximately summarized as follows:

Component 1/ MRRD: US$ 141 million (ARTF Category 1, IDA Categories 1, 4a and 5a)
Component 2/ IDLG: US$ 59 million (IDA Categories 2, 4b and 5b)
Component 3/ KM: US$ 80 million (IDA Categories 3, 4c and 5c)

Funding source	Category	Total	IA
ARTF	1	125,000,000	Only MRRD
IDA	1	2,063,000	Only MRRD
	2	50,062,110	Only IDLG
	3	72,892,635	Only KM
	4	27,506,655	All 3 IAs
	5	2,475,600	All 3 IAs
	Subtotal	155,000,000	
Overall Total		**280,000,000**	

KEY STAKEHOLDERS:

A variety of stakeholders are involved in the REACH, ranging from the beneficiary household heads to Community Development Councils (CDCs)/ Gozar Assemblies (GAs)/ Gozar Councils (GCs) to Facilitating Partners (FPs) to IAs to other Government ministries/ agencies/ institutions, and the Donor community. The key roles and responsibilities of each, in relation to REACH, are outlined below.

Inter-Ministerial (Strategic) Task Force:

The REACH implementation will be overseen by an Inter-Ministerial Task Force chaired by the First Vice President (and/or his designated authorized representative). This Task Force will serve as the de-facto "Steering Committee" for REACH. Its membership will comprise of representatives from the CCNPP Coordination Unit with the MoF, IDLG, MRRD, KM, Ministry of Commerce and Industry (MoCI), Ministry of Public Health (MoPH), National Statistics and Information Agency (NSIA), and other relevant stakeholders. As the REACH project will be anchored within the overall Government relief and response efforts (including the bread distribution program), it will be overseen through this high-level strategic coordination body. The MoF CCNPP Unit will serve as the Secretariat for this Task Force. The Task Force will be responsible for the strategic directions and key decision-making for the Project, especially related to issues of coverage, size and type of relief package, use of United Nations (UN) agencies/ Non-Governmental Organizations (NGOs) in the relief efforts, public communications related to the Project at national level, etc. This task force also coordinates on a regular basis with the network of Provincial Governors and Municipal Mayors on overall COVID-19 response efforts and obtains situational information across the country. The detailed ToRs for the Task Force will be prepared by the Secretariat shortly.

Inter-Ministerial (Technical) Working Group:

The Working Group will be responsible for overseeing the Project in terms of key policy and procedural issues, approvals of policy frameworks/ manuals, ensuring timely work and budget plans and their implementation, review of key monitoring findings and/or grievance reports, overall progress and financial progress of the Project across IAs and against approved work plans, etc. Each of the 3 IAs will

take turns serving as the Secretariat for this Task Force. The detailed Terms of Reference (ToRs) for the Working Group will be prepared by the Secretariat shortly.

Implementing Agencies (IAs):

- **MRRD:** The Component 1 of REACH will be implemented by MRRD, primarily through its General Directorate (GD) handling the rural Citizens' Charter Afghanistan Project (CCAP) including the subprograms for Grain Banks/ Social Inclusion Grants (SIG) and the Maintenance and Construction Cash Grants (MCCG), the CASA-1000 Community Support Program (CSP), and the Early Warning, Action, and Finance project being designed (ENETAWF). The General Directorate will be supplemented with short-term new staff hired for functions such as field monitoring, phone monitoring, grievance handling, field facilitation supervision etc. The MRRD Deputy Minister for Programs will directly oversee the MRRD REACH operations.

- **IDLG:** The Component 2 of REACH will be implemented by IDLG, primarily through its Project Implementation Unit (PIU) handling the urban CCNPP and the Eshteghal Zaiee—Karmondena Project's Component Two (EZ-Kar C2). The PIU will be supplemented with short term new staff hired for functions such as city-wise project management, data entry, communications, field monitoring, phone monitoring, grievance handling, field facilitation supervision etc. The IDLG Deputy Minister for Municipalities will directly oversee the IDLG REACH operations.

- **KM:** The Component 3 of REACH will be implemented by KM, primarily through its Project Implementation Unit (PIU) handling the Kabul Municipal Development Project (KMDP) and the Eshteghal Zaiee—Karmondena Project's Component Four (EZ-Kar C4). The PIU will be supplemented with short term new staff hired for functions such data entry, phone monitoring, gender, safeguards and grievance handling. The Kabul Deputy Mayor (Finance and Administration) will directly oversee the KM REACH operations. The KMDP team leader will then serve as the de-facto urban REACH director for Kabul city. One other REACH Deputy Program Manager will also support the team leader in managing this Component.

- **All IAs:** The key roles and responsibilities of the IAs with regard to REACH are as summarized below:

    - Ensure program implementation in line with agreed financing and grant agreements, and that the dated covenants are met in a timely manner.
    - Ensure that the policies and procedures outlined in the Operations, Financial and Training Manuals are adhered to in all aspects of REACH implementation.
    - Ensure the preparation (and subsequent implementation) of the Environmental and Social Safeguards Management Framework (ESMF), the Stakeholders Engagement Plan (SEP) and other key documents required in the legal agreements.
    - Ensure the preparation, and with the No Objection of the World Bank, the implementation of detailed work plans and budgets for the REACH implementation.
    - Ensure that the FPs are contracted as per procurement methods agreed with the World Bank, and in a timely manner, such that they are on board as soon as feasible after Project effectiveness.
    - Contract the required additional staff required for the REACH implementation and/or monitoring in line with staffing plans and budgets NoLedby the World Bank.
    - Prepare detailed training packages and implement the same with the PMU and FP key staff for REACH.
    - Ensure all required inputs needed for the smooth and efficient REACH operations, including but not limited to human resources, goods, consulting and non-consulting services, incremental operating costs etc. are in place and provided in a timely manner.

- Manage the REACH FPs and all REACH staff, including those serving from CCAP/ EZ-Kar/ CSP/ MCCG contracts, and ensure that the code of conduct for REACH (as shown in the Annexes with the Forms) is adhered to, and work outputs are managed.
- Ensure national and local level communication campaigns and suitable communication products and channels for the public outreach of the project.
- Ensure timely monitoring and grievance handling as per the agreed protocols for the Project.
- Ensure timely and accurate reporting, both physical and financial, of the Project to the Government leadership and the Donors. This will include timely tracking and reporting on all Results Framework indicators for REACH.
- Actively participate in the Inter-Ministerial (Strategic) Task Force and the Inter-Ministerial (Technical) Working Group of the Project.

Facilitating Partners (FPs):

- **Component 1 FPs:** The MRRD is contracting satisfactorily performing rural CCNPP FPs to serve as its rural REACH FPs in the same provinces as they currently facilitate rural CCNPP in, through direct contracting procurement procedures. Note: The MRRD is contracting FPs only for the work related to the tranche 1 in all communities to be covered under Component 1. The facilitation and monitoring work required for the tranche 2 in the 19 PCCs also covered by the MRRD under this Component will be handled by MRRD hired short-term REACH field staff, and not by the FPs.

- **Component 2 FPs:** The IDLG is contracting the same urban CCNPP FPs in the cities of Herat, Jalalabad and Kandahar for the REACH coverage areas in these 3 cities. For the remaining 11 provincial capital cities in its REACH coverage, the IDLG will be contracting the rural CCAP/ REACH FPs covering the rest of those 11 provinces. All FPs for this Component too are procured on direct contracting basis.

- **Component 3 FPs:** The KM is contracting NGOs with relief/ development experience in Kabul city as its REACH FP.

- **All FPs:** The detailed Terms of References (ToRs) for the REACH FPs will be as stated in their respective contracts. FPs will play a dual facilitation and monitoring role on behalf of the IAs, with the communities to be covered. Their primary roles will be to:

  - Ensure the principles of inclusion and all REACH mandated field procedures and policies as outlined in the Operations Manual are implemented on the ground.
  - Ensure the remobilization/ re-activation of existing and functional CDCs established under the National Solidarity Program (NSP), or GAs established under UN-Habitat's Cities for All Program (CFA), wherever present.
  - Establish ad-hoc CDCs (A-CDCs) or Gozar Councils (GCs in Kabul city only) as appropriate in areas without viable NSP CDCs or CFA GAs. These A-CDCswill serve only for the duration of REACH and will only be responsible exclusively for the implementation of REACH in their stated communities.
  - Facilitate the registration of all CDCs/GAs/A-CDC/ GCs to be used under REACH, and open REACH-specific temporary bank accounts for them in the provincial DAB branches.
  - Facilitate and support the CDCs/ GAs/ GCs/ A-CDCs to create household lists, identify beneficiary households based on the pre-defined criteria, to ensure special consideration for very poor (women-headed households), and the safe distribution of food or cash items.
  - Conduct verification of a sample of the households in the lists provided by the CDCs/ GAs/ GCs/ A-CDCs and ensure their existence and verify the details provided for them, including phone numbers and/ortazkira numbers.

- Support CDCs/GAs/ GCs/ A-CDCsin requesting for REACH grant disbursements and managing withdrawals of the grants from their bank accounts.
- Verifyall core REACH forms prior to the submission to the IA PMUs/ PIU.
- Train and then support the CDCs/ GAs/ GCs/ A-CDCs (and/or their designated sub-committees) in handling the procurement and accounting related to the in-kind package purchases for their respective communities/ gozars.
- Review and report on the quality and quantities of the in-kind packages procured by the CDCs/ GAs/ GCs/ A-CDCs and provided by the contracted suppliers.
- Manage monitor and report on the distribution of the relief packages, and help IAs in resolving grievances raised.
- Ensure timely submission of all original forms to the IA PMUs as outlined in this manual.

Community Development Councils (CDCs)/ Gozar Assemblies (GAs)/ Ad hoc CDCs (A-CDC)/Gozar Councils (GCs):

The CDCs/GAs/A-CDC/ GCsreferred to in this chapter include the NSP CDCs used for REACH under Components 1 and 2, CFA GAs used for REACH by Component 2, and Ad-hoc Covid-19 Relief CDCs/GCs created under the REACH Project by Components 1, 2 and 3. For the purposes of REACH, they will be viewed as the de-facto implementing partners (IPs). Each CDC/ GA/A-CDC/ GC will have an executive committee of four members, namely the Chairperson, Vice Chairperson, Secretary and Treasurer. Where there is requirement for only 1 bank signatory from the CDC, this role will be limited to the Chairperson only. Where more signatories are required, the other office bearers will also sign on behalf of the community they represent. The CDC/GA/ GC/ A-CDC Treasurer is mandatorily a signatory for the given community's bank account.

The CDC/GA/A-CDC/GC key roles and responsibilities for REACH are as outlined below:

- Inform all community residents of the REACH as the Government's emergency response to the Covid-19, its intended target group, the exclusion criteria, the sanctions policies that will apply to the whole community if falsified information is provided, grievance update channels and procedures, and other details through the various phases of the Project's implementation in the given community. All such information should be aligned to the ESMF and the SEP.
- Inform all community residents of the Covid-19 preventive measures advocated for and required by the Project. All such information should be aligned to the ESMF and the SEP.
- To ease implementation, CDCs/ GAs/A-CDC/GCs will cluster households in urban communities, with FPs and PMUs, to create temporary, REACH specific geographic units (or sub-neighborhoods).
- Work closely with FPs to draw up temporary geographic units (sub-neighborhoods) to make the REACH implementation more manageable and to ensure that each pocket of each community has representation by a CDC/GA/GC/ A-CDC member. CDCs/GAs/A-CDC/GCs must ensure that these temporary geographic units (sub-neighborhoods) are equitably formed across the community to ensure no household is missed for inclusion in one of the sub-neighborhoods/community.
- Open and operate the community's bank account in the provincial DAB branches, in a transparent and accountable manner.
- Prepare full household lists for the community, ensuring accurate details for each as required in the mandated forms, and making all efforts not to present falsified data or allow exaggeration in household numbers, including splitting of organic households into families or new households to receive more relief packages.
- Mark out the beneficiary households from these lists, applying the exclusion criteria fairly and transparently across all households as stated in this manual. Apply inclusion principles, ensuring that households that are poor, very poor, female headed, headed with people with disabilities (PWDs), internally displaced persons (IDPs), returnees, Kuchi or nomadic, economic migrants and others,

especially the recent returnees/IDPs resulting from the Covid-19 crisis, are included (except where they may exceptionally fall under the exclusion criteria).

- Ensure that the hard copy original forms for whole and beneficiary HH lists in the community are provided to the FPs, after those lists have been validated by key community members and FP representatives.
- In urban communities where NSP CDCs or CFA GAs are used for REACH, decide between the cash or in-kind options in consultation with their constituents and in line with REACH policy. (Note: The cash option is not available to any rural community, or to any urban community with an Ad-hoc CDC/GC for REACH.)
- Work with the FPs in preparing accurate disbursement requests for the first tranche. (Note: The second tranche disbursement requests from urban communities will be decided upon after the decisions on the modality of the second tranche is determined.)
- In all rural communities and in urban communities that have opted for/ are limited to the in-kind option, work with FPs to learn the REACH community procurement and accounting forms and procedures.
- Conduct procurement exercises for the in-kind packages as per the REACH Community Procurement Manual, ensuring full and satisfactory documentation for the same is maintained and handed over to the FP immediately after the first/ second tranche distribution is completed.
- In all rural communities and in urban communities that have opted for/ are limited to the in-kind option, ensure close coordination with supplier(s) on package quantities, quality of items procured, transportation, date/ venue and modality of distribution.
- Ensure the beneficiary households are informed of the distribution dates, times, modality, venue etc. Where zonal distributions are used, ensure that the beneficiary households are divided into smaller groups for each 30-minute time slots to avoid overcrowding at the distribution venues.
- Ensure all persons in the distribution teams observe the Covid-19 prevention norms prescribed, including but not limited to the use of masks and gloves disposed safely daily, and the use of disinfectants and hand sanitizing for recipients.
- Monitor the distribution of the relief package (cash/ in-kind) whether through distribution events or door-to-door, such that there is at least 1 CDC/GA/A-CDC/ GC office bearer and 1 CDC/ GA/A-CDC/ GC neighborhood representative in all distributions. Where distribution events are used, ensure that there are arrangements made for the doorstep delivery of the relief package for female-headed households and households without able-bodied adult male members. Ensure that any households that do not collect their relief package (cash/in-kind) are provided with packages either through alternative pick-up arrangements or through door-to-door delivery.
- Provide FPs with all signed distribution confirmation sheets in hard copy originals.
- Support FPs and IAs in addressing/ investigating any grievances received from within the community.

Ministry of Finance (MoF)

While not a direct IA for REACH, MoF, as the key signatory to the legal agreements for REACH on behalf of the "Recipient" (here the Government of Afghanistan), and similar to the role it plays for the CCAP, will serve as a coordinating body between the three IAs, the first Vice President's and President's offices, and other line ministries. It will specifically:

- Serve as the Secretariat for the REACH Inter-Ministerial Task Force
- Serve as a key member of the Inter-Ministerial (Technical) Working Group
- Support the preparation and finalization of an inter-ministerial Memorandum of Understanding (MoU) for REACH with the private sector. (Note: The actual drafting of the MoU will be done jointly by all IAs, but all subsequent processes will be led by the MoF).
- Support in compilation and submission of key reports from the three IAs to the Government leadership and the donors, as required

- Support the national level communication campaign for REACH
- Serve as a key member of the technical level working groups for the REACH related to monitoring, grievance handling and communications

Mayor's Offices, Municipalities and Nahia Officials

In urban communities, the City Mayor, his/ her office, the wider municipality and nahia(urban district) officials will support FPs and PMUs/PIU in identifying/ defining clear boundaries, assist in resolving grievances where feasible, ensuring inclusion of all households of the city into the proposed communities. These officials will ensure local media channels/ outlets are used to inform the city residents of the REACH as a Government response, and its key features.

They will play a monitoring role on REACH and all key urban REACH activities in the given city will be informed to them in advance, with clear dates provided for distributions in each community. They will participate in actual distribution, and/or monitor randomly selected distributions of the REACH relief packages.

District and Provincial Governors/ Their Offices

In rural districts and all provinces, the district and provincial governors have been tasked to support the Project. They are welcome to observe distributions and assist in resolving grievances where feasible. Their presence and active participation in the Project are encouraged also as a means to emphasize that the REACH is a Government response, and a whole-of-Government approach to the ongoing crises.

The provision of security for the Project implementation, and addressing any security challenges by the FPs/ PMUs, will also rest with these senior Government representatives.

Community Participatory Monitoring (CPM) Teams, Mullah Imams, Youth Representatives

As a part of the stakeholder engagement and in line with the Community Driven Development (CDD) approach, it is proposed to include members of the community, other than CDCs/GAs/ GCs (and/or their immediate family members) in various aspects of the REACH implementation.

Local Mullah Imams are proposed as key figures for the confirmation of the household lists, beneficiary household lists and in verification of the distribution exercises, in urban communities.

Youth committees/ associations (where present) and/or youth volunteers from the local committees, will support the door-to-door distributions of in-kind relief packages. Where distributions are by neighborhood, these youth will handle the transportation of the in-kind packages, to FHHs and households without adult able-bodied male members.

CPM teams, comprised of four to six respected community members, not related to the CDC/ GA members, will oversee the entire REACH processes within the community. This committee is also responsible for grievance redressal at the CDC/GA/GC and the detail of the grievance redressal will be elaborated in the grievance redressal and Gender Based Violence manual.

Private Sector, MoCI and MAIL

The volume of the REACH procurement of in-kind packages is expected to be huge. The injection of cash grants to households will also cause a surge in food and other groceries from the local markets in a short timeframe. As such, there are concerns about price fluctuations, artificial price hikes, availability/

shortages of certain items in some parts of the country, monopoly of a few large scale/ whole sale suppliers, hoarding of food products by retailers, quality of goods provided, packaging of goods especially when the quantities required are not as per the local market standard packaging, etc. To address all of these concerns, it is proposed to have a MoU between the Government stakeholders related to the project and with representatives of the private sector.

The Government will be represented in this MoU by MoF, the three IAs, and the Ministry of Commerce and Industry (MoCI) and the Ministry of Agriculture, Irrigation and Livestock (MAIL). The private sector will most likely be represented by the Associations of Food Product whole sale/ retail suppliers.

The private sector, through this MoU, will be responsible to ensure adequate supply and availability of all common user food and hygiene items, in all of the REACH coverage areas, for the duration of the Project (and further if deemed necessary), ensure fair market prices for the same, and ensure quality and quantity specifications for the packages are adhered to.

CHAPTER TWO (Part 1): COMPONENT ONE: MRRD REACH COVERAGE

Note: Chapter 2 is divided into 2 parts. Part 1 outlines the overall policies, procedures and processes for the REACH Component 1 areas. Some of these areas are then also under the ENETAF Project, and Part 2 then details the specific guidelines that applies for REACH coverage in ENETAF areas, in addition to or in variation of part 1 of this chapter,

Contents:

Important Note on Coverage for Component One:

Under the rural CCNPP Covid-19 response, MRRD covers over 100 rural districts and 19 provincial capital cities (PCCs). Under the rural REACH, MRRD will be covering 234 rural districts (not covered by CCAP) and also the second tranche for the 19 PCCs. While it is understood that the 19 PCCs include urban/ municipal areas, for ease of reference under REACH, these 19 PCCs will also come under the MRRD and will be referred to as "rural REACH" coverage. Also, in terms of REACH policies and procedures, the urban municipal areas within these 19 cities will also follow the rural REACH modalities for the most part, except in that (unlike other rural REACH communities), the communities in the municipal areas of these 19 PCCs will receive the second tranche as well.

The IDLG will be covering the municipal areas of the 14 remaining PCCs, other than Kabul city. It is also important to note that the non-municipal areas of these 14 PCCs will remain the responsibility of MRRD and will be included for coverage under the rural REACH.

Definitions Used for REACH Rural Component 1:

Rural household: is a socio-economic unit and consists of all persons who eat from a common kitchen / cooking pot (khana), and this could include one or more families. It is a unit often used for public planning as they usually have some form(s) of income, public service requirements and social needs. On average, a household in rural Afghanistan, is estimated to include around 7 persons.

- ***Rural Female Headed Household (FHHs):*** For the purposes of REACH Component 1 alone, a FHH includes single or widowed women, with or without families, living separately from the rest of their household; and married women without adult able-bodied male men in the household making them the de-facto heads. The latter may also include women married to men with disabilities. (Note: All FHHs will be included in the beneficiary lists and receive benefits under REACH).

- ***Family/ Relative:*** Husband/ wife, father/ mother, father/mother-in-law, brother/sister, brother/sister-in-law, son/daughter or son/daughter-in-law of any individual is defined as "family" for REACH.

- ***REACH rural community:*** In rural districts previously covered by the NSP, the same communities for which NSP CDCs were elected will form the communities under the REACH. (Note: The MRRD is aware that certain communities have split into smaller artificial units under the NSP to avail of higher block grant entitlement ceilings than if they had remained a single community with more than 300 households. In such communities, it is strongly recommended that such sub-units rejoin as a single community under REACH, given that the size of the community and number of families/ households will not affect the size of the REACH grants involved and for the purposes of unity.)

  In districts to be covered by REACH but have never been covered by the NSP, a rural community (in REACH) must have a minimum of 25 households. Any exceptional communities with less than 25 households (in mountainous places or in places where households are scattered far away from each other, will be dealt with based on the physical verification and other supporting documents verified by the REACH FP, the ruralCCNPP provincial offices or MRRD provincial directorates. Such communities must have at least 1 Jummah mosque and must be attested by the district governor's office as an independent community. Communities established under NSP with less than 25 households will be accepted as such. It should be noted that there is no maximum number of households defined for a rural community.

- ***FP Social Organizers (SOs):*** FP field staff, sometimes called social mobilizers or facilitators, who will be the primary face of the MRRD with the communities to be covered. Almost all of the roles and responsibilities of the FPs related to REACH community work will be handled by these staff. A minimum of 1 male facilitator for 10 communities and a minimum of 1 female facilitator for a minimum of 30 communities. The female facilitator will essentially work with the three male facilitators that cover the 30 communities she is responsible for.

- ***REACH CDC:*** This will include the NSP CDCs used by rural REACH, REACH Ad-hoc-CDCs, all registered under REACH Component 1.

- ***REACH "Rural PMUs":*** This will include all 34 Provincial Management Units (PMUs) set up under the rural Citizens' Charter Afghanistan Project (CCAP) which will also be expanded for REACH specific purposes..

- ***PPE:*** The personnel protective equipment (PPE) mandated for use under this Component includes the following: disposable masks and disposable gloves, 1 per day. These will be provided to all male/ female CDC members, all active CPM members, all participating mullah /imams, all FP SOs, all GD/ PMU/ district MRRD staff visiting the communities. FPs will be required to provide their SOs with hand sanitizers with minimum 70% alcohol content in 250 ml bottles, 2 per facilitator. Where zonal distribution is being used, the PPE will also include disinfectant sprays and/or hand-washing facilities for all

beneficiary household representatives involved in the collection of the relief packages. The masks are to be used for all REACH related meetings and gatherings by all participants mentioned above.

- ***Rural REACH Relief Package:*** The rural REACH relief package is AFN 4,000/ household to be disbursed in one tranche and will be in-kind for all the rural coverage areas. Exceptionally, the urban (municipal) areas within the 19 PCCs to be covered by MRRD will be entitled to a second tranche, also of AFN 4,000/ household, and exclusively in-kind.

- ***Administrative and Transportation Costs:*** Administrative costs are those costs required by the CDC for them to fulfil their CDC mandates under the REACH project. Administrative costs will include bank fees if any, transportation cost for CDC bank signatories to and from the DAB provincial branches for REACH cash withdrawals, transportation of CDC for procurement of the in-kind package items, local travel to monitor the distribution within the community, etc. A maximum of AFN12,000 per community will be allowed per community, with AFA 2,000 as administrative costs and AFA 10,000 as transportation costs.

Introduction

The REACH Component 1 will be implemented by the Ministry of Rural Rehabilitation and Development via its General Directorate for the rural Citizens' Charter Afghanistan Project (CCAP). This Component will cover a total of 234 non-CCNPP rural areas (excluding"Hard-to-Reach (HtR)" districts. It will also cover all areas of the 19 PCCs (including within urban/ municipal areas) and the areas outside municipal areas in the 15 PCCs to be covered under Components 2 and 3.

In addition, in 52 districts of the rural REACH, the program will conduct a light version of the CCNPP social mobilization to prepare the ground for ENETAWF (Early Warning, Early Finance and Early Action Project), a program implemented by MRRD and funded by ARTF that focuses on building community resilience to shocks and improving the food security and nutrition for selected households. This work will begin after the REACH food distribution has been completed and will take roughly 3 months' work and should be completed by December so that ENETAWF can begin working with the newly established CDCs to roll out its safety net programs during the lean season.

Preparatory Work to be undertaken by MRRD Prior to the Rollout:

The following key tasks need to be completed by the MRRD prior to the actual ground level rollout of the urban REACH:

1. FP Contracting: It has been decided that the MRRD will contract rural CCNPP FPs who cover the current provinces on a direct contracting basis, given their experience and know-how in terms of MRRD's CDD approach, as well as the training investments that MRRD has made during CCAP. FPs will be contracted for all facilitation of Component 1 in the given province, whether rural district or the PCC.

2. PPE Procurement: All procurement of the stated PPE will need to be completed and distributed to each of the PMUs and 19 cities and provided to all MRRD REACH field staff and FPs to use as required under REACH.

3. MIS Module Design and Set-Up: The REACH rural Management Information System (MIS) covering all the core processes and forms in this chapter needs to be set-up, pilot tested and decentralized.

4. Temporary Staff Hire: The rural REACH will need a total of 630 additional temporary staff specifically hired under REACH contracts. All operations staff need to be on board prior to the rollout and the remaining staff need to be on board shortly after. The staff will be hired for varying periods, depending on

their need. Not all of the staff hired will fall under the NTA. Staff for REACH may be hired on daily wage or output based contracts and/or on lumpsum milestone-based contracts. Note: All staff positions (including short term, daily wage positions) for REACH will need to be approved by the World Bank prior to contracting. All recruitment of REACH staff outside of the NTA scale must follow the approved recruitment guidelines for REACH. All staff falling under the NTA scale needs to be hired via the NTA recruitment processes.

5. PMU Expansions: Clear arrangements need to be made in the 34 CCNPP PMUs to house the REACH field staff for all REACH Component 1 communities. The required goods, vehicle rentals and non-consulting services all need to be procured and delivered, with adequate offices set up prior to rollout.

6. National Communication Campaigns: The national level communications campaign, supporting the awareness raising of the public on the REACH should be rolled out to the REACH component 1 areas and from the center via television and radio networks, both national and local.

7. Communication Products for the Local Level: The standardized print products (including pamphlets, brochures and posters) to be used at community level need to be designed and provided to the FPs.

8. Training of MRRD and FP Staff on Component 1: All MRRD REACH specific staff involved in the Component 1, and the REACH FP field staff, need to be trained in all aspects of this Component's implementation, in this Operations Manual and in the MRRD specific REACH Training Manual.

9. Training of MRRD REACH Staff on Focused Areas: Staff hired as field monitors, phone monitors, data entry officers and grievance officers need to be trained in their specific ToRs and expected outputs. FP SOs need to especially be trained in the step-by-step guidelines.

10. Obtaining lists from NSP/ MRRD on actual CDC membership (including and especially contact details for the four office bearers in each CDC) for the rural communities and the 19 cities of coverage and providing the same to the related FP. At a minimum, the data for a NSP community to be covered under REACH needs to include community name and ID, # of families and/or # of population originally included divided by 7, list of CDC members and contact details, especially phone numbers, of the office bearers. Note: The number of families is not to be confused with number of households. However, given the time lapse since the NSP family number data was collected, and when rural REACH will be rolled out, and given the influx of returnees/ IDPs, it is assumed that the number of NSP families will be close to the number of REACH households.

Demarcation between Urban and Rural Coverage Areas for 34 PCCs

The MRRD will work closely with IDLG and KM to mark out the municipal boundaries of the 34 PCCs. The MRRD will cover 19 PCCs in full for REACH, both rural and urban areas. The MRRD will also cover the non-municipal areas of the remaining 15 PCCs (14 under IDLG Component 2 and 1 under KM Component 3) for REACH. Care should be taken to (a) avoid households not being covered by either of the IAs covering these 15 PCCs and (b) ensure households are not covered by both IAs covering a given PCC.

Three Modalities to be used in rural REACH communities:
(Note: The rural REACH here includes the 19 PCCs)

There are three implementation modalities in rural communities and each of these is determined by type of community in relation to NSP. Implementation Modality 1 will be implemented in roughly 16,000 communities that were covered under NSP III A and B (Repeater Block Grant), NSP I closed in NSP III, and NSP II, closed in NSP III, as long as these communities have CDCs in place with Office Bearers still

working or only 1 or 2 Office Bearers that are no longer in the community (have left, expired) or a unwilling to serve. Implementation Modality 1 will require anywhere from 4-6 visits to complete the entire REACH process. Implementation Modality 2 will be implemented in roughly 8,000 communities that were covered under NSP I and closed under NSP I or II, NSP II closed under NSP II; and NSP I, II, III A or B where CDCs did not complete projects (but are have not defaulted on funds and accounted for all resources provided to them during NSP), and communities where NSP did not work, and where as a result communities have no CDCs. The remaining 4,500 communities will be covered under the Implementation Modality 3 where NSP did not have a presence.

The following tables show the data that was extracted from the NSP database, which speaks to the numbers in terms of the types of communities. Each male FP facilitator responsible for 10 communities should determine which of his ten communities would fall under Implementation Modality 1 or 2 and follow the step-by-step guidelines for each type. Note that the numbers in the tables are to provide a sense of overall implementation modality 1, 2 and 3 numbers and to help in terms of planning, but there may be communities that fall under Implementation Modality 1 in terms of the data, but when visited /contacted by FP Social Organizers may illustrate that an ad-hoc CDC has to be formed. MRRD's step by step guidelines for the REACH implementation provides all the details needed for Social Organizers to propose which modalities to be applied and how to implement each modality.

Table 1: Rural NSP CDCs to be Implemented Under Modality 1

Type of Community / CDC	# of type of Community / CDCs	# in insecure areas where Humanitarians will provide relief	Implementation Modality	Key Characteristics of Modality
NSP III A	6,380	1724	Modality 1	4-6 visits; CDCs and CPMs in place, CDCs have proven to complete projects and know procurement and accounting steps
NSP III B (RBG)	8,568	1158		
NSP I, closed in NSP III	599	64		
NSP II, closed in NSP III	350	68		
Total	**15,897**	**3,014**		

Table 2: Rural NSP CDCs that closed under NSP I or II or did not complete projects but remained active either by receiving funds and implementing projects or by engaging in community activities during the past five years under Implementation Modality 2

Type of Community / CDC	# of type of Community / CDCs	# in insecure areas where Humanitarians will provide relief	Implementation Modality	Key Characteristics of Modality
NSP I closed under NSP I or II	3,334	584	Modality 2	5-7 visits; need to establish temporary COVID 19 CDCs, require procurement and accounting
NSP II closed under NSP II	1,485	326		
NSP I, II, III	2,266	693		

A or B where CDCs did not complete projects				
No NSP CDC	1,200	300		
Total	**7,985**	**1,603**		

Table 3: Rural non-NSP CDCs to be Implemented Under Modality 3

during the implementation of EQRA they found a considerable number of NSP I and NSP II CDCs that had received funds from other donors and were active in the community – holding CDC meetings and addressing development issues as they arise. Here, CC would like to work with existing CDC members (we will reflect this in the step by step guidelines).

Type of Community / CDC	# of type of Community / CDCs	# in insecure areas where Humanitarians will provide relief	Implementation Modality	Key Characteristics of Modality
Not covered under NSP	4,500	0	Modality 3	5-7 visits; need to establish temporary COVID 19 CDCs, require procurement and accounting
Total	**4,500**	**0**		

Trainings to Trainers:

A structured full 2 to 3-day training plan will be prepared and implemented by MRRD's CCNPP Capacity Development Division for the MRRD REACH FPs and MRRD REACH field staff. The trainings will be based on the step-by-step guidelines and this chapter of the OM and the forms in the annex. All field implementation, and especially the work of the field staff, will need to closely adhere to the step-to-guidelines that serves as an Annex to the Training Manual.

Wherever feasible, the initial trainings will be conducted in MRRD's offices. Where not feasible, they may be conducted virtually through WebEx or zoom. (Note: Exceptionally, it is allowed to conduct trainings without the field/ classroom approach that CCNPP /MCCG/ CSP have taken; once the situation returns to 'normal' and meetings are possible, trainings will include field visits.)

The trainings will be organized covering the content of each of the facilitator's visits to the communities. For communities under Implementation Modality 1, this means anywhere from 4-6 facilitator visits and for communities under Implementation Modalities 2 and 3, this means anywhere from facilitator 5-7 visits. The step-by-step guidelines for each visit lays out the key activities and steps that have to be followed and these should be trained sequentially.

Consultation with Sub-National Government:

Once the FP is mobilized for each province, the Provincial Manager and the FP key staff will arrange meetings with the City Mayor (for the 19 PCCs) and with Provincial Governors. The first meeting will be conducted with the Provincial Governor/ his or her representative, City Mayor/ his or her representative, 1 representative per PMU and FP key staff.

The concept of the Covid-19 response and what it entails in REACH Component 1 areas, will be outlined by the REACH team. The roles and responsibilities expected by the Government of the Governor's and Mayor's offices will also be briefly outlined. The key REACH stakeholders in the province will be introduced. Channels of periodic reporting will be established.

The estimated number of communities and beneficiary households to be covered by REACH in that province, and an early timeline of the process will also be shared. Their cooperation and support with regard to ensuring the cooperation of the private sector, proper security for the project personnel and beneficiary HH representatives during distribution, avoidance of interference in the process beyond monitoring and grievance redressal roles for nahia and municipal officials, will be shared with the Provincial Governor and Mayor.

Mobilization Approach of Community Development Councils, Local Leaders, and Youth for REACH Relief Distribution

REACH will work with local leaders (NSP CDCs and elders, teachers, imams/ mullahs) to engage in outreach and convey key messages and knowledge about COVID 19 to their people, identify the beneficiaries, publicize the lists of beneficiaries, ensure the inclusion of women-headed households (households that do not have physically capable adult men), and distribute the relief aid in a safe manner. At the same time, Community Participatory Monitoring (CPM) committees will be established to monitor the work of local leaders and account to communities and to the Government. Essentially, the difference between 'regular' Community Driven Development (CDD) and REACH is that the former emphasizes consultative governance, building/ increasing social cohesion across various socio-economic groups, and empowering key groups in society (women, highly vulnerable groups, and the poor); whereas REACH focuses on equitable, safe, and organized food / cash (urban) distribution using local community leaders to identify the most vulnerable. Further, where food packages are involved, the quality and quantity of food should be consistent across each community.

Rural: CDC Remobilization and ad-hoc CDC Formation
(see Step-by-Step Guidelines for how to remobilize and how to form ad-hoc CDCs)

(a) Communities with NSP CDCs (Either Modality 1 or Modality 2)

In communities where CDCs were established, the SOs (either through a visit or phone call) determines if the CDC is still functioning and if it requires new members to replace old ones and if the bank signatories are in place or need to be selected from among the CDC members. There should be at least 10 male NSP CDC members and 5 female NSPCDC members remaining in the community for the implementation of the REACH program.

Where there are less than 10 male and 5 female CDC members remaining in a given community, new members need to be nominated. If new CDC members need to be nominated or new office bearers selected, the SO will assist the existing, remaining members with this process. The selection of new CDC members should involve the other local leaders that will be invited (teachers, imams/mullahs, youth, CPM) and the selection of new Office Bearers will be done by the CDC members (not to include the other leaders).

Any new CDC members must meet the following criteria:

- Must be a citizen of the Islamic Republic of Afghanistan;
- Must be minimum of 18 years of age;
- Must have continuous residence in the given community for a minimum of 1 year immediately prior to the time of REACH rollout (with the exception of returnees/ IDPs for whom the continuous residence requirement is relaxed to a minimum of 3 months);
- Must have no known records of mental disorders that incapacitate coherent decision making (not including depression and similar illnesses) and/or criminal records.
- Must have his/her household's primary residence in the community. (So, a person whose household has 2 or more residences in different communities/ cities should then be eligible to vote in only 1 of the communities. This would require him/ her to spend a minimum of 9 months in a given year in one of those residences for it to be considered the primary residence).
- Must have no record of criminal conduct or human rights violations;
- Must have sufficient time and willingness to work voluntarily as a CDC member;
- Must hold no elected office at the provincial council or national assembly;
- Must be credible, recognized and respected within the community.someone who can take responsibility and can be held accountable.
- Must be willing to work with all community members and all other CDC members in that given community
- Cannot be a relative of anyone else on the CDC.

(b) Communities without NSP CDCs or inactive CDCs for more than 5 years

In communities with no CDCs or where CDCs have not been active for more than 5 years, the SOs will establish ad-hoc CDCs that consist of informal leaders (those that conduct jirgas and help people solve problems) and teachers. During the meeting that the ad-hoc CDC is established, the imams/mullahs from each mosque in the community should be in the meeting (not to be a member of the ad-hoc CDC, but to be a monitor of sorts). Each neighborhood in the community must be represented by at least one male and one female. Large neighborhood should have two or more male representatives in the ad-hoc CDC. If any of the elders are too old to serve (because their face greater health risk from COVID than younger people), they should nominate someone that can serve in their stead. These should be people who are helpful, respected, trusted, known to be honest. Once the ad-hoc CDC members have been determined, the group will amongst themselves decide the three bank signatories.

Just as with the criteria stated above for new CDC members in existing CDCs, the ad-hoc CDC members must meet the same criteria outlined above.

CDC Registration and Bank Account Opening (this applies to both CDC and ad-hoc CDCs:

The FP then registers all details regarding neighborhoods and sub-neighborhoods that the community decided upon, the CDC members and office bearers, and the CPM team members into the **REACH Form 3a:** Beneficiary Household Selection and Distribution Verification per Neighborhood, and REACH Form 2: CPM Team Formation/ Reformation.

Note: Where more than 10 male CDC members exist, there will be more than 1 member assigned per neighborhood, but still keeping the distribution as equitable as feasible. Where the female CDC members are less than 10, more than 1 neighborhood may be assigned to the same female member.

The bank signatories required for REACH community accounts will be limited to three per CDC account and will comprise of CDC office bearers exclusively (i.e. not including other CDC members to serve as

bank signatories). The CDC Treasurer is a required bank signatory. The CDC decides on which of theother three office bearers will serve as bank signatories to the REACH CDC account.

The FP then prepares the **REACH Form 3: CDC Bank Account Opening Form**. The FP, along with the 3 bank signatories will visit the provincial bank account to open a new REACH CDC account accordingly. (Note: The approval of the MRRD rural CCAP/ REACH Provincial Manager needs to be secured on the form prior to the visit to the Bank.)

Mobilizing CDCs /ad-hoc CDCs and other leaders to implement REACH in urban and rural areas

Although the social mobilization process does not include community consultation and instead focuses heavily on local leaders, the basic principles of analysis, discussion/ deliberations, action are not suspended but remain practice. In other words, local leaders (male and female) need to be engaged to:

a) consider why social distancing, masks, and handwashing are important, develop strategies how to convey the importance to the community; and understand the special care that needs to be afforded to elderly and chronically ill persons;
b) consider the relief effort (must be discussed with women) and the work it entails and how they will collectively achieve this, and what is expected of them;
c) know the basis for the identification of beneficiaries;
d) gain awareness as to who the very poor are (women-headed households and households where men are impaired because of physical or mental disabilities, old age, or addiction);
e) gain a sense of the utmost care that must be taken during distribution so as to not spread the COVID 19 virus.

(Note: Where joint sessions with male and female CDC members/ community leaders are not feasible, separate sessions need to be held for women for all of the above).

During the above sessions, SOs must refrain from lecturing and telling people what to do; and instead facilitate a process that helps people understand and internalize (and therefore act on) the processes that should be followed to prevent further spread of COVID 19, ensure that the poorest and most vulnerable are especially considered and if needed the food is brought to them, that beneficiary selection follows the guidelines, and that food is procured in a way that the AFN 4,000 purchase the quality and quantity that is the market rate and that there is no leakage of food from the store to the household. These sessions should be conducted with people facing each other and having discussions (wearing masks and practicing social distancing). See the step-by-step guidelines that discuss the preparation and activities that SOs need to engage in each modality to be implemented.

Some rules and procedures will not require the same type of engagement that is needed for the above topics and these are

a) the monitoring systems (the community based one as well as the Government and Third-Party Monitors) and the post monitoring;
b) the forms that have to be completed;
c) the Grievances mechanisms in place and how it works (women leaders must learn of the Grievances mechanism);
d) the sanctions that will be applied if there is misuse of funds or corruption.

For these, the SO can simply convey the information and use the forms to explain, and a poster to outline Grievances mechanism and the sanctions.

The CDCs and A- CDCs will be assigned work that needs to be completed – e.g. the households level data and the beneficiary household list preparation. A minimum of 2 working days (smaller communities) and a maximum of 5 working days (larger communities) is allowed for the data collection.

The specific processes related to the mobilization of CDCs and ad-hoc CDCs and other leaders for each visit is outlined in the step-by-step guidelines that each SO should have a copy of and use to prepare for their session and to use as a reference guide before the sessions.

Creation of Community Profile

Youth (with at least a 6th class education) from each neighborhood, with the help of and supervision by teachers, should be engaged in going door to door and completing a one-page questionnaire about each household. This form (called Household Profile Form) takes just 5-10 minutes at each household. The teachers should aggregate each neighborhoods' forms into the Community Profile Intermediate Sheet. The FP SOs then aggregate the Community Profile Intermediate Sheets into the Community Profile Form. The Youth should be allocated no more than 20 households and should complete their work in two days. See Step-by-Step Guidelines how to collect the Community Profile.

REACH Component 1 Household Exclusion Criteria and Beneficiary Selection

REACH will cover roughly 90 percent of households in Component 1 coverage areas; but this coverage must be established through a clear process. Pilots of relief distribution in CCNPP indicate that if leaders are aware that 90 percent of households will be targeted, they are likely to inflate the numbers. It is therefore proposed that the 90 percent inclusion is not specifically stated, until the community profile (household count) has been completed.

An important difference in the identification of beneficiaries in REACH Component 1 as opposed to rural CCAP, MCCG, CSP is that in REACH, the CDC or A-CDCs will identify those that do **not** need the food aid. The key criterion for exclusion is food security. In other words, households that continue to be food secure despite COVID 19 lockdowns and the economic downturn, will not receive food aid. Note: All FHHs (as defined above) will be entitled to the REACH relief packages and be part of the beneficiary lists automatically.

It should be noted that the percentages of exclusion from different neighborhoods is likely not to be uniform. Some in the more affluent parts of the community may have a larger percentage of HHs excluded, while the poorer neighborhoods may have none or lower percentages of HHs excluded. It is expected that around 10% of the HHs may be exempted by using the food security criteria.

Based on the household profile forms, the youth team with CDC members will prepare a complete list of HHs in that neighborhood using **REACH Form 3b: Summary for all neighborhood Beneficiary selection**. The details collected for each HH will include the following details: For the head of the household: full name (as shown in the Tazkira if any), Tazkira number (if available), sex (male/ female), phone number; For the whole HH: house address (if in a city), # of members in the HH, whether or not the HH meets the food security exclusion criteria. The CDC member may be required to speak to the head of the household to collect such information. The Tazkira numbers and phone numbers provided for each household must be that of the same person listed as head of the household. The HH will be informed that they may be receiving a phone call to validate the phone number and household eligibility.

(Note: Where the head of the household does not have either a phone number or Tazkira, those of another adult member of the family could be used. But again, both the phone number and the Tazkira number needs to be that of the same household member. The CDC member needs to also note if the phone number is registered in the name of the household head/ member, and if it actually works. Where no adult member of a given household has a functional phone number, the phone number of an immediate adult neighbor may be provided but this must then be noted on the form).

Note: Under exceptional circumstances (and with prior notice) some communities would be permitted NOT to provide phone numbers. This was expected only in places where limited connectivity meant that

few people even had phones. Where communities do not come under this exception, any community with more than 8% HHs without phone numbers will not be accepted.

The individual neighborhood lists are then signed by the assigned CDC member and verified by the local mullah/ imam (if he is willing) or a local respected teacher from within the community, and submitted to the wider CDC. The FP with the wider CDC then reviews each of the neighborhood lists and proposals for HH inclusion and makes a final decision on the same on the same form. *See Step by Step Guidelines how to conduct the beneficiary selection.*

Verification Process:

After the lists of all neighborhoods of a given community are approved by the CDC and provided to the FP, the FP will examine if the verification requirement has been triggered. In rural communities, the trigger will be if the total number of households stated by the CDC as currently residing in the community is over 10% of the total number of families listed in the NSP database. (Note: For ease of calculations and given the number of years since NSP data was collected, the population number of NSP will be divided by 7 to find out the HH numbers. An increase of up to 10% over and above the NSP total family count in the current number of HHs proposed by the CDC will not trigger any verification requirement. Where the number is higher than 15%, the FPs will be required to conduct a physical verification process of 10% of households in the community. In rural areas, the verification will not be uniform across *Mohallas*. Instead, the FP will select those Mohallas showing larger numbers of IDPs/ returnees/ economic migrants/ kuchi households. (See step-by-step guidelines for how to conduct the verification).

The details of the verification process and the confirmation of the CDC being informed of the sanctions policy is then recorded on to the **REACH Form 4: Verification of HH Lists and Sanction Policies andREACH Form 7: Verification of In-kind Distribution**.

Where the verification process indicated errors or discrepancies, the CDC has to redo the entire HH lists and beneficiary lists. Where the verification process indicates that the lists are largely accurate (over 70% of those physically verified are indeed accurate), the community may then move on to the disbursement request preparation.

Sanctions Policy:

The FP will inform the CDC member, mullah imams, and CPM team members of the following policies and procedures, and require them to also communicate the same to all households during the data collection:

1. In the 19 cities, if any verification undertaken by any party (not limited to FP, PMU, TPMA) before the second tranche indicates that there has been an exaggeration of HH numbers in the total count of HHs and/or as beneficiary HHs for the REACH project, in the data we have provided above and in the Form 2 as the CDC, the entire community will forfeit the right to the second tranche of REACH relief grants. In rural areas, if there are exaggerations of household numbers or if better-off households that were food secure have been included or if it is reported that the food packages do not value AFN 4,000, the community will be put on notice and future development funding and grants (including those of a future CCNPP expansion in these areas) will be jeopardized.

2. In the 19 cities, if any verification undertaken by any party (not limited to FP, PMU) prior to the second tranche indicates that there have been better-off households that do meet the exclusion criteria still included as beneficiary households for the REACH, by the CDC, the community will be penalized by a reduction in the second tranche of REACH grants as stated here: # of better-off HH that are included as

beneficiaries (X) x 2. The CDC understands that it will have to still distribute the second tranche in full to all the remaining HHs, making up for the difference spent on the better-off HHs in the first tranche.

3. If either of the above two discrepancies are noted after the second tranche distribution, the CDC understands and has informed the community that future development and relief funding from the government may be forfeited for the whole community.

In-Kind Relief Package

The relief package for rural areas will be in kind and will contain food items valuing AFN 4,000. There will be different food contents in the packages depending on the region / province and the food preferences of local people. Packages must consist of either wheat flour and rice, as well as beans, cooking oil, and soap; or wheat flour, beans, cooking oil, and soap, or rice, beans, cooking oil, and soap. In other words, each package must have one carbohydrate (can have two) as well as beans, cooking oil, and soap.

19 PCCs: In-Kind/ Cash Options and Conditions:

The relief package for the communities within the municipal areas of the 19 PCCs covered under Component 1 is AFN 8,000/ household in two tranches of AFA 4,000 each. The first tranche can be in-kind for any community, or in cash for those communities that meet the following conditions:

a) Communities with NSP CDCs are permitted to consider the cash option. A-CDCs are not allowed the cash option; and
b) Communities where the CDC can guarantee safe transport of the cash from the provincial DAB branch to the community and distribute the same without threat of security incidents and/or loss of funds.

For those communities eligible for either, the FP then works with the CDC to discuss the pros and cons of both options and then decide of one of the options for the community. (Note: All beneficiary households in a given community will have the same option (cash/ in-kind) for the first tranche. The CDC cannot opt for different options for different households).

The In-Kind Relief Package per household approved for this Component is outlined below. Communities are required to procure only the approved packages and at the fixed costs (in AFN) stated below.

Table 1:

Item	Unit	Unit Cost AFN	

			Quantity	Total AFN
Wheat flour	Kg	40	50	2,000
Rice	Kg	100	13	1,300
Beans	Kg	125	3	375
Oil	Litre	110	2	220
Soap	Piece	30	2	60
Total costs in AFN				3,955

Table 2:

Item	Unit	Unit Cost AFN	Quantity	Total AFN
Wheat flour	Kg	40	75	3,000
Beans	Kg	125	5	625
Oil	Litre	110	3	330
Soap	Piece	30	4	120
Total costs in AFN				4,075

Table 3

Item	Unit	Unit Cost AFN	Quantity	Total AFN
Wheat flour	Kg	40	75	3,000
Beans	Kg	125	7	875
Soap	Piece	30	4	120
Total costs in AFN				3,995

Table 4

Item	Unit	Unit Cost AFN	Quantity	Total AFN
Rice	Kg	100	35	3,500
Beans	Kg	125	4	500
Soap	Piece	30	3	90
Total costs in AFN				4,090

Table 5

Item	Unit	Unit Cost AFN	Quantity	Total AFN
Rice	Kg	100	30	3,000
Beans	Kg	125	5	625
Oil	Litre	110	3	330

Soap	Piece	30	3	90
Total costs in AFN				4,045

Disbursement Request 1st Tranche:

The FP then helps the CDC/ ad-hoc CDCs in Component 1 to fill out the **REACH Form 6: Rural REACH Disbursement Request** for the first tranche. The Form indicates the total number of households, total number of beneficiary households, core REACH grant tranche 1 (calculated as AFN 4,000 x the # of beneficiary households), and the administrative and transportation costs, as applicable by the option selected. The Form 5 will first be approved by the CDC/ GA (urban) office bearers, and by the FP REACH Provincial Manager. (Thumbprints may be accepted in lieu of signatures for the CDC/ GA members alone).

The originals of all Forms from 1 to 5 are ideally submitted to the PMU within 2 working days of their completion. The PMU staff (i.e. Accountant/ Admin/Fin officer where relevant and PMU for all forms) will need to approve these forms as well, and then ensure that the forms are scanned and uploaded in the REACH MIS module, tagged by Community ID.

Note: The Disbursement Request for the tranche #2 will be determined at a later date once the final decisions on the modality of the tranche (cash/ in-kind/ mobile money etc.) are confirmed.

Fund Disbursement and Withdrawals:

Once the scanned Forms 1 to 5 for a given community is available in the REACH MIS, the Finance/ Grants Unit will examine them for completeness and then process the necessary paper work to prepare batches, secure management approvals and make the fund transfers, via the Ministry of Finance (MoF) and the Da Afghanistan Bank (DAB) to the community bank accounts. The Unit will also be responsible to inform the FPs and PMUs of the disbursement being made, via the Field Coordination Unit, with exact lists of communities for which the transfer has been made.

All stakeholders in the grant disbursement process (i.e. the MRRD PIU Finance/ Grants Unit, the PIU Management, MRRD leadership where signatures may be needed, MoF Budget and Treasury Units, and the DAB HQ and Provincial branches) should ensure speedy processing of the disbursement requests. Given that the REACH is undertaken as an emergency response, the time from submission of disbursement request by the FP to the PMU, and the actual receipt of funds in the CDC/GA bank accounts should not exceed 15 working days or 3 calendar weeks whichever is shorter.

Community Procurement for In-Kind Relief Packages:

This section applies only for where the in-kind relief package option is selected. The following is only a very brief summary. Please refer to the separate REACH Community Procurement and Accounting Manuals for further details:

The procurement training and actual finalization of the purchase order need to be completed in the time interval between submission of the Disbursement Request and actual receipt of funds in the CDC/GA bank accounts.

For rural communities, where in-kind relief is the default option and in those urban communities that have selected the in-kind relief package option, the FP will then train the CDC/GA on the REACH community procurement requirements. The FP will also prepare the **REACH Form 8: REACH In-Kind Relief**

Package Bid Quotation Form with the pre-agreed package for the given city and the costs for the same per household already incorporated into the form. The price of the package per household is already pre-defined as AFN 4,000 as shown above. The CDC takes the Form 6 to medium to large sized grocery stores or wholesale stores in the village or closest city and the 19PCC communities preferably even in the same nahia, and examine the possibilities of the supplier providing the stated package in the quantities required. The suppliers willing to provide the packages in the quality, quantity and prices already defined in the form are identified. The CDC then negotiates with them on the transportation costs, clearly outlining the modality of distribution: by neighborhoods in general, and door-to-door for FHHs and households without adult able-bodied male members. The transportation costs are also included in the bid quotation form. (Note: Where the CDC is handling the transportation of the in-kind packages independently without relying on the supplier for the same, transportation costs will not be included in the supplier contracts.)

Where a single supplier is able to provide the required number of packages for all beneficiary households in the community, then this supplier is preferred. Where there are no such suppliers, the CDC may opt for a second supplier. It is recommended to keep the number of suppliers for all the relief packages for all the households in a given community preferably limited to one or exceptionally a maximum of two.

The modality of payment is also discussed and agreed with the selected supplier. Wherever feasible, payments to the supplier should be made as bank transfers, directly from the CDC bank account to the bank account to be provided by the supplier and stated in the contractual terms. Where this is not feasible, the second preferred option would be to pay through cheques issued by the CDC to the supplier as per the payment terms. (Note: This is feasible only if the DAB provincial branches are willing to provide the CDC with cheque booklets).

After all the negotiations, when such a supplier is (or exceptionally 2 suppliers are) identified through the quotations, the CDC (supported by the FP) then prepares the **REACH Form 9: REACH Purchase Order (PO) Form**, in line with the selected quotation. Both the CDC/GA and the supplier need to sign the same to finalize the procurement itself. There will be one PO per supplier.

(Note: The CDC/GA members that participate in the procurement will not be allowed to then verify the distribution from that supplier. As such, it is important to limit the number of CDC/ GA members involved in the procurement directly to 3 persons, other than the Chairperson).

The payment terms are then negotiated with the preferred supplier. In rural communities, given the distance between the community and the supplier, the CDC makes payment to the supplier immediately after the collection of the goods (if handled by the CDC) or immediately after delivery in each mohallah (if handled by the supplier).

Both Forms 8and 9 in signed hard copy originals, along with invoices/ receipts from the supplier need to be provided by the FP who will then provide the same to the IDLG REACH City Office/ PMU within 3 working days of final payments to the supplier(s).

Withdrawals from the CDC Bank Accounts:

Once the funds are received into the provincial DAB community bank accounts, the FP and the CDC will determine the amount needed to be withdrawn given the following:

a) In-kind option: Agreed payment needed to be paid to the supplier after the purchase of the food and non-food items.
b) Cash option: Amount that can be distributed to the beneficiary households on the same day of withdrawal.

The actual authorization for each withdrawal by the CDC/GA from their bank accounts need to be provided first by the FP Provincial Manager and then by the MRRD CCAP/ REACH PMU Manager, using the **REACH Form 10: CDC Bank Withdrawal Authorization Form**.

It is advised that the withdrawal authorization and actual first withdrawals take place within a maximum of 3 working days of funds being made available in the CDC/ GA bank accounts. To minimize the risk of a large number of CDCs (bank signatories) going to the DAB provincial branch at the same time, the SO would coordinate this by assigning different time slots to different CDCs in agreement with the provincial DAB branches. It is also advisable to limit the authorization and actual withdrawals for what can be distributed (for cash option) or paid to suppliers (for in kind option) on the same day. However, exceptionally, the authorizations and withdrawals can be made for the whole first tranche amount for the whole community. These exceptional cases are only considered where the time needed for each trip to the bank for withdrawals is considerable, and where the CDC/GA can ensure safe storage of the cash withdrawn.

The MRRD Finance/ Grants Unit and the PMUs should liaison with the DAB HQ and the provincial DAB branches respectively to ensure sufficient cash liquidity in the banks for easy withdrawals by the CDC/ GA members, and for the cash distribution in larger currency notes only.

Distribution of Relief Package:

The actual distribution for the in-kind will be handled by the distribution committee of the CDCs, though suppliers may be responsible to provide transport. The actual distribution of the cash option where used in select communities in the 19 cities will be handled by the CDC.

Whether cash or kind, the distribution team should include the following mandatorily for all distributions: a minimum of 1 CDC office bearer, a minimum of 1 CDC representative for the given neighborhood (other than those CDC members involved in the procurement), 1 FP facilitator, and 1 mullah imam (or his designated representative from within the local mosque committee) or a community elder (not in the CDC) or a respected local teacher .

The FPs are responsible to inform the PMUs in advance of the planned distribution dates for each community. In the 19 PCCs, the PMU Managers are responsible to inform the Mayor's office and the municipality of these dates as well.

For REACH Component 1 coverage areas,MRRD will use the neighborhood (*mohallah)* approach and distribute in fixed distribution points.The actual confirmation of the distribution by the beneficiary household representative (preferably the head of household) is undertaken through the following means: Signatures or thumbprints in the last 2 columns of the REACH Form 3 against the respective HH details.

In addition to the distribution verification, the FP SOs will also verify the following details of each beneficiary household by comparing between what is available in the mobile app, and the actual documents/ sim cards available with the household representative:

a) Full name of beneficiary household representative
b) Tazkira number if available
c) Phone number if available

The following additional norms are to be adhered to for the distributions: proper social distancing facilities, proper use of PPE, the provision of hand-sanitizers for all door-to-door distribution, the provision of disinfectant hand sprays for all neighborhood distributions.

After the distribution for each tranche is completed for the entire beneficiary HHs in a given community in the 19 PCCs, and the one-time package in other Component 1 rural districts, the CDC office bearers sign the REACH Forms 9 and 10. As stated earlier, a minimum of 1 FP facilitator must be present for all distributions. He/ she will be the first point of verification outside the CDC members/ office bearers. Where mullah imams, teachers, elders or PMU staff were also present for the distribution, they will also add their signatures as additional levels of confirmation for the distributions.

The signed hard copy original distribution confirmation forms need to be submitted by the FPs to the PMUs within 2 working days from completion of the distribution in each community.

Documentation requirements

The MRRD PMUs will maintain hard copy folders, one per community in REACH. REACH Forms 1 to 8 need to be provided in hard copy, signed originals by the FP to the PMU in the timelines mentioned above. The PMU staff are responsible to file the originals in chronological order of forms for each community per folder.

Urban REACH Form 3 will need to be prepared in 3 hard copy originals. 1 is retained by the CDC/GA, 1 is submitted by the FP to the PMU at the time of disbursement requests, and 1 is retained by the FP for use at the time of distribution verification (last 2 columns). The REACH Form 3 original retained by the FP also needs to be submitted to the PMU after the distribution verification columns are filled in.

For in-kind procurements, in addition to the Forms 1 to 8, FPs also need to submit the original copies of the invoices/ receipts of payments to the suppliers, and bank statements for each community.

Note: The exact document requirements for the second tranche is as yet unclear but is expected to be limited to the following: Disbursement request for tranche 2, and a print out of the Form 3 household data with columns for signature of beneficiary household representative, for verification of distributions in kind.

Data entry requirements

All data in the REACH Forms 1 to 8 need to be entered into the MRRD REACH MIS Module. However, the following special data entry needs need to be noted:

a. Every household needs to be linked by a clear ID number that then indicates the province, city, nahia, community and neighborhood it belongs to, and should match the data in Form 3. For example: Household ID: 01-01-01-01-01 would indicate that the community belongs to Province 1, District 1, Community 1, Neighborhood 1, and is the first house listed in that neighborhood.
b. All data entry for each community needs to be completed for the first tranche prior to the approval of disbursements for the second tranche (where applicable).
c. It is expected that the data entry requirements for the second tranche will be completed within one month of completion of the second tranche distributions in each community.

CHAPTER TWO (Part 2): COMPONENT TWO: MRRD REACH ENETAWF COVERAGE

In 52 Districts, the FPs will also implement a light version of CCNPP to prepare the ground for the ENETAWF program. In these 52 overlapping REACH districts, the FPs will work to establish the following:

1) CDCs (a la CCAP)
2) Vulnerable Group and Youth Sub-Committees

And conduct

3) Well-Being Analysis

For details on how to conduct these activities, FP Trainers and SOs should use the following.

For teaching how to do the elections and WBA: Chapter 2 and Chapter 3 of the (rural) CCNPP Training Manual 1 and Annexes 4, 5, 6, and 7 for the SOs to conduct the elections and WBA.

For teaching how to do create the Vulnerable Group and Youth Sub-Committee see Part 1 of the CC Training Manual 2, and SOs should use Annex 12 of the Training Manual 2.

These activities should take no more than 10 weeks' time and should begin at the latest by the end of November, 2020.

CDC and Office Bearer Election and Registration
Any community to be covered in the 52 overlapping REACH Districts must conduct a fresh round of CDC elections. This is irrespective of when the existing CDC (if any) in the community was last elected. Unlike the NSP, CDC elections in the CCNPP will allow only one type of elections permissible nationwide. For ease of reference, the selected election type is referred to as "election unit-type CDC election", wherein SOs working with the community form election units that are of equal size (in terms of number of households) and residents of each election unit stated in the Form 1will elect 1 male and 1 female CDC representative from within their election unit to represent that election unit in the CDC.

Please refer to Rural CCNPP Social and Training Manuals 1, Chapter 2 and Annex 4,5,6 for more detail.

CDC Account Signatories
Once the CDC is registered, the CDC consults with the community in terms of who among the CDC members will serve as the CDC bank signatories on behalf of the community. One of the four signatories is reserved for the CDC Treasurer. The remaining 3 signatories are selected by the wider community from among the elected CDC members/ office-bearers, noting that at least 1 of the 4 signatory positions should also be reserved for women CDC members/ office bearers. The selected bank signatories are introduced to the Bank using **Form 2a. CDC/GA Bank Account Opening Form** The bank accounts will be opened at the DAB provincial branches, will be exclusively 1 account for 1 CDC for CCNPP funds only, and will allow for sub-accounts for different sub-programs within the CCAP.

(Note: This bank account will be exclusively for CC transactions and must allow sub-accounts, 1 per CC sub-program).

The selection of CDC bank account signatories should be based on consultations with community and CDC members. If large meetings are not possible, then the CDC should select the OBs on their own. It is also proposed that Treasurers will be elected from among CDC members that are literate.

Wellbeing Analysis

Wellbeing Analysis aims to understand the socio-economic condition of the residents of the community.

It is used to understand:

- The class composition of the community and the extent of wealth and poverty and marginalization (the number of people in which groups and the number of landless, less than one jerib, etc.;
- Identify interest groups (widows, agricultural day laborers, etc.) for community led activities;
- Begin to get an understanding of the economic relations between rich and poor and middle and poor (who works for whom, etc.) and find ways to reduce these vertical dependencies;
- Identify the poorest households in need of rations, or eligible for state funded public work schemes;
- Identify people trapped in loans, advanced wages, and or high interest micro-credit and to subsequently develop strategies with these households to get out of such unequal relations.

This exercise is facilitated with minimum 60% of the community people. (*For more detail please refer to the training manual 1, Chapter 3 (for Trainers) and Annex 7 for SOs.)*

Vulnerable Group and Youth Sub-Committees:

Thematic sub-committees include Health, Education, Agricultural (all sectoral), Women, Youth, Vulnerable Groups (all social) and ESS. In the case of REACH, however, the FPS will establish VGD and Youth committees with specific activities to establish Grain Banks. See 2nd training of trainers' manual Annex, 13.1 how to establish Grain Banks.

CHAPTER THREE: COMPONENT TWOAND THREE: IDLG REACH COVERAGEIN 14 PROVINCIAL CAPITAL CITIES and KM REACH COVERAGEIN KABUL MUNICIPALITY

Contents:

Definitions Used for REACH Urban/ Component Two and Three:

- ***Urban household:*** For the purposes of urban REACH, a household is defined as a socio-economic unit and consists of all persons who eat from a common kitchen / cooking pot (khana), and this could include one or more families. It is a unit often used for public planning as they usually have some shared form(s) of income, public service requirements and social needs. As per NSIA data, urban HHs range from 6 members to 12 members per household in different provinces. For ease of reference, an average of 7.7 members is considered per HH under REACH Component 2.As such, families living together and sharing a kitchen, in one house or in one compound will be deemed a single household. Where an adult son or a widowed woman lives alone or with his/her families in a separate house/ compound, these will be deemed as separate households. Households that own two or more houses in a given community will be counted only once. Households that have more than one house in different communities and reside part of the year in one and part another (as common in eastern provinces) will only be counted in the community of their primary residence. (Primary residence would require the HHs to be living there for a minimum of 9 months in any given 12 month period).

- ***Urban Female Headed Household (FHHs):*** For the purposes of REACH Component 2 and 3, a FHH includes single or widowed women, with or without families, living separately from the rest of their household; households where the eldest member is a widow, and married women without adult able-bodied male men in the household making them the de-facto heads. The latter may also include women married to men with disabilities. For the purposes of Components 2 and 3 of REACH, all FHHs are considered as beneficiary households.

- ***Family/ Relative:*** Husband/ wife, father/ mother, father/mother-in-law, brother/sister, brother/sister-in-law, son/daughter or son/daughter-in-law of any individual is defined as his/her "family" for REACH.

- ***REACH urban community:*** A community covered by a Community Development Council (CDC) established by the National Solidarity Program (NSP) or a Gozar Assembly (GA) established by the Cities for All Project (CFA) or an Ad-hoc CDC (A-CDC) established under REACH in the14 PCCs' municipal areas and 22 districts of Kabul city. For REACH Components 2 and 3, each of these CDCs, GAs. GCs and A-CDCs need to be registered/ re-registered.

- ***Social Organizers:*** FP field staff, sometimes referred to as social mobilizers/ facilitators, who will be the primary face of the IDLG and KM with the communities to be covered under Components 2 and 3 respectively. Almost all of the roles and responsibilities of the FPs related to REACH community work will be managed by these staff. A minimum of 1 male facilitator for 400 beneficiary households and a minimum of 1 female facilitator for 1,600 households are required for the REACH Components 2 and 3. (Note: In larger communities where there will be multiple SOs assigned, 1 SO will be designated as the lead SO for the given community, and will coordinate the work of the other SOs especially with regard to collection and verification of HH lists, and verification of the relief package distributions).

- ***REACH "Urban CDCs/GAs/A-CDC/ GCs":*** This will include the NSP CDCs, CFA GAs and REACH A-CDCs for Component 2, and ad-hoc gozar councils (A-GCs) for Component 3, all registered under REACH.

- ***REACH "Urban PMUs":*** This will include the urban CCAP/ EZ-Kar C2 Provincial Management Units (PMUs) in the cities of Jalalabad, Kandahar, Herat and Mazar, and all the temporary staff hired for each of the other 10 cities for Component2. The urban REACH "Provincial Operations Manager" in each of these 10 cities will then serve as the de-facto urban REACH "PMU Manager" (as may be required for approvals in various processes and forms). For Kabul city, this will also include the KMDP office in Kabul and all the temporary staff hired for each district under Component 3.

- ***PPE:*** The personal protective equipment (PPE) mandated for use under these Components will be procured by the IDLG and KM respectively. At a minimum, they include the following: disposable masks and disposable gloves, 1 per day. These will be provided to all CDC/ GA/A-CDC/ GC members, all active CPM members, all participating mullah imams, all FP facilitators, all PIU/ PMU/ city IDLG and KMDP staff visiting the communities. PPE will also include 2 bottles of hand sanitizers to be provided to each FP SO. Where zonal distribution is being used, the PPE will also include disinfectant sprays and/or hand-washing facilities for all beneficiary household representatives. The use of PPE for all REACH meetings by the persons stated above where present is deemed mandatory under the REACH ESS policies.

- ***Urban REACH Relief Package:*** The urban REACH relief package is AFN 8,000/ household to be disbursed in two tranches. The first tranche may be distributed in-kind (in any community) or in cash (only in those that meet the stated conditions). The second tranche, expected four to six months after the

first tranche, is more likely to be limited to cash or mobile money transfers for Component 2, and will be limited to in-kind for Component 3.

- ***Administrative Costs:*** Administrative costs are those costs required by the CDC/GA/ A-CDC/GC for them to fulfil their CDC/GA/ A-CDC/GC mandates under the REACH project. Administrative costs will include bank fees if any, transportation cost for CDC/ GA bank signatories to and from the DAB provincial/Kabul city branches for REACH cash withdrawals, transportation of CDC/ GA/A-CDC/ GC for procurement of the in-kind package items, local travel to monitor the distribution within the community etc. It is understood that there are administrative costs attached for both in-kind and cash distributions. For cash distributions, it is proposed to include a maximum of AFN 3,500/ community and, for in-kind distributions, it is proposed to include a maximum of AFN 7,000/ community as administrative costs for each CDC/ GA/A-CDC/ GC for the first tranche of distributions. The administrative costs for the second tranche will be determined later. There will be no administrative costs for mobile money transfers. (Note: Administrative costs will not include PPE equipment which will be provided for the CDC/ GA/A-CDC/GC/ CPM representatives and mullah imams/ mosque representatives involved by the IDLG and KM as required in this Manual in their respective coverage areas).

- ***Transportation Costs for In-Kind Packages****:* Transportation costs here refers to the costs of transporting in-kind relief packages from the supplier's store/ shop/ warehouse in the same city to the designated points of distribution, whether door-to-door or by neighborhood, and can be up to AFN 75/household for door-to-door distribution. For each community that opts for the in-kind relief package, transportation is negotiated during the procurement of the supplier, and included in the supplier's contract clearly. The transportation costs per household can be up toAFN 75 depending on the distance and accessibility, but cannot exceed AFN 75 per household. The negotiation cost for transportation needs to be clearly included in the supplier's contract for it to be eligible.

Introduction

Component 2: The REACH Component Two will be implemented by the Independent Directorate of Local Governance (IDLG) via its Project Implementation Unit (PIU) for the urban Citizens' Charter Afghanistan Project (CCAP) and the Eshteghal Zaiee – Karmondena Project's Component Two (EZ-Kar C2). The PIU will be expanded by REACH specific staff both at the headquarters and in the 4 CCNPP PMUs and in the 10 city offices (set up in those cities without urban CCAP). This Component will cover the municipal/ urban areas within the 14 provincial capital cities (PCCs) listed below:

Table 1. Estimated number of communities and households by city for Component 2

Province	District	# of communities	Estimated # of total HHs
KAPISA	MahmodeRaqi	99	17,075
PARWAN	Charekar	55	23,632
PANJSHER	Bazarak	31	3,957
BAMYAN	Bamyan	20	12,236
PAKTYA	Gardez	114	23,028
NURISTAN	Parun	11	2,450

SAMANGAN	Aybak	66	16,833
GHOR	Ferozkoh	32	11,903
BADGHIS	Qala-e-Naw	47	13,876
NIMROZ	Zaranj	149	18,207
NANGARHAR	Jalalabad	293	102,239
BALKH	MazareSharif	87	77,047
KANDAHAR	Kandahar	67	30,000
HERAT	Herat	152	105,179
Total	**14**	**1,223**	**457,662**

It should be noted that part of the cities of Jalalabad, Mazar, Kandahar and Herat are covered under the urban CCAP. These communities will be covered for similar Covid-19 response relief packages under the urban CCNPP Covid-19 relief sub-program. At the time of this OM preparation, it is estimated that a total of 850 communities covering a total population of around 192,000 households will be covered for the Covid-19 response under the CCAP. The remaining communities within the official municipal boundaries in these 4 cities and all communities within the official municipal boundaries in the remaining 10 cities will also be covered under the urban REACH Component 2.

It should be also be noted that the 19 provincial capital cities (PCCs) not mentioned in the table above (other than Kabul), have been covered by MRRD under the rural CCNPP and hence will also be covered for the Covid-19 relief response under the rural CCNPP Covid-19 Response (for the first tranche) and Component 1 of REACH (for the second tranche).

Exceptionally, the FP costs for facilitation of the urban CCNPP Covid-19 response in CCNPP areas in Mazar city will also be covered under the REACH Component 2, while theCCNPP Covid-19 grant funds for the same will still be covered by the urban CCAP.

Component 3: The REACH Component three will be implemented by the Kabul Municipality via its PIU Kabul Municipal Development Program (KMDP) and the Eshteghal Zaiee – Karmondena Project's Component four (EZ-Kar C4). This component will cover the municipal/urban areas within the 22 districts of Kabul listed below:

Table 2. Estimated number of communities and households by district and zone for component three

Municipality	District	# of Gozar	Estimated # Population	Estimated # of HH
Kabul	1	27	113,465	19,293
	2	54	138,190	2,267
	3	51	167,365	27,613
	4	41	356,094	56,073
	5	19	328,700	54,021
	6	36	363,923	62,469
	7	38	435,300	72,471
	8	65	361,868	55,348
	9	95	313,045	4,944
	10	31	383,946	64,031
	11	53	300,519	48,213
	12	38	55,343	8,561
	13	38	254,078	42,567

	14	21	300,000	51,020
	15	12	411,083	65,718
	16	24	178,338	29,182
	17	17	111,899	17,244
	18	29	68,000	11,564
	19	38	90,000	15,306
	20	109	72,500	12,329
	21	41	106,300	18,078
	22	8	280,000	47,619
Total	**22**	**885**	**5,189,956**	**785,931**

The data in table 2 has been derived from KM records. The same estimated number of CDCs and Gozars will be established and or reactivated under Kabul REACH Component three.

Preparatory Work to be undertaken by IDLG and KM (as appropriate) Prior to the Rollout:

The following key tasks need to be completed by the IDLG/KMDPprior to the actual ground level rollout of the urban REACH:

1. FP Contracting: It has been decided that the IDLG will use the same urban CCNPP FPs for the urban REACH in the cities of Jalalabad, Kandahar and Herat. For the remaining 11 cities, IDLG will contract the rural REACH FP assigned to the given province. Where the rural REACH FP is a joint venture (JV), the NGO responsible for the province in which the concerned PCC is located will be contracted. All 14 of the urban REACH FP contracts need to be finalized on a priority basis. At the same time KMDP will contract four FPs for Kabul. The 22 districts of Kabul have been grouped into four zones; each zone will have its assigned FP to implement the program.

2. PPE Procurement: All procurement of the stated PPE will need to be completed and distributed to each of the 14 cities and Kabul, and provided to all IDLG/KM REACH field staff and FPs to use as required under REACH. Centrally managed procurement can be broken up into city-wise packages, and with delivery terms mandated in the contracts/ purchase orders to be in the relevant city of use.

3. MIS Module Design and Set-Up: The REACH urban Management Information System (MIS) covering all the core processes and forms in this chapter needs to be set-up, pilot tested and decentralized by both IAs.

4. Mobile app/ ODK Set-Up: The REACH ODK app to be used for distribution verification needs to be prepared, pilot tested, made functional and shared with FPs to use on their male facilitators' smart phones.

5. Phone Monitoring System Set-Up: The required MIS-module for the phone monitoring needs to be prepared, and the phones and headsets procured in advance.

6. Call Centre Set-Up for Grievances: It has been agreed that the IDLG will set up the REACH call center for grievances across all three components. Grievances related to the other IAs will be transferred to the respective IA either through MIS or manually through call operators.

7. Staff Hire: The urban REACH for Components 2 and 3 will need a total of 183 (IDLG) and 99 (KM) additional staff respectively, specifically hired under REACH contracts. The field staff related to operations need to be hired before rollout. The monitoring and grievance staff may be hired in phases.

8. PMU Expansions and City Office set Up: Clear arrangements need to be made in the 4 urban CCNPP PMUs and the 10 municipalities to house the REACH field staff for IDLG. The required goods, vehicle rentals and non-consulting services all need to be procured and delivered, with adequate offices set up prior to rollout. The number of KMDP staff will increase with recruitment of short-term staff for Kabul REACH. Therefore, a separate office with adequate facilities will be rented for the project duration where all Kabul REACH field staff will be placed.

9. National Communication Campaigns: The national level communications campaign, supporting the awareness raising of the public on the REACH should be rolled out in all 14 cities and Kabul and from the center via television and radio networks, both national and local. IDLG may also take over public communications for all 34 PCCs.

10. Communication Products for the Local Level: The standardized print products (including pamphlets, brochures and posters) to be used at community level needs to be designed by the IDLG and KM and provided to the FPs in soft/ electronic copy. It will be the FP responsibility to print the products required within the communities. Other print products will remain the responsibility of the IDLG CCNPP Public Communications Unit and KMDP communication unit.

11. Training of IDLG/KMDP and FP Staff on Component 2& 3: All IDLG urban CCAP/ EZ-Kar C2 and REACH specific staff for Component 2, and all KM KMDP/ EZ-Kar C4 and REACH specific staff for Component 3, and FP field staff of both IAs need to be trained in all aspects of this Component implementation.

12. Training of IDLG REACH Staff on Focused Areas: Staff hired as field monitors, phone monitors, data entry officers and grievance officers need to be trained in their specific ToRs and expected outputs.

13. Obtaining lists from NSP/ MRRD and CFA/ UN-Habitat on actual CDC/ GA membership (including and especially contact details for the four office bearers in each CDC/GA) for the 14 cities of coverage and providing the same to the FPs per city. (At a minimum, the data needs to cover city name, community/ gozar name and ID, # of households originally included when CDC/GA was formed, list of CDC/GA members and contact details, especially phone numbers, of the office bearers).

14. An expert GIS team from the IDLG has worked with the respective Municipalities and/or the Provincial Rural Development Directorate (PRRD) and mapped out actual municipal boundaries, and approximate boundaries of the communities as covered by the National Solidarity Program (NSP) with Community Development Councils (CDCs), the communities covered by the Cities for All Program (CFA) with Gozar Assemblies (GAs), and gozars and nahias within the municipal boundaries not covered by both NSP CDCs or CFA GAs. (Note: There is a proposal to use FlowMinder to determine approximate number of households in each community as a means of triangulation of the data collected from the ground. As and when a clear decision is arrived at in this regard, it will need to be specified here.). KMDP GIS expert will closely work with KM MIS directorate and MRRD in mapping out actual municipal boundaries, and approximate boundaries of the communities as covered by the NSP with CDCs and other projects.

Demarcation between Urban and Rural Coverage Areas (only for Component 2/IDLG)

Based on the above-mentioned maps: the general agreement between the three IAs is as follows: In the 14 cities covered by IDLG under Component 2, and in Kabul city covered by KM under Component 3, all areas within the municipal boundaries will be covered by the IDLG or KM, while all areas outside these boundaries will be covered by the MRRD. The only exceptions to this rule are as follows:

a) Where an NSP-established CDC community or CFA established GA, community is partly within the municipal boundaries (with a larger portion of the households) and partly outside the

municipal boundaries (with a lesser portion of the households), such communities will be fully covered by IDLG under Component 2.

b) In the city of Parun exceptionally, all 10 communities identified (including the 9 outside the municipal boundaries but being provided services by the municipality rather than the rural provincial directorate) will be covered by the IDLG under Component 2.

(It should be noted that MRRD will cover the 19 PCCs under Component 1 fully, both within and outside municipal boundaries).

In all cases, care will be taken by all IAs to ensure that there is no duplication of households or communities in both the urban and rural coverages. Care should also be taken that no households or communities remain uncovered by both for REACH.

Demarcation of Urban REACH Community Boundaries (only for Component 2/ IDLG)

Urban REACH communities may be divided into two broad categories:

a) Communities with CDCs established under NSP and Communities with no CDCs but with GAs formed by CFA; and
b) Communities with no CDCs or GAs where ad-hoc CDCs (A-CDCs) will need to be established by IDLG, or where ad-hoc Gozar Councils (GCs) will need to be established by KM.

The work of the Facilitating Partners (FPs) will vary slightly in each of these cases as is further detailed below. However, the following sequential ordering should also be noted in this regard:

- An urban community for components 2 and 3 will comprise a minimum of 50 and a maximum of 1,500 households. It is important to emphasize that all households in the 14 Component 2 and 1 Component 3 cities will need to be included in the coverage of one of the urban communities defined under REACH with a CDC/ GA/ GC/ A-CDC.
- Where a community with an existing CDC or GA currently exceeds 1,500 households and is up to 2,000 households, such communities will be split as follows: the existing CDC/ GA will include up to 1,500 HHs, and the remaining households in close proximity will be covered by a new A-CDC.
- Where a community with an existing CDC or GA currently exceeds 2,000 households, such communities will be split into multiple communities where new A-CDCs need to be established in each. In such cases, the original CDC/ GA is considered cancelled and not applicable for REACH. (Note: This applies also to the CDC/ GA officer bearers and members, and CPM teams. New A-CDCs and CPM teams will be created for each new community created).
- Where up to 50 households exist that not covered by an established community with a CDC or GA but is close enough to be accessed from and by that CDC/ GA, these households will then be included into that CDC's/ GA's mandate for this REACH response.
- Similarly, where the number of uncovered households in a city largely covered by CDCs/ GAs is more than 50 but less than 150, the first preference would be to divide them based on accessibility/ proximity and merge them with one or more of the existing CDCs/ GAs.
- Where more than 150 households exist within a nahia that are not covered by an existing CDC or GA, they will be grouped together to form a newly established temporary community with an A-CDC.

Note: Given the whole range of variations that can arise from the above, urban REACH FPs will be contracted on the following basis:

a) The number of communities (CDCs/ GAs/ GCs/ A-CDC all together) stated in the table above will be used as baseline data.
b) A small margin of up to 10% additional communities will be included in each city into the FP contracts. However, for FPs to cover more than the numbers stated in the table above, they will

need to get written approval of the IDLG and KMDP REACH management teams in advance of coverage.

c) FP contracts will be lump sum, milestone-based payment types, such that the additional communities factored into their contracts will not be paid for unless actually covered with approvals.
d) Where FPs cover the additional communities with A-CDC formation without prior approvals, such communities will not receive REACH grants and the FPs will not be paid for the same.

Trainings of Trainers:

A structured full 2 to 3-day training plan will be prepared and implemented by the IDLG CCNPP Training Unit and KMDP technical units for the IDLG and Kabul REACH FPs and IDLG/KMDP REACH field staff. The trainings will be based on the Step-by-Step Guidelines and the Training Manual, and this Operations Manual and related forms. All field implementation, and especially the work of the field staff, will need to closely adhere to the step-to-step guidelines provided in the Training Manual.

Wherever feasible, the initial trainings will be conducted in IDLG/KMDP/ Municipality/ FP offices. Where not feasible, they may be conducted virtually through WebEx or zoom. (Note: Exceptionally, it is allowed to conduct trainings without the field/ classroom approach that CCNPP has taken; once the situation returns to 'normal' and meetings are possible, trainings will include field visits.)

The trainings will broadly be divided into 4 parts:

1. Specific Covid-19 related norms and procedures, including the proper use (and disposal) of PPE and need for social distancing at all times of the project;
2. Stressing the community driven development approach (CDD) and principles guiding the REACH urban;
3. Actual policies and procedures outlined in this chapter; and
4. REACH urban forms 1 to 10: proper documentation.

Consultation with Sub-National Government (only for Component 2/ IDLG):

Once the FP is mobilized in each city, the Provincial Operations Manager/ PMU Manager and the FP key staff will arrange meetings with the City Mayor and, wherever feasible, with Provincial Governors. The first meeting will be conducted with the Provincial Governor/ his or her representative, City Mayor/ his or her representative, 1 representative per nahia, PMU and FP key staff, and any leading city clerics.

The concept of the Covid-19 response and what it entails in urban REACH areas, especially in the given city, will be outlined by the REACH team. The roles and responsibilities expected by the Government of the Governor's and Mayor's offices will also be briefly outlined. It will be made clear that the Provincial and District Governors, Municipal Mayors and their offices do not have a role in targeting or identification of beneficiaries. They do have a mandate in public communications about REACH in their respective provinces/ districts/ municipalities, but will need to stick to the talking points provided by the REACH Communications Sub-Working Group and/or the Inter-Ministerial Task Force.

The other key REACH stakeholders in the city will be introduced. Channels of periodic reporting will be established. The estimated number of communities and beneficiary households to be covered by REACH in that city, and an early timeline of the process will also be shared. The need for their cooperation and support with regard to ensuring the cooperation of the private sector, proper security for the project personnel and beneficiary HH representatives during distribution, observation of distribution and handling of grievances addressed to them directly, will be shared with the governor and mayor.

Community Mobilization (Expected Norms to be followed):

Under REACH and given the social distancing norms, while the social mobilization process does not include community consultation and instead focuses heavily on local leaders, the basic principles of analysis, discussion/ deliberations, and actions are not suspended but remain in practice. In other words, local leaders (both male and female) need to be engaged through the process of reflection, consultation, self-realization and action to:

- Consider why social distancing, masks, and handwashing are important, develop strategies how to convey the importance to the community; and understand the special care that needs to be afforded to elderly and chronically ill persons;
- Consider the relief effort and the work it entails and how they will collectively achieve this, and what is expected of them;
- Know the basis for the identification of beneficiaries ;
- Gain awareness as to who the very poor are (women-headed households and households where men are impaired because of physical or mental disabilities, old age, or addiction);
- Gain a sense of the utmost care that must be taken during distribution so as to not spread the COVID 19 virus.

During the sessions mentioned below, SOs must refrain from lecturing and telling people what to do; and instead facilitate a process that helps people understand and internalize (and therefore act on) the processes that should be followed to prevent further spread of COVID 19, ensure that the poorest and most vulnerable are especially considered and if needed the food is brought to them, that beneficiary selection follows the guidelines, and that food is procured in a way that ensures best value for money, and that there is no leakage of food/ cash during distribution, including from the store to the household. These sessions should be conducted with people facing each other and having discussions (wearing masks and practicing social distancing). Where sessions with both male and female CDC/ GA/ GC members are not feasible, female SOs need to handle these sessions for women alone separately.

Some rules and procedures will not require the same type of community engagement training but requires knowledge transfer type of trainings that is needed for the above topics and these are:

- The monitoring systems (the community based one as well as the Government and Third-Party Monitors) and the post monitoring;
- The forms that have to be completed;
- The Grievances mechanisms in place and how it works;
- The sanctions that will be applied if there is misuse of funds or corruption.

For these, the SO can simply convey the information and use the forms to explain, and a poster to outlined Grievances mechanism and the sanctions.

CDC/GA/A-CDC/ GC Formation/ Remobilization

(a) Communities with NSP/ CFA established CDCs/ GAs (only applicable to Component 2/ IDLG)

First consultative meeting: Where the NSP or CFA database provide functional phone numbers for the CDC/GA Chairpersons and/or of other CDC/GA office bearers, the FP SO informs them of the proposed first visit in advance, requesting them to also invite all CDC/GA, the mullah imams and CPM members still residing in the community and the local mullah imams to a first consultative meeting.

Where functional phone numbers do not exist for a given community's CDC/GA, the FP SO will first visit these communities and contact the CDC/ GA office bearers listed as per the NSP/ CFA databases or CDC/ registration forms. The FP, with the support of the CDC/ GA members available, will also invite the local mullah imams, any existing NSP/ CFA CPM team members, and any youth representatives in the community to join a first consultative meeting. (It should be noted that in some cases, the first visit will be limited to just the invitations and confirming a subsequent date and time for the first consultative meeting). (FPs will also keep PMU/ city offices informed of the rollout of the program by visit date in each community. PMU/city officials may choose to send monitors to attend and observe these meetings for monitoring and reporting purposes).

Through the available CDC/GA office bearers, the FP will determine and list all the elected CDC/ GA members still resident within the community. The FP will then determine whether or not (a) there are at least 10 male and 5 female CDC/GA members still resident in the community, and (b) all of the 4 bank signatories to the CDC's/ GA's NSP/ CFA bank account are still resident in the community. Where there are less than 10 male and 5 female CDC/GA members residing in the community, the FP will consult with the existing CDC members to nominate non-family adult members from within the community that meet the following criteria to be nominated as CDC/GA members:

- Must be a citizen of the Islamic Republic of Afghanistan;
- Must be minimum of 18 years of age;
- Must have continuous residence in the given community for a minimum of 1 year immediately prior to the time of REACH rollout (with the exception of returnees/ IDPs for whom the continuous residence requirement is relaxed to a minimum of 3 months);
- Must have no known records of mental disorders and/or criminal records.
- Must have his/her primary residence in the community. (So, for a person who has 2 or more residences in different communities/ cities should then be eligible to vote in only 1 of the communities. This would require him/ her to spend a minimum of 9 months in a given year in one of those residences for it to be considered the primary residence).
- Must have no record of criminal conduct or human rights violations;
- Must have sufficient time and willingness to work voluntarily as a CDC/GA member;
- Must hold no elected office at the provincial council or national assembly;
- Must be recognized within the community as someone who has good judgement and is honest, trustworthy, transparent and accountable in his/ her dealings;
- Must be willing to work with all community members and all other CDC/GA members in that given community
- Must not be a family member of a CDC/ GA member.

Nominations will be made for the required number of members meeting the above-mentioned criteria, in addition to the CDC/GA members who remain in the community, to make the CDC/GA a minimum total of 10 male and 5 female members. The FP and the existing CDC/GA members invite the nominated members to also join the CDC/GA. For the purposes of REACH, CDCs/GAs can comprise a minimum of 15 (i.e. minimum 10 male and 5 female members) and a maximum of 20 members.

Where the existing CPM team comprises at least 5 members, this will suffice. If less than 5 members, community members not related to the CDC members will be nominated by the CDC members and elders and mullah imams, such that each community has a neutral CPM team of minimum 5 members.

Second Consultative Meeting: (Note: This may be third meeting for some). The original CDC/GA members are required to invite all the nominated CDC/GA members and any available and nominated CPM team members still residing in the community and return to a second meeting, with the date and time defined in the first meeting. (Note: In some cases, this may actually be the third meeting). Old and newly nominated members are required to bring their tazkira and functional phones to this meeting. At

this meeting, the FP SO confirms the consent of all CDC/GA members, both original ones from NSP and CFA and the newly nominated ones, in terms of willingness to serve as CDC/GA members for the REACH.

For the purposes of REACH, if any of the 4 CDC/GA office bearers (i.e. Chairperson, Vice Chairperson, Secretary and Treasurer) are no longer resident in the community; these posts will then also need to be filled by a simple vote from among the existing and newly nominated CDC members. The FP will first explain the key roles of the office bearers briefly before the elections are held. It is recommended that at least two of the four office bearer positions are limited to literate CDC/GA members only. After the whole CDC/GA is formed with a minimum of 10 male and 3 female members, and the four office bearers are present/ elected accordingly.

The FP works with the CDC/GA formed to draw a rough map of the community, now also including the additional households (up to 50 households not included in other communities). (These maps are used by the FP to also ensure that there are no duplications in HHs between neighboring communities, and also no households are left out from all the communities covered by REACH in the given city.) The community is then divided into between 10 and up to 30 approximately equal neighborhoods with a maximum size of 50 households per neighborhood (and a maximum of 1,500 households per urban community), with the emphasis being on equitable division of the households among the neighborhoods. Ideally, the variation in number of households assigned to the various neighborhoods does not exceed 5. With consultations with the CDC/ GA members, they are assigned neighborhoods, preferably but not mandatorily the ones that they reside in. Each neighborhood needs to have at least 1 male CDC/ GA member assigned. Where the number of male members exceed the number of neighborhoods, more than 1 may be assigned to the same neighborhood. To the extend feasible, FPs and CDCs/GAs will attempt to ensure equitable distribution of neighborhoods among the male CDC/GA members. As there may not be adequate female members, each may be assigned to more than 1 neighborhood.

Note: In some exceptional cases, the FP may find that it is no longer feasible to work with the existing CDC/GA given that all the office bearers have left the community, less than 5 members remain in the community, or because the wider community does not accept or recognize the existing CDC/GA anymore. In such cases, the FP will inform the PMU/ city manager of the same and this community will then be considered as one without a CDC/GA. Such decisions will be documented as email correspondence from the FP and email approval by the PMU only.

(b) Communities without NSP/ CFA established CDCs/ GAs and KM communities

First Consultative Meeting: The FP SO will visit such communities and meet with mullah imams, village elders introduced by the mullah imams, wakili gozars, nahia officials available and explain the REACH objective and the need to establish an Ad-hoc CDC (A-CDC for Component 2) or an ad-hoc Gozar Council (GC for Component 3) for the community. To the extent feasible, the FP will try to ensure that this initial consultative group includes some representation from all parts of the community. The FP will then work with this group of individuals, sharing the community boundary map prepared in advance by the IDLG/ KM GIS teams, to prepare a more detailed map of the community, marking out the mosques, schools, clinics and other public buildings (if any) and noting all the residential areas. Working with these representatives, the FP will divide the residential areas such that the entire community is divided into 10 neighborhoods, with roughly the same estimated number of households in each. The neighborhoods are identified both by name and serial number (into the Form 1), and will be marked into the community map.

Between the 1st and 2ndConsultative Meeting: The representatives will then select street representatives such that each one is assigned up to 50 neighboring households maximum. Ideally, the street

representatives will be elders, teachers, etc. that have established reputations that they would seek to maintain even in their work for REACH as volunteers. The street representatives selected need to meet the following criteria:

- Is an adult able-bodied male community member living in the same neighborhood;
- Has at least 10^{th} grade education;
- Is able to access all the households in the street(s) assigned to him.

The village elders, mullah imams and the nominated street representatives will be provided a basic introduction of what the REACH objectives are and what the roles of the A-CDC/ GC would be. They are then tasked to consult with the residents of the ten neighborhoods identified and nominate 1 male and 1 female member to the A-CDC/ GC. The nominees should meet the same criteria as outlined in the section above for CDCs/GAs. (Note: Street representatives may also be nominated as A-CDC/ GC members, in which cases they will then be referred to as CDC/ GC members, not street representatives, after the registration of the A-CDC/ GC).

The group is also informed of the CPM team functions and the need to nominate a team of 6 CPM team members, of which at least 2 must be female. The CPM nominees must meet the following criteria:

- Is not related to the CDC/ GA members (as per the family definition mentioned above)
- Is an adult able-bodied community member
- Be adequately literate to document grievances received
- Is able to access the entire community

The date and time for the next visit of the FP is confirmed with the group, and they are advised to invite the new A-CDC/ GC and CPM nominees to the next meeting. (Note: If any of the nominees refuse the offered roles of CDC or CPM membership, the representatives can nominate others from the same neighborhood(s) to take their place).

Third consultative meeting: At this meeting, the nominees for the A-CDC/ GC and the CPM for the given community are introduced by the elders to the FP. The details of the nominees in terms of Tazkira numbers, phone numbers, addresses, age, profession etc. are collected by the FP. The nominees of the A-CDC/ GC are listed by the neighborhoods they represent.

The FP then outlines the roles of the A-CDC/ GCwith regard to REACH and the specific roles of the office bearers. The SO then conducts a simple hand-raising election from among the nominated A-CDC/GC members for the 4 office bearer positions.

(Note: For the purposes of this Manual and REACH operations, the A-CDC/ GC will also be referred to simply as "CDC/ GC")

Note 1: The following sections in this Chapter refer to all types of A-CDCs, CDCs, GAs and GCs mentioned above even where not mentioned individually.

Note 2: In all forms mentioned in this Chapter and its related forms, "signatures" for CDC/GA/ GC/ CPM office bearers/ members may be substituted by thumbprints for those of them who are illiterate.

CDC/GA/ GC Registration and Bank Account Opening:

The FP then registers all details regarding the 10 neighborhoods defined for the given community, the CDC/ GA/A-CDC/ GC members and office bearers, and the CPM team members into the **REACH Form 1: CDC/GA/A-CDC/ GC Registration Form**.

Note: Where more than 10 male CDC/GA members exist, there will be more than 1 member assigned per neighborhood, but still keeping the distribution as equitable as feasible. Where the female CDC/GA members are less than 10, more than 1 neighborhood may be assigned to the same female member.

The bank signatories required for REACH Components 2 and 3 will be limited to three per CDC/GA/ GC account and will comprise of CDC/GA/ GC office bearers exclusively (i.e. not including other CDC/GA members to serve as bank signatories). The CDC/GA/ GC decides on which of the 3 office bearers will serve as bank signatories to the REACH CDC/GA/ GC account.

The FP then prepares the **REACH Form 2: CDC/A-CDC/GA/ GC Bank Account Opening Form**. The FP, along with the 3 bank signatories will visit the provincial bank account to open a new REACH CDC/GA account accordingly. (Note: The approval of the Provincial Operations Manager/ Provincial Manager needs to be secured on the form prior to the visit to the Bank.)

Training of Communities:

While REACH is recognized as an emergency relief project, its implementation will be guided by the Community Driven Development (CDD) principles. As such, bottom-up, participatory and inclusive approaches will be emphasized throughout. For trainings other than those related to procurement and accounting (which will use the knowledge transfer training modalities), the FPs will use the more participatory process-oriented capacity building model for all the trainings outlined below. All aspects of the trainings will be guided by the step-by-step guidelines and the training manual.

The FP will then conduct trainings for all of the CDC/GA/ GC members (but also highlighting significant signatory functions for the office bearers), the CPM team members, the local mullah imams and any youth volunteers involved in REACH. In keeping with the WHO guidelines, it is advisable to conduct such trainings outdoors where feasible given weather conditions. Where conducted in-doors, the FP must ensure that not more than 15 persons, including the trainers, are present at each session. Where all male CDC/GA members and male CPM members cannot be accommodated in a single session, it is mandatory to include the following: the 4 office bearers, plus 6 other male CDC/GA members representing the remaining 6 neighborhoods, such that there is at least 1 CDC/GA representative from each neighborhood trained. Joint trainings for both men and women in the same venue is recommended wherever this is feasible. Where not feasible given local traditions or security concerns or need for social distancing, the same trainings need to be provided separately by the female SOs for the female CDC/GA and CPM members.

The trainings for this group in each community will be as stated in the training manual. Broadly, the following five focus areas need to be covered in detail:

a) REACH urban objectives, and as a Government response; especially emphasizing the need to include the poor and marginalized, including and especially those recently displaced and FHHs and households with/ headed by PWDs.
b) The need to take Covid-19 prevention seriously throughout the project and beyond, how to prevent the virus spread, what to do if infected, and how to access help for others if infected
c) The policies and procedures around the relief packages, especially the beneficiary household selection norms, the procurement and accounting, and the distribution guidelines, emphasizing the need for transparency and accountability throughout.
d) The forms and other documentation required of the CDCs/GAs/ GCs as part of this project.

e) Sanction policies and grievance uptake channels.

After the trainings, the FP agrees with the CDC/GA on the timeline for collection of the household-level data and the beneficiary household list preparation. A minimum of 3 working days (smaller communities) and a maximum of 5 working days (larger communities) is allowed for the data collection.

Special focus needs to be paid during these trainings on the accurate data collection of each household. CDC members need to be informed and also need to inform all community households on the need to provide accurate details (especially but not limited to names, phone numbers and tazkira numbers), and how those details will serve as accountability measures and for monitoring purposes.

Urban REACH HH Exclusion Criteria:

The CCNPP Covid-19 response will focus on almost universal coverage of HHs, and will use limited exclusion criteria, rather than an inclusion criterion for beneficiary HH selection. While the budget preparation is based on an estimation of 93% of HHs covered, there will be no mention of this to the communities. The training for the CDC members and others in how to ensure the proper exclusion will emphasize the universal coverage of the very poor, poor, female headed and households with people with disabilities. For REACH, all FHHs will automatically be eligible for relief, regardless of socio-economic conditions. The following exclusion criteria will apply for Components 2 and 3:

- As solo-criteria (only 1 of these need to apply):
  - Employment of non-HH members as domestic staff;
  - HH having the regular use of a Government plated vehicle.
- At least two of the following criteria need to apply:
  - Ownership of a double-story concrete house;
  - One or more members of the HHs employed with the UN or NGOs;
  - Ownership of agricultural land of 5 jeribs or more;
  - Ownership of one or more vehicles not used as a cab or for goods transport as primary form of income;
  - Ownership of businesses that have continued to operate during the Covid-19 lockdowns.

While these criteria will apply uniformly for the stated households, it is recognized that there may be some exceptions that need to be documented and need to be approved exceptionally by the PMU.

It should be noted that the percentages of exclusion from different election units is likely not to be uniform. Some election units in the more affluent parts of the community may have a much larger percentage of HHs excluded, while election units in the poorer neighborhoods may have none or much lower percentages of HHs excluded. It is expected that around 10% of the HHs in the overall urban REACH coverage may be exempted by using these criteria, but the percentage will not be uniform in all neighborhoods or all communities.

Note: The expected 7% to 10% HHs exclusion rate should not be informed to the communities. But FPs and PMUs/ IDLG may use this as a general guide to mark trends in each city or by FP.

Sanctions Policy:

The sanctions policy outlined in this chapter must be carefully explained to all CDC/GA members and CDC/GA members need to acknowledged that they have been informed of and understood it (in the

REACH Form 4). In particular, CDC and GA members, and through them the community, need to be informed of the fact that the second tranche will be forfeited by the whole community if the percentage of deviations exceeds the pre-set threshold, and what counts as a "deviation". The goal of the sanctions policy is to a) identify and discourage provision of falsified information or any attempts to defraud or embezzle funds from the project, and b) inform communities of the possible sanctions that would apply in such cases.

By stating the sanctions policy upfront, it can discourage or at least make CDC/GA members and households more nervous to cheat in any way. The sanctions will be imposed on the basis of various types of deviations recorded by the project, including:

- Falsely reporting additional households, either households that don't exist, households that aren't eligible, or multiple members of the same households in order to increase the amount of support to the community;
- Any kind of collusion or preferential treatment of suppliers of in-kind relief items, with the goal of skimming or otherwise fraudulent purposes;
- Submission of any fraudulent signatures or documents;
- Manipulation of documents after they have been signed by FPs or community members, especially but not limited to the addition or removal of beneficiaries;
- Procuring more food items than needed;
- Falsely reporting the amount of "leftover" food packages that are not picked up by beneficiary households;
- Failure to inform beneficiaries that they are eligible to receive benefits.

The various types of checks that will be conducted include:

- Verification of the beneficiary household list
  a) by a random spot check basis,
  b) checked with SMS messages sent to beneficiary phone numbers to check their validity. (More than 8% missing or invalid phone numbers will require the CDC/ GA to correct the list and be re-verified before proceeding) and
  c) with the population comparison against an external benchmark where feasible (NSP/CFA/ Flow-minder).
- Verification of procurement documents: FP, PMU and/or WB TPM agent will perform additional audits on procurement documents submitted. Any documented deviation from procurement rules will result in sanctions that may extend to loss of the whole or part of the second tranche for the given community.
- Verification of distribution: this will be done by IA phone monitors and by the WB TPM to beneficiary HHs using the phone numbers listed by on Form 3. More than 10% of phone calls either not reaching the right beneficiary HH, or if any of the beneficiary HH reporting not receiving the stated package, will trigger an investigation by the PMU and then if needed by PIU. These will also be registered as grievances and will follow the GRM process outlined in the separate chapter.
- Investigations into grievances received: Any grievances received from the community that are investigated and verified find wrongdoing on the part of the CDC/GA, it will be determined on a case by case basis whether the community can be eligible for the second tranche.

The FP will inform the CDC/GA member, mullah imams, street representatives and CPM team members of the following sanctions, and require them to also communicate the same to all households during the data collection.

- If any verification undertaken by any party (not limited to FP, PMU, TPM) before the second tranche indicates that there has been an exaggeration of HH numbers in the total count of HHs and/or as beneficiary HHs for the REACH project, in the data we have provided above and in the Form 3 as the CDC/ GA, the entire community will forfeit the right to the second tranche of REACH relief grants.
- If any verification undertaken by any party (not limited to FP, PMU, TPM) prior to the second tranche indicates that there have been rich households that do meet the exclusion criteria still included as beneficiary households for the REACH, by the CDC/ GA, the community will be penalized by a reduction in the second tranche of relief grants as stated here: # of rich HH that are included as beneficiaries (X) x 2. The CDC/ GA understands that it will have to still distribute the second tranche in full to all the remaining HHs, making up for the difference spent on the rich HHs in the first tranche.
- If either of the above two discrepancies are noted after the second tranche distribution, the CDC/ GA understands and has informed the community that future development and relief funding (including future CCNPP expansions) from the government may be forfeited for the whole community.

Beneficiary HH Selection Process

The CDC/GA member assigned to each neighborhood, together with the one or more street representatives assigned for that neighborhood, will prepare a complete list of HHs in that neighborhood using **REACH Form 3: Beneficiary HH Listing/Distribution Verification**. They will also prepare simply hand drawn maps of the neighborhood, clearly labelling the neighborhood, and marking out the streets and houses within each neighborhood, with the same serial coding as will be used in Form 3, and in chronological order of their geographic location within the neighborhood. (For examples, a neighborhood listed as #5 in a given community with 20 households will have the households listed as follows: house at the farthest end of the neighborhood as HH#1, the house immediately opposite to it (if any) as HH#2, the house next to HH#1 on the same side of the road as HH#3, the house next to HH#2 on the same side of the road as HH#4 and so on).

The details collected for each HH will include the full name of the head of the household (as shown in the Tazkira), Tazkira number, sex (male/ female), phone number, house address, # of members in the HH, whether or not the HH meets any of the exclusion criteria, and if yes, which of the criteria the HH meets. The CDC/GA member/ street representative may be required to speak to the head of the household to collect such information. The Tazkira numbers and phone numbers provided for each household must be that of the same person listed as head of the household.

(Note: Where the head of the household does not have either a phone number or Tazkira, those of another adult member of the family could be used. But again, both the phone number and the Tazkira number needs to be that of the same household member. The CDC/GA member needs to also note if the phone number is registered in the name of the household head/ member, and if it actually works. HHs unwilling to provide phone numbers must be informed that this could mean that they will be excluded from consideration for the relief package. Where no adult member of a given household has a functional phone number, the phone number of an immediate adult neighbor may be provided but this must then be noted on the form. Where this is not feasible, the HH must agree that the phone number of their CDC neighborhood representative will be used instead. Every single household on the list must have a phone number associated with it. The form will be sent back if it is incomplete.

The individual neighborhood lists are then signed by the assigned CDC/ GA member and verified by the local mullah imam, and submitted to the wider CDC/ GA. The FP with the wider CDC/ GA then reviews each of the neighborhood lists and proposals for HH inclusion and makes a final decision and records their concurrence of the same with their (CDC office bearer and FP) signatures on the same form.

Verification Process:

The HH numbers/ details stated in the Form 3s for each neighborhood will be verified as follows:

a) The street representative or CDC member collecting the data will verify 100% of the phone numbers and tazkira numbers provided for each HH
b) The FP will verify around at least 3 households per neighborhood mandatorily. It is recommended that FPs cover around 30% of households in the community in this verification process, focusing more on neighborhoods with high numbers or percentages of IDPs/ returnees shown.

The verification by the FP will need to be done through actual site visits to the HHs being verified. The details of the verification process and the confirmation of the CDC/GA being informed of the sanctions policy is then recorded in the **REACH Form 4: REACH Sanctions and Verification Form**.

Where the verification process indicated errors or discrepancies, the CDC/GA has to redo the entire HH lists and beneficiary lists. Where the verification process indicates that the lists are largely accurate, the community may then move on to the disbursement request preparation. At the end of the verification process, the FP and CDC office bearers sign the form, indicating that the form contains the true information to the best of their knowledge.

Immediately after the verification, the CDC/GA is to inform all approved beneficiary HHs of their inclusion. This should be done right away to avoid any manipulation of the list after it has been approved by the relevant stakeholders. At this time a brochure or pamphlet may be provided to all identified beneficiary HHs, with information on the program, the GRM uptake numbers, and basic COVID info. Household should be encouraged not to lose or give away the pamphlet.

As an additional measure towards accountability and transparency, and in lieu of social audit, the finally approved list of beneficiary HHs must be photocopied and posted publicly in the community, in such venues as will have the most visibility.

In-Kind/ Cash Options and Conditions:

The relief package for the urban household is AFN 8,000/ household in two tranches. The first tranche can be in-kind for any community, or in cash for those communities that meet the following conditions:

- Communities with NSP CDCs or CFA GAs are permitted to consider the cash option. A-CDCs and GCs are not allowed the cash option; and
- Communities where the CDC/GA can guarantee safe transport of the cash from the provincial DAB branch to the community and distribute the same without threat of security incidents and/or loss of funds.

Note: All travel with cash is subject to some level of risks. PMUs, FPs, CDC and GA office bearers must all consult on the safety of the cash option before deciding on it. The reputational risks for the project for grants stolen or lost is huge, as also the risks to the community as a whole as future development funding could be forfeited if REACH funds are lost. As such, all mitigating measures must be considered to reduce the risks in cash transfers between the CDC/ GA bank account and the beneficiary households. This can include (but not be limited to) phased and smaller withdrawals from the Bank by the CDC/ GA.

For those communities eligible for both, the FP then works with the CDC/GA to discuss the pros and cons of both options and then decide of one of the options for the community. (Note: All beneficiary households in a given community will have the same option (cash/ in-kind) for the first tranche. The CDC/GA cannot opt for different options for different households).

The In-Kind Relief Package per household approved for this Component is outlined below. Communities are required to procure only the approved packages and at the fixed costs (in AFN) stated below.

Table 2. Contents of Relief Packages by Region

City	Item	Unit	Unit cost AFN	Quantity	Total cost AFN
Western CitiesHerat, Ferozkoh, Qala-e-Naw	Wheat flour	Kg	25.0	40.0	1,000
	Rice	Kg	76.0	25.0	1,900
	Dried beans/ lentils	Kg	90.0	6.0	540
	Oil	Liter	92.0	5.0	460
	Soap cubes	Cube	25.0	4.0	100
	Subtotal				4,000
Eastern Cities Jalalabad, Gardez, Parun	Wheat flour	Kg	34.5	20.0	690
	Rice	Kg	77.6	24.5	1,900
	Dried beans/ lentils	Kg	105.7	7.0	740
	Oil	Liter	90.0	5.0	450
	Soap cubes	Cube	18.3	12.0	220
	Subtotal				4,000
Southern Cities of Kandahar, Zarang	Wheat flour	Kg	31.8	44.0	1,400
	Rice	Kg	69.5	20.0	1,390
	Dried beans/ lentils	Kg	100.0	6	600
	Oil	Liter	92.0	5.0	460
	Soap cubes	Cube	25.0	6.0	150
	Subtotal				4,000
Northern Cities of Mazar-i-Sharif, Kunduz, Aybek	Wheat flour	Kg	33.0	50.0	1650
	Rice	Kg	85.0	10.0	850
	Dried beans/ lentils	Kg	117.0	4.0	470
	Oil	Liter	90.0	10.0	900
	Soap cubes	Cube	21.0	6.0	130
	Subtotal				4,000
Central Cities of Kabul, Charikar, Bazarak, Mahmood Raqi, Bamyan	Wheat flour	Kg	33.0	50.0	1700
	Rice	Kg	90.0	10.0	900
	Dried beans/ lentils	Kg	117.0	4.0	470
	Oil	Liter	80.0	10.0	800
	Soap cubes	Cube	21.0	6.0	130
	Subtotal				4,000

(Note: Where some of the goods are not included in some of the city packages, please state N/A (Not Applicable) in the relevant cells).

Disbursement Request:

The FP then helps the CDC/GA to fill out the **REACH Form 5: REACH Disbursement Request** for the first tranche. The Form indicates the total number of households, total number of beneficiary households, core REACH grant tranche 1 (calculated as AFN 4,000 x the # of beneficiary households), and the administrative and transportation costs, as applicable by the option selected. The Form 5 will first be approved by the CDC/ GA office bearers, and by the FP REACH City Manager.

The originals of all Forms from 1 to 5 are ideally submitted to the PMU/KMDP/ City Office within 2 working days of their completion. (Please see additional requirements for Form 3 as stated elsewhere in this Chapter). The PMU/KMDP/ City staff (i.e. Accountant/ Admin/Fin officer where relevant and PMU/ City Manager for all forms) will need to review and approve these forms as well, and then ensure that the forms are scanned and uploaded in the REACH MIS module, tagged by Community ID. A key part of the review at the city/PMU level is for completeness and accuracy of the data in the forms. Where incomplete or inaccurate, these are returned to the FP for completion/ corrections. (Note: Returns for correction/ completion must be done only once for each form and must be done within 1 working day of receipt of the same from the FP. Where feasible, the correction/ completion not needing CDC/GA signatures may be undertaken by the FP at the PMU/ city offices itself). From receiving the returned form(s), the FP then has 3 working days to submit the revised version.

Note: The Disbursement Request for the tranche #2 will be determined at a later date once the final decisions on the modality of the tranche (cash/ in-kind/ mobile money etc.) are confirmed.

Fund Disbursement and Withdrawals:

Once the scanned Forms 1 to 5 for a given community is available in the REACH MIS, the Finance/ Grants Unit will process the necessary paper work to prepare batches, secure management approvals and make the fund transfers, via the Ministry of Finance (MoF) and the Da Afghanistan Bank (DAB) to the community bank accounts. The Unit will also be responsible to inform the FPs and PMUs of the disbursement being made, via the Field Coordination Unit, with exact lists of communities for which the transfer has been made.

All stakeholders in the grant disbursement process (i.e. the IDLG PIU/KMDP Finance/ Grants Unit, the PIU Management, IDLG/KMDP leadership where signatures may be needed, MoF Budget and Treasury Units, and the DAB HQ and Provincial branches) should ensure speedy processing of the disbursement requests. Given that the REACH is undertaken as an emergency response, the time from submission of disbursement request by the FP to the PMU, and the actual receipt of funds in the CDC/GA bank accounts should not exceed 15 working days or 3 calendar weeks whichever is shorter.

Community Procurement for In-Kind Relief Packages:

This section applies only for where the in-kind relief package option is selected. The following is only a very brief summary. Please refer to the separate REACH Community Procurement and Accounting Manuals for further details:

The procurement training and actual finalization of the purchase order need to be completed in the time interval between submission of the Disbursement Request and actual receipt of funds in the CDC/GA bank accounts.

For those communities that have selected the in-kind relief package option, the FP will then train the CDC/GA on the REACH community procurement requirements. The FP will also prepare the **REACH Form 7: REACH In-Kind Relief Package Bid Quotation Form** with the pre-agreed package for the given city and the costs for the same per household already incorporated into the form. The price of the package per household is already pre-defined as AFN 4,000 as shown above. The CDC/GA takes the

Form 6 to medium to large sized grocery stores or whole sale stores in the same city, preferably even in the same nahia, and examines the possibilities of the supplier providing the stated package in the quantities required. The suppliers willing to provide the packages in the quality, quantity and prices already defined in the form are identified. The CDC/GA then negotiates with them on the transportation costs, clearly outlining the modality of distribution: # of HHs for door-to-door or # of HHs by neighborhood/ zonal distribution. The transportation costs are also included in the bid quotation form.

Where a single supplier is able to provide the required number of packages for all beneficiary households in the community, then this supplier is preferred. Where there are no such suppliers, the CDC/ GA may opt for a second supplier. It is recommended to keep the number of suppliers for all the relief packages for all the households in a given community preferably limited to two. Exceptionally where they may not be adequately large suppliers able to provide all the packages for a given community, more than two suppliers may be used, but the preferred norm is to limit to one or two suppliers only for all the in-kind packages of a given community.

The payment terms are then negotiated with the preferred supplier. The preferred payment terms for REACH are 100% of the total costs after the distribution is made. However, where this is not agreed to by the supplier, the CDC/GA can include the following payment terms in the contract: Up to 10% of the total costs as advance payments. All remaining payments will be made after satisfactory delivery, but can be tranched such that payments can be made to the supplier after full satisfactory distribution if verified per REACH defined neighborhood.

The modality of payment is also discussed and agreed with the selected supplier. The preferred option is to invite the supplier to the provincial/city DAB bank branch and pay the supplier in the bank premises immediately upon cash withdrawal by the CDC/GA. Payments to suppliers may also be made as bank transfers, directly from the CDC/GA bank account to the bank account to be provided by the supplier and stated in the contractual terms. A third option would be to pay through cheques issued by the CDC/GA to the supplier as per the payment terms. (Note: This is feasible only if the DAB provincial branches are willing to provide the CDC/GAs with cheque booklets).

After all the negotiations, when satisfactory suppliers are identified through the quotations, the CDC/GA (supported by the FP) then prepares the **REACH Form 8: REACH Purchase Order Form**, in line with selected quotations. Both the CDC/GA and the supplier need to sign the same to finalize the procurement itself.

(Note: The CDC/GA members that participate in the procurement will not be allowed to then verify the distribution from that supplier. As such, it is important to limit the number of CDC/ GA members involved in the procurement directly to 3 persons, other than the Chairperson).

Both Forms 7and 8 in signed hard copy originals, along with invoices/ receipts from the supplier need to be provided by the FP who will then provide the same to the IDLG REACH City Office/ PMU/KMDP within 3 working days of final payments to the supplier(s).

Withdrawals from the CDC/GA Bank Account:

Once the funds are received into the provincial DAB community bank accounts, the FP and the CDC/GA will determine the amount needed to be withdrawn given the following:

c) In-kind option: Agreed advance payment needed to be paid to the supplier
d) Cash option: Amount that can be distributed to the beneficiary households on the same day of withdrawal.

The actual authorization for each withdrawal by the CDC/GA from their bank accounts need to be provided first by the FP City Manager and then by the IDLG REACH City Manager/KMDP team leader, using the **REACH Form 6: CDC/GA Bank Withdrawal Authorization Form**.

It is advised that the withdrawal authorization and actual first withdrawals take place within a maximum of 3 working days of funds being made available in the CDC/ GA bank accounts. To minimize the risk of a large number of CDC/ GAs (bank signatories) going to the DAB provincial branch at the same time, the FR would support this by assigning different time slots to different CDC/ GAs in agreement with the provincial DAB branches. It is also advisable to limit the authorization and actual withdrawals for what can be distributed (for cash option) or paid to suppliers (for in kind option) on the same day. However, exceptionally, the authorizations and withdrawals can be made for the whole first tranche amount for the whole community. These exceptional cases are only considered where the time needed for each trip to the bank for withdrawals is considerable, and where the CDC/GA can ensure safe storage of the cash withdrawn.

The IDLG/KMDP Finance/ Grants Unit and the PMUs should liaison with the DAB HQ and the provincial DAB branches respectively to ensure sufficient cash liquidity in the banks for easy withdrawals by the CDC/ GA members, and for the cash distribution in larger currency notes only.

Distribution of Relief Package:

While all ground personnel and community members involved in activities under REACH need to follow the Covid-19 preventive measures, including but not limited to the social distancing norms and requirements for the use (and safe disposal) of the PPE, this is especially important during the distributions of the relief packages. FP SOs and CDC/GA members should jointly ensure that there is no crowding at any of the distribution points or for the movement of the distribution team within the community. (Please refer to the OM Chapter on Gender and ESS, and to the Training Manual, to ensure the adherence to the required protocols for social distancing and PPE use/ disposal).

The mandatory mode of distribution in urban communities for both cash and in-kind options is door-to-door for each beneficiary HHs. The only exceptions to this rule are where either or both of the following apply:

a) There are HHs/ neighborhoods in a community that cannot be accessed by vehicles or wheel barrows given the poor qualify or non-existence of road infrastructure.
b) There are heightened security concerns for door-to-door distributions for the distribution team, over and above that would be the case if it were zonal distributions.

It should be noted that even where the distribution is decided to be zonal, the actual distribution for FHHs and HHs headed by PWDs, will receive their relief packages at their door-step.

The actual distribution for the in-kind option will be handled by the suppliers themselves. The actual distribution of the cash option will be handled by the CDC/GA.

Whether cash or kind, the distribution team should include the following mandatorily for all distributions: a minimum of 1 CDC/ GA office bearer, a minimum of 1 CDC/ GA representative for the given neighborhood (other than those CDC/GA members involved in the procurement), 1 FP facilitator, and 1 mullah imam (or his designated representative from within the local mosque committee) for all distribution, and at least 1 representative of the supplier for the in-kind distribution. The entire distribution team is required to observe each delivery to each beneficiary HH for both types of distributions.

The FPs are responsible to inform the PMUs/KMDP/ City Offices in advance of the planned distribution dates for each community. The PMU/KMDP/ City Managers are responsible to inform the Mayor's office and the municipality of these dates as well. Where PMU staff, nahia/ municipal representatives would like to join the distribution for observation purposes, this is also encouraged; but the costs for these observers will not fall under the administrative costs for the CDC/ GAs.

The CDC/GA then informs the beneficiary HHs (via the CDC member assigned for each neighborhood, and using the street representatives or youth volunteers as needed) of the exact date and possible time range when the distribution is expected for door-to-door distribution, and of the venue and time assigned for each beneficiary HH for the exceptional zonal distributions. This information needs to be communicated at least 2 working days prior to the actual distribution to ensure that the heads of the households are available at the time of the distribution. Beneficiary HHs are also informed to keep the tazkira and functional phones of the head of the household ready for verification at the time of distribution. (Note: For zonal distributions, only 5 HHs heads are invited for every 30-minute slots, and only 2 persons per beneficiary HH are allowed to come to collect the packages, to prevent over-crowding.)

Prior to the actual distribution, the IDLG/KMDP PIU MIS team will coordinate with the FPs to ensure that the basic details of all beneficiary households of a given community are available in the REACH mobile app to be uploaded in the FP male social organizer's phones, as per the Form 3. The male SO will also receive training on how to use the app. The FP SO will also carry 1 original of the finalized Form 3 in hard copy. (Note: The verification process in urban areas will use both paper hard copies and mobile apps).

The actual confirmation of the distribution by the beneficiary household representative (preferably the head of household) is undertaken through the following means:

a) Signatures and thumbprints in the last 2 columns of the paper copies of the REACH Form 3 against the respective HH details; and
b) Full names, signatures and photographs on to the REACH urban mobile app on the **REACH Form 9: REACH Relief Package Receipt Confirmation: Cash** or **REACH Form 10: REACH Relief Package Receipt Confirmation: In Kind.**

In addition to the distribution verification, the FP SO will also verify the following details of each beneficiary household by comparing between what is available in the mobile app, and the actual documents/ sim cards available with the household representative:

- Full name of beneficiary household representative
- Tazkira number
- Phone number

The following additional norms are to be adhered to for the distributions: proper social distancing facilities, proper use of PPE, the provision of hand-sanitizers for all door-to-door distribution, the provision of disinfectant hand sprays for all neighborhood distributions.

The signatory confirming the receipt of the package is preferably the head of the household listed in the Form 3/ 9/ 10. Where the head of household is absent, for door to door distributions, another adult member of the HH may sign in his/her stead, but this must be mentioned in the form. For zonal distributions, only the stated head of the household is allowed to sign for the receipt of the relief package.

For either type of distribution, any HHs that was unable to collect their package at the given time will be allowed to collect the same on the same or the next working day from the local mosque in the presence of the full distribution committee. Such collections can only be undertaken by the head of the household as listed in the Form 3.

Where any HH does not collect the package (within the time frame mentioned above) or any HHs designated beneficiary has since left the community prior to the distribution, the cash is returned by the CDC/GA to their bank account (for cash distributions). Where in-kind, such packages should be returned to the supplier and refunds collected and documented by the CDC/GA. Where suppliers do not accept returns and/or refunds, the extra in-kind packages may be exceptionally distributed (in addition to their mandated package) exclusively to female headed households without adult able-bodied male members. Such distributions of extra packages need to be approved by the FP and PMU prior to distributions, and needs to be documented and reported to the PMU.

After the distribution for each tranche is completed for the entire beneficiary HHs in a given community, the CDC/ GA office bearers sign the REACH Forms 9 and 10. As stated earlier, a minimum of 1 FP facilitator must be present for all distributions. He/ she will be the first point of verification outside the CDC/ GA members/ office bearers. Where mullah imams, nahia or municipal officials or PMU staff were also present for the distribution, they will also add their signatures as additional levels of confirmation for the distributions.

The signed hard copy original distribution confirmation forms need to be submitted by the FPs to the PMUs within 2 working days from completion of the distribution in each community.

Documentation requirements

The IDLG 4 PMUs and 10 City Offices and KMDP office will maintain hard copy folders, one per community in REACH. Urban REACH Forms 1 to 8 need to be provided in hard copy, signed originals by the FP to the PMU/KMDP/ City office in the timelines mentioned above. The PMU/ City office staff are responsible to file the originals in chronological order of forms for each community per folder. Given that these documents contain personal information that should be kept confidential and secure, the data security protocols for the same will be outlined to the city managers of the 14 PCCs by the MIS Unit.

Urban REACH Form 3 will need to be prepared in 3 hard copy originals. 1 is retained by the CDC/GA (and is to be used only for sharing information to community HHs or monitors/ TPM), 1 is submitted by the FP to the PMU/KMDP at the time of the first disbursement request, and 1 is retained by the FP for use at the time of distribution verification (last 2 columns). (Note: Only the original retained by the FP is to be used at the time of the distribution). The Urban REACH Form 3 original retained by the FP also needs to be submitted to the PMU after the distribution verification columns are filled in.

Urban REACH Forms 9 and 10 only exist in soft form in the mobile apps.

For in-kind procurements, in addition to the Forms 1 to 8, FPs also need to submit the original copies of the invoices/ receipts of payments to the suppliers, and bank statements for each community.

After completion of both tranches of distribution, the hard copy original files of the 10 cities with only temporary IDLG/KMDP REACH offices will need to be brought and archived at the IDLG PIU HQ and KMDP office. The hard copy original REACH folders in the 4 cities with urban CCNPP PMUs will be archived in those PMU offices itself.

Note: The exact document requirements for the second tranche is as yet unclear but is expected to be limited to the following: Disbursement request for tranche 2, and a print out of the Form 3 household data with columns for signature of beneficiary household representative, for verification of distributions in cash (not mobile transfers).

Data entry requirements

All data in the urban REACH Forms 1 to 8 need to be entered into the Urban REACH MIS Module. (The IA MIS Units will prepare a separate set of guidelines for all staff dealing with REACH data, which will include requirements to ensure data security, especially of the HH data being collected). However, the following special data entry needs need to be noted:

- Every household needs to be linked by a clear ID number that then indicates the province, city, nahia, community and neighborhood it belongs to, and should match the data in Form 3. For example: Household ID: 01-01-01-01-01-01 would indicate that the community belongs to Province 1, City 1, Nahia 1, Community 1, Neighborhood 1, and is the first house listed in that neighborhood.
- In order to be able to use the mobile app efficiently at the time of distribution verification, the following fields of data entry need to be completed in the 3 weeks from submission of the disbursement request to the time of actual cash availability in the CDC/GA bank accounts: Household ID, Full Name of HH Head/ Member, Phone Number, Tazkira Number (all linked to the same individual).
- All data entry for each community needs to be completed for the first tranche prior to the approval of disbursements for the second tranche.
- It is expected that the data entry requirements for the second tranche will be completed within one month of completion of the second tranche distributions in each community.

CHAPTER FOUR: MONITORING AND EVALUATION

Given the nature of the project, REACH incorporates various types of monitoring into its design. This chapter summarizes the key monitoring framework for the Project and briefly outlines possible evaluations as well. The **Project Development Objective (PDO)** of the REACH is to provide emergency support to selected households through communities in project areas during the COVID-19 outbreak. The primary responsible for the REACH monitoring management and reporting will be the following:

(a) Component 1 – MRRD rural CCAP/ REACH General Directorate (GD), M&E & MIS Divisions
(b) Component 2 – IDLG urban CCAP/ REACH Project Implementation Unit (PIU), M&E & MIS Units
(c) Component 3 – KM KMDP PIU, M&E/MIS Unit

Results Framework:

The following table summarizes the REACH Results Framework (RF), with indicators distinguished at the PDO level and intermediary level.

Indicator Name	Baseline	End Target
PDO Level Indicators		
MRRD: Households receiving in-kind support in rural or peri-urban areas (Number)	0	1,760,000
Of which female-headed (Number)	0	200,000
IDLG: Households receiving in-kind or cash support in provincial capital cities (Number)	0	363,000
Of which female-headed (Number)	0	36,000
KM: Number of households receiving in-kind or cash support in Kabul (Number)	0	500,000
Of which female-headed (Number)	0	50,000
Intermediary Level Indicators		
Field staff/ Social Organizers trained in COVID-19-compliant and gender-sensitive distribution of transfers to households (Number)	0	2,000
Percentage of field staff that are female	0	25%
Number of communities that receive support within 6 months of project effectiveness	0	14,000
Beneficiaries satisfied with support received (Percentage)	0	80%
Grievances Addressed (Percentage)	0	70%
Households reached through the Government's COVID-19 relief communications campaign (Number)	0	2,800,000

The targets stated for the PDO level are distinguished by the the coverage of each Implementing Agency (IA) and by the REACH Components 1, 2 and 3. The Intermediary indicators focus on the Component 4. Two of the indicators (percentage of grievances addressed and beneficiaries satisfied with the support received) is uniform across the three implementing agencies. The targets for the two remaining intermediary indicators are divided between the 3 IAs/ Components as follows:

Indicators	MRRD/ Comp 1	IDLG/ Comp 2	KM/ Comp 3	Total
Field staff trained in Covid-19 compliant and gender sensitive distribution of transfers to households	1,200	400	400	2,000
Communities that receive support within 180 days from effectiveness	12,000	1,200	800	14,000

Key Stakeholders for Monitoring REACH:

The following stakeholders will be key in monitoring of the REACH project as various levels as will be further outlined later in this chapter:

CDCs/ GAs: The CDCs/ GAs will serve in a mixed role of both primary implementer and also monitoring agent for the REACH. While individual CDC/GA representatives will be collecting the household data and proposing which households should be beneficiaries, the final approval of the beneficiary household lists for each community rests with the wider CDC/ GA. CDCs and GAs should especially monitor that there is no exaggeration in the household lists, no inclusion of rich households in the beneficiary lists, and especially, no exclusion of poor households from these beneficiary lists. For in-kind distribution, CDCs/GAs will need to monitor the quality and quantities of the packages provided by the supplier, against what was contracted. For all types of distribution, cash or in-kind, by neighborhood or door-to-door, at least one CDC/GA office bearer and one CDC/GA member needs to be present to monitor the distribution itself.

CPM Teams: Community Participatory Monitoring (CPM) teams will be registered in each community covered under the REACH project. They will be trained by the FPs and the IA field monitors to monitor the work of the CDC/GA and the FP field staff for this project. Distribution to each household needs to be monitored by at least 1 CPM member.

Mullah Imans/ Community Youth/ Vulnerable Group Sub-Committees: Wherever available and present, it is recommended that mullah imams of local mosques and/or his representatives, youth and vulnerable group sub-committee members monitor the selection of beneficiary HHs and the distribution of the relief packages to ensure the inclusion of the marginalized groups, especially IDPs, returnees, Kuchis, FHH, households headed by PWDs etc.

FP: The FP social organizer also plays a dual role for REACH, both as facilitator and as monitor. The FP oversees the work on the CDC/GA in all REACH processes. At least 1 FP staff member is required to be physically present and monitor distributions to 100% of the beneficiary HHs.

IA Field Monitors: The 3 IAs will also monitor the REACH directly through its field monitors on a sample basis of 10 % of communities.A total of 34newly hired MRRD field monitors will monitor real-time on the ground for Component 1,42IDLG monitors for Component 2, and 66 KM monitors for Component 3.

IA Phone Monitors: The 3 IAs will also include phone monitors, placed within their HQ offices that will conduct post-distribution monitoring surveys. It is estimated that approximately 35 phone monitors will be hired in total and they will contact approximately 1,600 respondents (beneficiaries and CPM members) per day.

ARTF TPM/ SA: A sample of approximately 25% of communities and gozars will be monitored for REACH by the ARTF Third Party Monitors/ Supervisory Agents (TPM/SA) as well. The TPM will also conduct random phone surveys of beneficiaries.

Others: All 3 IAs core management staff will monitor small samples of the distribution in all provinces covered.

Nahia officials, municipality representatives, and district/ provincial governors' office representatives may also monitor the REACH in randomly selected small samples of communities. However, the norms for monitoring the project will need to be against the policies and procedures of this Operations Manual, and the related training manuals. No officials may impose changes in any part of the policies, processes and procedures outlined in this Manual, without a formal revision of the OM and with prior approval of the World Bank.

Different Types of Monitoring in REACH

CPM: The CPM teams will be trained in the Monitoring Form 2 (see Annex). Any issues observed will be reported to the CDC/GA, FP or IA staff as appropriate, immediately upon observation. Remedial actions for issues raised by the CPM needs to be taken on the ground immediately, and no later than two working days of the issue being raised.

Field Monitoring: The IA field monitors (mentioned above) will use the Monitoring Form 2 (see Annex) to review the whole REACH processes on the ground. The Form includes beneficiary HH selection, procurement and accounting for in-kind packages, quality and quantities of in-kind packages, distributions of all types of relief packages, behavior and conduct of key stakeholders in the field, etc. It includes both direct observation by the Field Monitors and interviews with community representatives on the ground. The completed Monitoring Form 2s should be submitted to the PMUs/ PMU-equivalents in each provincial center for each IA concerned, within 2 working days of completing the monitoring. The monitoring forms will be scanned and shared with the IA PIU/ GD HQ offices electronically. Data entry for the same will be limited to essential data only, and will be linked to the wider REACH MIS database by the unique community or household identifier number.

Phone Monitoring: The IA phone monitors (mentioned above) will use the Monitoring Form 3 (beneficiary households) and Monitoring Form 4 (CPM members) (see Annex) to call around _@48__ beneficiary households and CPM members per monitor per work day. The survey checks on the veracity of the relief package distributions and the satisfaction of the beneficiary households represented by the phone respondents. The responses provided will be entered into the REACH MIS monitoring module during the call itself for the most part. A large part of the survey can be covered in optional responses and so a drop-down menu of response options for most queries will help with the data entry.

ARTF TPM: This monitoring will include (a) focused sampling on household numbers proposed as beneficiaries or excluded from beneficiary lists; (b) the actual distribution monitoring in real time on a small sample basis; and (c) post-distribution small sample surveys by phone calls and/or site visits. Reports will be shared with the IAs through online deviation trackers, that help IAs address problematic issues quicker. Combined analyzed monitoring reports will be shared with the World Bank and the IAs on a monthly and quarterly basis.

Management Information System (MIS)

The MRRD rural CCAP/REACH General Directorate MIS Division will prepare the MIS module for rural REACH/ Component 1. The IDLG urban CCAP/ REACH Project Implementation Unit MIS Unit will prepare the MIS module for the urban REACH/ Component 2, and will support the KM in preparation of the MIS module for the urban REACH/ Component 3. The MIS modules for all three components are expected to be fully functionalby late September 2020.

The MIS modules for all three components will include space for storage of the following scanned documents: (a) REACH Forms 1 to 10, (b) invoices/ receipts for in-kind package procurements, and (c) bank statements.

The MIS module for Component 1 will also include space for data entry for all beneficiary households, grant disbursements, and relief package distributions. The MIS modules for Component 2 and 3 will include links to a mobile app created specifically for REACH. These modules will include features for automatic uploading of basic key identifier data of beneficiary households from the MIS into the smart phone apps created for REACH, and also uptake of data from these mobile apps used during distribution into the MIS. Given the requirement to use the smart phone app for confirmation of the distribution of relief packages in Components 2 and 3, it is also agreed that the basic key identifier indicators for all beneficiary households need to be entered into the MIS within a maximum of four weeks from the date of

receipt of the approved, scanned beneficiary household lists in the MIS modules of these Components. The basic key identifier data that will need to be uploaded includes the following:

a) At community level: Community ID, neighborhood ID
b) At household level: Full name, age, sex, Tazkiranumber (where applicable) and phone number of the head of the household, or any able-bodied adult member of the household as stated in the beneficiary household list.

The time line for complete REACH data entry for all required fields into the database/ MIS module for component 1 is 6 months from the completion of the first tranche distribution. The timeline for complete REACH data entry for all required fields into the database/ MIS modules for Components 2 and 3 is three months after the completion of the first tranche and one month after the completion of the second tranche.

All 3 MIS modules will also include a dashboard, linked to real-time MIS data availability, of all key output indicators that can be reviewed by the management at any time. At a minimum, the dashboard needs to include the following data for each IA: Province/ # of CDCs or GAs covered/ total # of HHs listed/ total # of beneficiary HHs listed/ distribution divided into # of HHs receiving cash/ in-kind and tranche #, # of FHHs received benefits, # of grievances received and addressed

Monitoring Reporting Requirements for REACH:

The MIS and M&E Divisions/ Units of each of the IAs will be required to produce the following reports for the entire duration of the REACH project:

a) Weekly quantitative reports of agreed key output indicators
b) Monthly quantitative reports of agreed key output indicators including RF indicators
c) Quarterly reports combining qualitative monitoring findings/ lessons-learned, and quantitative output progress

Exceptional: Mobile Money Transfer Monitoring:

A pilot relief package distribution through mobile money via mobile money operators (MMOs) for select households is proposed for Components 2 and 3. The proposal currently is that beneficiary households where an able bodied adult male member of the household (preferably head, but not mandatorily so) has a sim card registered in his own name and has a tazkira(where applicable) in the same name as the sim card registration, could receive the second tranche of the relief package through mobile money transfers.

The monitoring modalities will only be clear as and when the MMOs are contracted and services clearly described. In the interim, it is expected that CDC/GA members, CPM members and FP staff will be unable to monitor such mobile money transfers or their liquidation on the ground as different beneficiary households may opt to go to different outlets at different dates and times.

As such, where such mobile money transfers occur, it is proposed that the field monitors and the ARTF TPM conducts the sample monitoring at various MMO agent outlets in the selected cities for the pilot. It should be noted that the forms currently designed does not cover the mobile money transfers.

Evaluation/ Studies:

The current design of REACH does not include any evaluations or studies. However, questions/ concerns that could be further or better explored through qualitative studies or post-distribution evaluations:

a) Intra-household distribution of the relief packages or their benefits, especially on households including non-FHHs with widows;
b) Potential for or actual re-sale of in-kind relief packages in the local markets by beneficiary HHs/ CDCs or GAs;

c) Impact of the large volume of food purchased under REACH on the local markets and on the national economy on the short-term;
d) Analysis between the various modalities used: preferences for in-kind or cash relief packages and the rationale for the same; and distribution by neighborhood or door-to-door, and their implications for the project per se and for the beneficiary HHs.

CHAPTER FIVE: GENDER, ENVIRONMENTAL AND SOCIAL RISK MANAGEMENT

Introduction:

Gender: Past pandemics and disease outbreaks have shown that female-headed households are at a greater risk for increased poverty and nutrition/ food insecurity than male-headed households. Similarly, situations of national or local economic crises, war, conflict etc. also have more adverse effects on women. FHHs are already more vulnerable and suffer disproportionately from price increases and loss of income. ALCS (2016-17) reports that people in FHHs experience moderate to severe hunger more than twice as much as others. It is also recognized that in such times, the prevalence of gender-based violence (GBV) rises. In Afghanistan especially, women are far less likely to participate in the labor force, and when they do, it's largely in the informal sector. This also means that they are often left out of social protection measures targeted to workers in the formal sector. As such, this Chapter outlines the agreed measures needed in REACH to ensure the inclusion of FHHs as beneficiaries, and the protection of women from GBV that could arise from the Project itself.

Environmental and SocialRisks (ESS): The REACH design and implementation modalities are considered to include any significant environmental safeguard but does include some social safeguard and health risks, including GBV related risks. The emergency nature of the Project, the national coverage in a relatively short time frame, and the significantly high percentages of the population proposed to be covered by the Project during the Covid-19 outbreak, all poses considerable social and health risks that need to be managed. Given that the REACH Operations Manual is an effectiveness condition, this chapter is being prepared ahead of the Project effectiveness date and in line with the Environmental and Social Commitment Plan (ESCP). However, as and when the Environmental and Social Management Framework (ESMF) and its related forms are prepared, these will be included as part of the OM.

Gender-related Indicators:

To ensure the of inclusion of women, REACH has specified the need for gender-disaggregated data for the beneficiary household heads as follows:

- # female headed households identified for assistance
- # female headed households received in-kind support
- # women from the community participated COVID-19 orientation
- # women from the community received COVID-19 orientation
- # field staff/facilitators trained in COVID-19-compliant and gender-sensitive distribution of transfers to FHHS
- % of field staff who are female
- # of women provided with support within 6 months of project effectiveness
- % of grievances received from women through any channel of the GRM

a) All three of the PDO level indicators covering the number of beneficiary households in rural and peri-urban areas covered by MRRD, and urban areas covered by IDLG and KM for REACH, have been split such that the number of female-headed households (FHHs) among the beneficiary households needs to also be reported. The target set for FHH beneficiaries is around 10% of the total number of households receiving the relief packages and amounts to 285,000 FHHs. The breakdown of the targets defined are as follows:
   - for Component 1 (rural and peri-urban REACH): 200,000 FHHs
   - for Component 2 (urban REACH): 36,000 FHHs
   - for Component 3 (Kabul city REACH): 49,000 FHHs

b) For the purposes of REACH, FHHs are defined as households headed by women, widowed or otherwise, with or without children, and irrespective of the ages of children if any. These may also include households headed by people with disabilities (PWDs), without adult able-bodied male

children; where the wife serves as the de-facto head. This further includes HHs with women in a polygamous marriage while living in a separate HH from their husband.

c) The Results Framework (RF) also includes an intermediary indicator on number of field staff trained in Covid-19 compliant and gender-sensitive distribution (as outlined in earlier chapters where FHHs would be provided relief packages at their homes or have assistance in transportation of kind packages, separate queues etc.) of the relief packages to the beneficiary households. The overall target for the same is 2,000 staff. The breakdown of the targets proposed are as follows:
   - for Component 1 (rural and peri urban REACH): 1,200 staff trained
   - for Component 2 (urban REACH): 400 staff trained
   - for Component 3 (Kabul city REACH): 400 staff trained

All indicators mentioned will need to be monitored and reported on regularly and gaps addressed by the relevant IA(s).

Measures to Enhance Inclusion of Women:

1. **Field Social Organizers/ Social Organizers:** While the REACH design requires a larger number of male staff, given the need to identify all beneficiary households, and in the case of urban REACH, manage door-to-door distribution, the Project acknowledges that reaching FHHs in particular would also require female staff at the ground level. Wherever feasible, it is recommended to have equal ratios of male and female field staff. At a minimum, one-fourth (or 25%) of all field facilitators or social organizers deployed by the IAs and/or FPs will need to be female. Female field staff will receive all the same trainings as their male counterparts, with special focus on inclusion of FHHs.

2. **Trainings:** IAs will need to ensure that all field staff, both male and female, will be trained in participatory process promoting the inclusion of women and other marginalized groups, especially the poor and very poor, in REACH. Basic introductory trainings also need to be provided on identifying GBV related to the Project, on the reporting and grievance-redressal mechanisms for the same.

3. **Focused Communication Strategies:** While both national and local communication channels are being employed for REACH, it is important to ensure that all key messaging also reaches FHHs and households with PWDs. Radio and TV messaging needs to ensure the selection of networks that have the widest coverage in each province, with special focus on remote rural districts. Wherever feasible, key messages must also be relayed through Masjid loudspeakers in each coverage community. In rural villages, this could be through Masjid loudspeakers (each Mullah generally has a small Masjid) and /or with youth doing transect walks with key messaging passed on through hand-carried loudspeakers, such that FHHs could also hear them from their homes. In urban areas, it is proposed that the key messaging on REACH is passed on through the Masjid loudspeakers, mid-way between regular prayer time slots, such that they attract the most attention of the listeners. Female facilitators/ social organizers should also attempt to distribute pamphlets with key messages in pictorial form to the identified FHHs prior to the relief-package distributions. (Please see the relevant Communications chapter for more details).

4. **Beneficiary HH Identification Exceptions**: While all male-headed households will be required to mandatorily provide Tazkira numbers and phone numbers of the heads of households, it is understood that many FHHs may not have one of these, and in exceptional cases, both of these. First, in FHHs, it is acceptable to use Tazkira numbers or phone numbers of other members of such households. Second, in such rare cases where none of the household members have either functional phone sim cards or Tazkira, the CDC representative for that given neighborhood can stand-in as guarantee for them.

5. **Relief Package Distribution Exceptions:** For all FHHs and other households without able-bodied adult male members, the distribution of the relief packages, whether cash or in-kind, is proposed to be

at their doorstep. The responsibility for the distribution will remain with the CDC/ GA/ A-CDC/ GC in all areas but in urban areas, the actual transportation of the goods could be contracted out to the suppliers. The CDC/ GA and FP involved needs to especially monitor their conduct with regard to FHHs. Such suppliers/ vendors need to be sensitized in advance by the FP/ CDC/ GA on the expected code of conduct (outlined below) for the REACH. In the exceptional cases where doorstep delivery for FHHs may not be feasible and, distribution of the relief packages is done by neighborhood, the following exceptions will apply:

- Dates, times and venues for the distribution will factor in the safety of women;
- The FHHs and households headed by PWDs will be assigned a separate queue and/or a separate time-slot for the collection;
- Such households, without able-bodied adult males, may be represented for the collection by an authorized relative or neighbor but without any fees or commissions for the same; and
- For in-kind distributions other than door-to-door, youth volunteers will be tasked to transport back the relief packages from the distribution site to the doorsteps of such households and ensure a proper handover.

6. **Monitors:** The IAs will ensure that the staff employed as phone monitors for the post distribution phone surveys will include a minimum of 50% or higher female staff where feasible. Similarly, for the ground-level monitoring, the IAs will ensure that there will be a minimum of 40% female staff, where applicable.

7. **Grievance Handling:** The hotline planned as the primary grievance uptake channel for each IA for REACH will include female grievance officers, especially trained in GBV related grievances. (Note: There are other grievance uptake channels as well as discussed in a separate chapter in this Manual).

ESS Policy Framework:

The three IAs will be required to implement material measures and actions so that the Project is implemented in accordance with the Environmental and Social Standards (**ESSs**) of the Environmental and Social Management Framework (**ESMF**). The IAs will also comply with the provision of the Environmental and Social Management Framework (ESMF) to be prepared within 30 days of Effectiveness Date, and the timelines specified in it. The proposed project ESMF will also include necessary guidance to effectively manage any foreseeable pollution risks as well as it will spell out the preparation of necessary pollution prevention and management tools as specified under ESS3.

Implementation of the material measures and actions stated here will be monitored and reported to the Bank by the IAs, and the Bank will monitor and assess the implementation progress and completion throughout the Project.

The ESCP may be revised from time to time during Project implementation, to reflect adaptive management of Project changes and unforeseen circumstances or in response to assessment of Project performance conducted under the ESCP itself. In such circumstances, the IAs will agree to the changes with the Bank and will update the ESCP to reflect such changes. Agreement on changes to the ESCP will be documented through the exchange of letters signed between the Bank and the Government. The IAs will promptly re-disclose the updated ESCP.

Where Project changes, unforeseen circumstances, or Project performance result in changes to the risks and impacts during Project implementation, the Government shall provide, after a thorough assessment, additional funds, if needed, to implement actions and measures to address such risks and impacts.

Key ESS Requirements of the IAs:

1. **ESMF:** Prepare, adopt, disclose and implement an Environmental and Social Management Framework (ESMF). Assess the environmental and social risks and impacts of proposed Project activities, including to ensure that individuals or groups who, because of their particular circumstances, may be disadvantaged or vulnerable, have access to the development benefits resulting from the Project, this would include women, people with disabilities and those who need to self-isolate due to the coronavirus. The ESMF needs to be prepared within 30 days of the Effectiveness.

2. **ESMP:** Prepare, disclose, adopt, and implement any Environmental and Social Management Plans (ESMPs), Infection Control and Medical Waste Management Plans (ICWMPs) or other instruments required for the Project activities based on the assessment process.

3. **ESS Reports:** Prepare and submit to the Bank regular monitoring reports on the environmental, social, health and safety (ESHS) performance of the Project, including but not limited to the status of preparation and implementation of E&S documents required under the ESCP, stakeholder engagement activities, and the operation of the Project's grievance mechanisms. The reports need to be submitted on quarterly basis.

4. **Stakeholder Engagement Plan (SEP):** The IAs will update, adopt, disclose, and implement a Stakeholder Engagement Plan (SEP) acceptable to the Bank within 30 days of effectiveness

5. **Grievance Handling:** The IAs will ensure that accessible grievance mechanisms as defined in the SEP shall be established and made publicly available to receive and facilitate resolution of concerns and grievances in relation to the Project, in a manner acceptable to the Bank.

6. **Incident and Accident Reporting:** Regularly monitor and promptly notify the Bank of any incident or accident related to the Project operations which has, or is likely to have, a significant adverse effect on the environment, health, that affected communities, the workers or any other party, including security related issues or any sort of harassment. Provide sufficient details regarding the incident or accident, indicating immediate measures taken or that are planned to be taken to address it, and any information provided by any agency and or supervising entity, as appropriate. Subsequently, as per the Bank's request, prepare a report on the incident or accident and propose any measures to prevent its recurrence. The initial report is required promptly but no later than 48 hours after noticing of incident or accident

7. **Staffing:** While all 3 IAs will use existing staff. PIUs for the REACH oversight and implementation, the IAs will assess the need for additional personnel not later than 30 days after the Effective Date; and if necessary, hire staff as soon as practically possible but within 60 days of project effectiveness. The IAs will also finance essential goods for efficient and safe benefit delivery, such as smartphones and personal protective equipment for staff from the Project funds.

8. **Incorporating ESS Requirements into Contracts:** Incorporate the relevant aspects of the ESMF into the specifications of the procurement documents and contracts with FPs, supplier associations, and supervising firms. Thereafter ensure that the contractors and supervising firms comply with the specifications, including but not limited to the use and disposal of Personal Protective Equipment (PPE). The requirements of the ESMF should form part of any future contracts.

9. **Trainings Required:** The IAs will ensure that the following trainings are incorporated into the REACH training package for all personnel and FP personnel involved on the ground:
   - Training topics as per the WHO Guidelines on Safe Management of Wastes from Health-Care Activities (including proper use and disposal of PPE)
   - Training on World Bank interim guidelines on Health and Safety in projects
   - ILO Standards for COVID-19

- ESF training (on relevant E&S Standards)
- Stakeholder mapping and engagement
- Emergency preparedness and response
- GRM Manual and handling procedures.
- GBV training (WSH, SEA, GBV action plan)

10. **Excluded Activities:** The IAs will ensure that the following activities will not be financed by REACH funds and that these exclusions shall be applied as part of the assessment process conducted: Activities that may
    - Cause long term, permanent and/or irreversible (e.g. loss of major natural habitat) adverse impacts on the environment
    - Have high probability of causing serious adverse effects to human health and/or the environment related exposure to COVID-19 infection
    - Have significant adverse social impacts and may give rise to significant social conflict(such as, but not limited to exclusion of any marginalized/ vulnerable groups, selection of beneficiaries by
    - Adversely Affect lands or rights of minorities
    - Involve permanent resettlement or land acquisition or adverse impacts on cultural heritage.

11. **Labor Management:** The IAs will ensure that a proper labor management plan is in place for the Project, implementing adequate occupational health and safety measures (including emergency preparedness and response measures), setting out grievance arrangements for Project workers. Particular attention will need to be paid to the security and safety of workers delivering food packages and cash transfers particularly in the REACH rural areas. Measures should include adequate PPE and relevant security measures for staff. The labor management plan should be completed not later than 30 days after the Effective Date.

12. **Code of Conduct:** Some Project activities may give rise to the risk of Gender-Based Violence (GBV), in particular, Sexual Exploitation and Abuse (SEA) and Sexual Harassment (SH) risks. As mitigation measures, the IAs will:
    - Require all staff of the IAs and the FPs working directly with the communities for REACH to sign a Code of Conduct (CoC) regarding GBV and SEA and general conduct with project beneficiaries and communities. The code of conduct should be sensitized prior to the carrying out of any project activity.

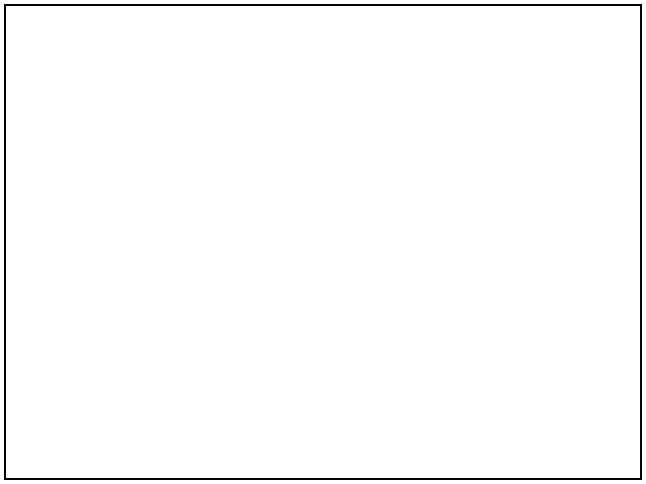
13. **Use of Security Personnel**: This Project does not foresee using security personnel. However, on an exceptional basis and if security personnel are required, the Government will need to ensure that those who provide security services act in a proper, professional manner with all stakeholders. The Government will also ensure that the World Bank team is informed of such use of security personnel. This means the IAs will not: sanction any use of force in providing security except when used for preventive and defensive purposes in proportionto the nature and extent of the threat including and especially the beneficiary households. At a minimum, the IAs need to:
    - Identify the structure under which the military will be operating for the Project itself and document (as far as possible) the same, including the chain of command, with specific reference to the activities they will or are likely to carry out;
    - Clarify who is responsible for human rights issues nationally;
    - Establish a procedure to be followed in cases of allegations of HR/SEA/SH violations or misbehavior:
    - Sign a MoU with the military with provisions that set out the ‘ground rules’ for military engagement, including: (i) A clear list of activities for the security personnel, (ii) requirements for them to comply with ESMF; (ii) reporting obligations (specify on what, how often, to whom); (iii) specific prohibitions e.g. no child labor, no forced labor, restrictions on what military

personnel under the age of 18 can do (if anything); (iv) health and safety requirements; (v) Code of Conduct (CoC) type obligations; (vi) requirements for the GRM; (vii) Specific trainings required, when and how often.

CHAPTER SIX: PUBLIC COMMUNICATIONS

Introduction:

The Government has chosen the name 'Dasterkhwan-e Meli' as the name of the REACH project, a phrase that implies "dining table cloth" literally. The approved logo for the Project is shown below and will form a key part of the Project's branding.



As emphasized throughout this Manual, the REACH is a highly visible project. It proposes to cover over 90% of all households in its coverage areas. As such, it is probably the single largest emergency relief response project in Afghanistan, and given its emergency nature, needs to be rolled out in a relatively short time frame. Expectations have already been raised with the announcement of the project by H.E. the President. As such, it is vital to ensure that all stakeholders, including and especially the potential beneficiary households, are all sufficiently informed of the Project and what it entails. All communication products and messages will need to emphasize the phased rollouts in different regions so as to manage expectations and prevent grievances of delays.

Results Framework (RF) Indicator:

The REACH RF includes a specific indicator to measure the success of the REACH communications campaigns. The indicator reads: Households reached through the Government's COVID-19 relief communications campaign, and has a target of 2.8 million households.

All IAs will separately track and report on the progress against this indicator in their quarterly reports.

Objectives:

The objectives of the public communications and media outreach under REACH will include:

- Informing the public, via the media, of REACH as the Government's response to the food insecurity exaggerated in the country given the Covid-19 breakout;
- Informing beneficiary households on what to expect as the relief package and the projected timelines for the actual distribution;
- Informing all stakeholders of the grievance redressal mechanisms, including and especially gender, environmental and social safeguards embedded in the project, and how to access the GRM;

- Sharing information with the communities covered on Covid-19 prevention measures, and the need and means to report on local infections; and
- Informing all stakeholders of the actual progress of the project implementation itself.

Key Reference Documents:

A draft REACH Stakeholder Engagement Plan (SEP) is in place for the REACH. This will need to be revised and adopted by the project within one month of the effectiveness date. The revised SEP will also be supported by a detailed communications work plan that will be prepared reflecting all requirements and agreements under the SEP. It should be emphasized that, while REACH is implemented as an emergency relief project, it will stay true to the Community Driven Development (CDD) approaches used in its parent programs. As such, its communications plans will be participatory, using inclusive learning approaches at the community level.

All messaging and channeling of public communications for REACH will also be gender sensitive and contextualized, especially also catering to traditional communities with high percentages of illiteracy and limited mobility for women.

Different Levels of the Public Communications:

National Level: At the national level, the Inter-Ministerial Task Force, chaired by the First Vice President's office, will be responsible. At this level, the public communications will cover national-level key messages and project updates. It is expected that this level of communication will primarily rely on press-conferences via national level TV and radio channels, TV and radio PSAs, wall painting, social media channels and billboards along key highway routes.

MoF: Similar to the role it plays in CCAP, the MoF (while not an IA) will serve in a coordinating role between the 3 REACH IAs, for a variety of functions, including and especially for public communications activities. It will also serve as the focal point between the IAs and the Office of the First Vice President for all communications issues related to REACH.

Each of the IAs: The public communication teams in each of the 3 IAs have formed a technical-level communication working group. This working group will ensure that each of the IAs plan, budget, design and broadcast the key messages at each IA level. Standardized products, including but not limited to, print products (banners, posters, pamphlets), audio-visual products for TV and radio, website and social media outlets will be used at this level.

Community Level: The FP staff will be provided with standard posters and pamphlets for awareness raising on all core aspects of REACH, including grievance uptake channels, at the communities they cover. Here, mosque and mobile loudspeakers will also be used to enhance the coverage of key messaging for female-headed households and for people with disabilities. Local TVs and radios are the other channels which will be used at community level. Messages through masjid loudspeakers can cover all key aspects about the program, including and especially the exclusion of the food secure households, what the package will entail, modality for distribution, grievance uptake channels etc.

Key Messages:

The following will form the key messages at the national level:

- Dasterkhwan-e Meli is nation-wide Government Program that supports food-insecure households with relief packages that value AFN 4,000 during the COVID 19 crisis in both Rural and Urban communities.

- Dasterkhwan-e Meli program will be implemented by Community Development Councils (CDCs) or Gozar Assemblies (GAs) and facilitated by Government-contracted NGOs serving as Facilitating Partners, and is supervised by MRRD, IDLG, and KM in their respective coverage areas.
- Dasterkhwan-e Meli will follow social distancing measures and will have a special focus to ensure that vulnerable households headed by women, persons over 55, and disabled persons will receive the relief packages. In most cases, the packages will be delivered to their homes.
- In order to prevent and mitigate misuse and corruption and to ensure transparency, Dasterkhwan-e Meli will be monitored by Central and Local Government, Media, Donors, Community Participatory Monitoring Teams, Mullah Imams, Teacher, Volunteers, Community Monitors, Youth Networks, Civil Society & Social Media Activists.
- There are specific grievances mechanism and channels at the urban and rural levels where people can register their complaints and the program shall redress and resolve it promptly. The actual uptake channels will be widely communicated to the public in general and to all communities covered by REACH. Dedicated hotlines with female staff will be available for grievances related to Gender Based Violence.

The following will form the key messages at the local level:

- Dasterkhwan-e Meli will be implemented through CDCs with the support of local leaders, such as Imams/ Mullahs, teachers, volunteers, community monitors, youth and their participation will be crucial to assist CDCs in community profiling and distribution.
- The relief packages are to be provided to households that are currently food insecure. Households that are currently food secure will be excluded.
- Households headed by women, the elderly (over 55 years), chronically ill, and those with COVID 19, will receive their relief packages in their homes and will not be asked to come to public distribution events.
- To ensure effective beneficiary selection and distribution and no misuse of funds or any form of corruption (including false household counts in communities), there will be monitoring by various actors: a) from the communities: Community Participatory Monitoring Teams, Imam/Mullahs b) from the Government: provincial monitoring officers; c) donors: contracted monitors; e) NGOs: monitoring staff; f) civil society and media: journalists and civil society activists.
- Infected persons with Covid-19, with or without the obvious symptoms (fever, dry cough, sore throat and/ or shortness of breath)) and people above 55 years, as well as weak and chronically ill persons, are advised to avoid participating the meetings & distribution events. Such persons may be substituted at these events by other healthy adult members of their households, or may inform the CDC/ GA/ GC/ A-CDC responsible of the need to be provided the relief package at home, through some contactless (with such persons) delivery process.
- Communities in which funds are misused in any form will have to repay the funds and/ or will be excluded from future government development programs.
- Peoples' complaints about any aspect of the program can be made through various uptake channels as will be listed in the community posters.

Key Communication Channels:

- Print: brochures, pamphlets, banners;
- TV: national and provincial level channels with news clips and B-rolls;
- Radio: national and provincial spots on prime channels with most local coverage;
- Media: news articles, press releases;
- Website and social media platforms: including Facebook, Twitter, Instagram;
- Traditional channels: wall murals/ paintings by youth, loudspeakers at mosques and transect walks.