



**PROGRAM CONTRIBUTION AGREEMENT**

Between the United States of America, acting through the United States Agency for International Development (“USAID”) and World Health Organization (WHO) (“Recipient”)

1. **Activity Title:** Gender Based Violence (GBV)

2. **USAID Activity Number:** AID-306-IO-15-00005

3. **Purpose:** USAID and the Recipient hereby agree to strengthen the capacity of the Gender Directorate at the Ministry of Public Health (MoPH) to deliver a multi-sectoral response to GBV, specifically in regard to prevention, response and management of GBV cases through the implementation of a GBV treatment protocol. The implementation of the GBV Treatment Protocol has the following key purposes:

- a. Improve the quality of care offered to GBV survivors.
  - 1) Strengthen the capacity and skills of healthcare providers on the GBV Treatment Protocol.
  - 2) Strengthen health systems, e.g. institutional policies, referral mechanisms and availability of equipment, to enable the provision of quality GBV care.
- b. Increase access and uptake of services by survivors of GBV.
- c. Integrate the GBV Treatment Protocol in various health and multi-sectoral GBV capacity strengthening packages and efforts.

4. **USAID Grant:** Pursuant to its authorities under the Foreign Assistance Act of 1961, USAID hereby grants to the Recipient an initial obligation of USD \$1,700,000 to be expended as described in this Agreement. The total expected value of the USAID contribution is USD \$4,919,380. The total value of the GBV Project to be implemented is USD \$6,025,584. The purpose of the Agreement is met upon disbursement by USAID to the Recipient.

5. **Period of the Agreement:** June 25, 2015 to June 24, 2020

6. **Grant Agreement:** This Agreement consists of (a) this Title Page, (b) Annex 1, the Program Work Description, (c) and Annex 2, Indicative Budget for the Activity.

7. **Disbursement.** Within 30 days of the last signature to this agreement, USAID will disburse the Program Contribution to the Recipient in U.S. Dollars by electronic funds transfer to the following site:

<p>██████████</p> <p>██████</p> <p>██████████</p> <p>██████████████</p> <p>██████</p>	<p>██</p> <p>██████████████████████████████████████</p> <p>██████████████████████████████████</p> <p>██████████████████████████████</p> <p>██████████████████████████████████████</p>
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Currency: USD

## 8. Reports and Financial Management

- a. Recipient will submit a final report within 60 days after award completion with the following information:
  - (1) Basic identifying information, such as program name, award number, approval date;
  - (2) The total cost of the program funded by USAID, actual or estimated counterpart contributions, and the best available estimate of other host country or partner resources that contributed to results achievement;
  - (3) Lessons learned from the program so that they can be applied to other USAID programs;
  - (4) A summary of performance indicators used and an assessment of their relative usefulness for performance management and reporting;
- b. The Recipient agrees to furnish USAID with an annual financial statement, certified by the Chief Finance (Head of Accounting), concerning the outputs of the account supported by this Agreement. These annual statements, which will cover the period of October 1 through September 30 of each year, will be provided by December 31 for each year covered by this contribution.
- c. The Recipient confirms that this award will be administered according to the Financial Regulations of the Recipient. The expenditure will be recorded in the accounts of the Recipient, which follow generally accepted accounting principles and will be subject to audit in accordance with the Recipient's standard audit procedures.
- d. The Recipient shall submit an annual performance report, which will cover the period of October 1 through September 30 of each year, to the Agreement Officer's Representative (AOR) at USAID/Afghanistan which will be due October 31 of each year. The performance report shall contain the following information:
  - The report shall describe the plan for the reporting period
  - Accomplishment during the reporting period (including outputs/outcomes achieved).

## 9. Information and Marking

The Recipient will give appropriate publicity to the Agreement as a program to which the United States contributes.

## 10. Termination and Other Remedies

- a. Either party may terminate this Agreement in its entirety by giving the other party 90 days written notice. In addition, USAID may terminate this Agreement in whole or in part, upon giving the Recipient written notice, if the Recipient substantially fails to comply with any provision of this Agreement, after efforts have been made by both parties to resolve the



issues.

- b. In the event of termination by USAID or in the event of termination by either party in the event of force majeure circumstances, the termination will not apply to funds irrevocably committed in good faith by the Recipient, including those entered into with third parties, before the termination date indicated in the notice of termination, provided that the commitments were made in accordance with this Agreement. Any portion of this Agreement which is not terminated will remain in full force and effect. If, however, the Recipient considers that the reduced funding makes the continuation of the Activity, or any part of the Activity, impracticable, the Recipient may terminate the Agreement in whole or in part.
- c. USAID, notwithstanding the availability or exercise of any other remedies under this Agreement, may require the Recipient to refund an amount of the Grant calculated proportionately by the actual contribution of USAID rather than the total contributions of all donors. If the provided, unspent balances attributed to USAID, as of the estimated completion date, is two percent or less of the amount contributed under this Agreement by USAID, then the Recipient may apply these balances to the continuation and close-out of the program of work beyond this date. The Recipient agrees to report to USAID within two years on how the balances were used for the purposes of this Agreement. In all cases, the Recipient must contact the USAID financial management representative listed below within 90 days of the estimated completion date, in the event of the availability of unspent and uncommitted funds.

## 11. Other Provisions

- a. Consistent with numerous United Nations Security Council resolutions, including [S/RES/1269 \(1999\)](#), [S/RES/1368 \(2001\)](#), and [S/RES/1373 \(2001\)](#), both USAID and the Recipient are firmly committed to the international fight against terrorism, and in particular, against the financing of terrorism. It is the policy of USAID to seek to ensure that none of its funds are used, directly or indirectly, to provide support to individuals or entities associated with terrorism. In accordance with this policy, the Recipient undertakes to use reasonable efforts to ensure that none of the USAID funds provided under this Agreement are used to provide support to individuals or entities associated with terrorism.

## 12. USAID Mailing Addresses:

USAID's technical representative for this Agreement is:

Rabia Akhtar  
U.S. Embassy Compound  
Great Massood Road  
Kabul, Afghanistan  
E-mail: [RAkhtar@state.gov](mailto:RAkhtar@state.gov)

USAID's alternate technical representative for this Agreement is:



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Charles Lewis  
U.S. Embassy Compound  
Great Massood Road  
Kabul, Afghanistan  
E-mail: [CLewis@state.gov](mailto:CLewis@state.gov)

USAID’s financial management representative for this Agreement is:  
The Controller  
U.S. Embassy Compound  
Great Massood Road  
Kabul, Afghanistan  
E-mail: [kabulaidevouchers@usaid.gov](mailto:kabulaidevouchers@usaid.gov)

### 13. Recipient Mailing Address:

WHO Afghanistan  
[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

The Recipient’s technical representative for this Agreement is:

[Redacted]  
[Redacted]  
[Redacted]

The Recipient’s financial management representative for this Agreement is:

[Redacted]  
[Redacted]  
[Redacted]

### 14. For the Recipient

Signature: \_\_\_\_\_

Name: Dr. Richard Peeperkorn  
Title: WHO Representative, Afghanistan  
Date: \_\_\_\_\_

### 15. For USAID

Signature: \_\_\_\_\_

Name: Craig Smith  
Title: Agreement Officer  
Date: \_\_\_\_\_

Annex 1 – Program Work Description  
Annex 2 – Indicative Budget



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## USAID PROGRAM CONTRIBUTION FISCAL DATA

1. BBFY: 2011
2. EBFY: 2012
3. Fund: ES
4. OP: AFGHANISTA
5. Prog Area: A08
6. Dist Code: 306-M
7. Prog Elem: A035
8. Team/Div: AFG/STAB
9. BGA: 306
10. SOC: 4100202
11. FOB: Destination
12. GLAAS Requisition No: REQ-306-15-000072

1. Amount Obligated for this Action: \$1,700,000.00
2. Total Obligated Amount: \$1,700,000.00
3. Total Estimated Amount: \$4,919,380.00
4. Activity Title: Gender Based Violence (GBV)
5. Agreement Officer's Representative (AOR):
  - i. Rabia Akhtar
  - ii. U.S Embassy Compound
  - iii. Great Massood Road
  - iv. Kabul, Afghanistan
  - v. E-mail: [RAkhtar@state.gov](mailto:RAkhtar@state.gov)

6. DUNS No.: 480997543
7. LOC Number: N/A
8. Paying Office:

Office of Financial Management  
USAID/Afghanistan  
6180 Kabul Place  
Dulles, VA 20189-6180



## **Annex 1 – Program Work Description**

### ACRONYMS

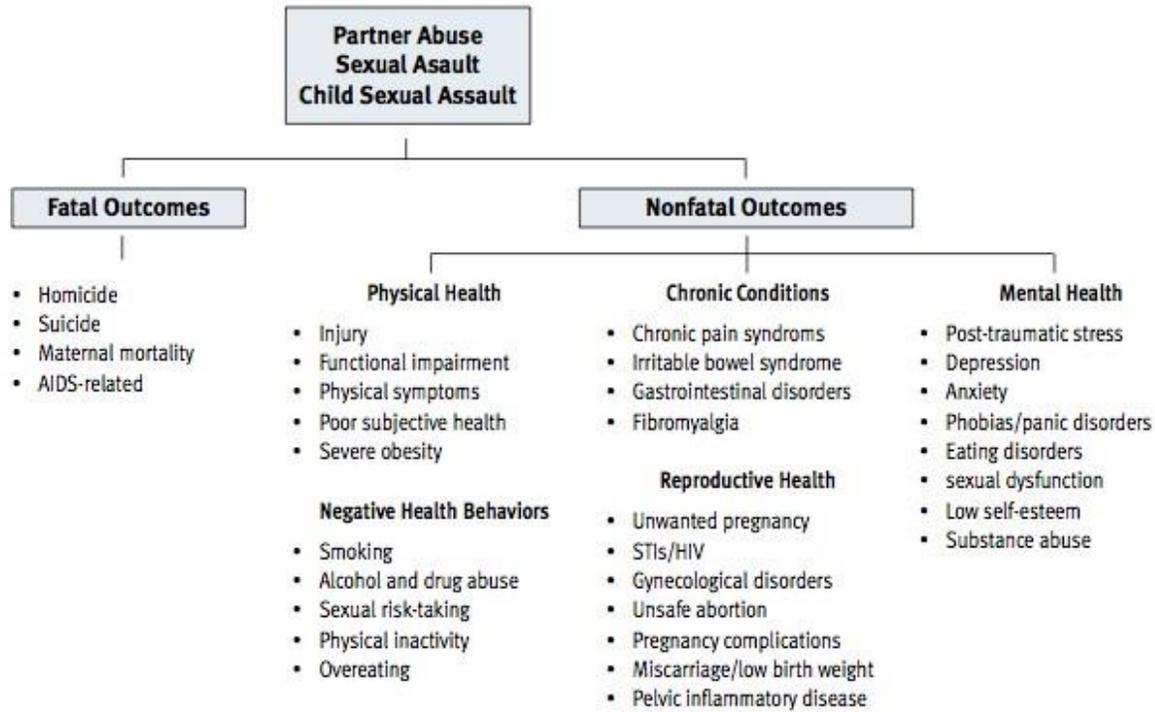
BHC	Basic health center
BPHS	Basic package of health services
CHC	Comprehensive healthcare center
DH	District hospital
EPHS	Essential package of hospital services
EVAW	Law on the Elimination of Violence against Women
GBV	Gender-based violence
HBV	Hepatitis B-virus
HIV	Human immuno-deficiency virus
MoPH	Ministry of Public Health
MoWA	Ministry of Women’s Affairs
OHCHR	Office of the United Nations High Commissioner for Human Rights
PEP	Post-exposure prophylaxis
PH	Provincial hospital
RH	Regional hospital
STI	Sexually transmitted infection
UNAMA	United Nations Assistance Mission in Afghanistan
UNFPA	United Nations Fund for Population Assistance
VAW	Violence against women
WHO	World Health Organization

### **1. Background**

Violence against women is one of the most pervasive yet among least recognized human rights violations in the world. It also constitutes a profound health problem, compromising women’s physical health, sapping their energy, and eroding their self-esteem and psychological wellbeing. In addition to causing injury, violence increases women’s long-term risk of a number of other health problems, including chronic pain, physical disability, drug and alcohol abuse and depression. Women with a history of physical or sexual abuse are also at increased risk for unintended pregnancy, sexually transmitted infections (STIs), and adverse pregnancy outcomes.



## Consequences of GBV on Health<sup>1</sup>:



Gender-based violence (GBV), particularly violence against women (VAW), is widespread in Afghanistan and impacts all segments of Afghan society. Gender-based violence may take on different forms, including physical, mental and sexual abuse as well as traditional harmful practices and is often condoned by and founded on deeply-entrenched principles that dictate a subservient status for women at the societal level.

A 2010 UNAMA report<sup>2</sup> identifies the following practices as examples of gender-based violence: forced marriage, child marriage, exchange marriage (Baadal), giving away girls to settle disputes (baad), honor killings, restriction on women’s freedom of movement and denying the right to education, work and access to health services. A desperate response adopted by many of those subjected to harmful traditional practices is the act of self-immolation (burning oneself). Many women victims of gender-based violence also run away from home, often resulting in re-victimization through a subsequent criminal charge of attempted adultery or adultery for which women risk imprisonment.

<sup>1</sup> Center for Health and Gender Equity (CHANGE) as published in Heise L, Ellsberg M, Gottemoeller M (1999) Ending Violence Against Women. Population Reports, Volume XXVII, Number 4, Series L, Number 11

<sup>2</sup> UNAMA and OHCHR (2010) “Harmful Traditional Practices and Implementation of the Law on Elimination of Violence against Women in Afghanistan”



Not enough country-wide research has been carried out on GBV in Afghanistan and a lot of the data is outdated. According to a 2008 Global Rights report<sup>3</sup> on domestic abuse, 87 percent of the women interviewed reported experiencing at least one form of domestic violence while 62 percent experienced multiple forms of violence. Seventeen percent reported sexual violence, 11 percent experienced rape and 52 percent were victims of physical violence. Moreover, 59 percent of survey respondents were forced to marry and 74 percent were victims of psychological violence. While women are most likely to experience gender-based violence in Afghanistan, men, and particularly adolescent boys, also experience gender-based violence through the traditional practice of sexual exploitation of adolescent males.

According to the 2013 annual report of the United Nations Assistance Mission in Afghanistan (UNAMA) and the United Nations High Commissioner for Human Rights, an estimated total of 1,669 incidents of violence against women were registered with Department of Women's Affairs, police and prosecutors in the 16 concerned provinces<sup>4</sup>. The report also highlighted that of those 1,669 registered incidents of violence against women, only 109 cases (seven percent) were processed by the formal justice system through the implementation of the Law on the Elimination of Violence against Women (EVAW law). The crime of battery and laceration was the most prevalent form of violence against women among the registered cases documented in the said period.

The AIHRC reports that 4154 cases of violence against women were registered by 1179 complainants at several AIHRC offices during the first six months of 2013. The majority of cases 1249 cases (30 percent) were related to physical violence, 976 cases (24 percent) were related to verbal and psychological violence, 862 cases (21 percent) were forms of economic violence, 262 cases (6 percent) were related to various forms of sexual violence and 805 cases (19 percent) were forms of other types of violence against women.

## 2. Introduction

The Gender-based Violence Treatment Protocol was developed as a commitment under a Memorandum of Understanding signed in January 2013 by UN Women, WHO and UNFPA, in order to support the Afghan Ministry of Public Health (MoPH) Gender Department's priority to strengthen capacity for the delivery of a multi-sectorial response to GBV, particularly with regard to the prevention, response and management of GBV cases. The GBV Treatment Protocol was developed based on the global *WHO Clinical and Policy Guidelines on responding to intimate partner violence and sexual violence against women*, launched in June 2013. The GBV Protocol for Afghanistan is the first of its kind to be adapted to a country context.

The 67<sup>th</sup> World Health Assembly in May 2014 passed a resolution on violence against women, urging member states to strengthen the role of their health systems in addressing GBV to ensure that all people at risk and/or affected by violence have timely, effective, and affordable access to health services, including health promotion, curative, rehabilitation and support services. Strengthening

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<sup>3</sup> Global Rights (2008) "National Report on Domestic Abuse in Afghanistan"



health sector response towards GBV is among WHO's top priorities.

## Assessments on Health Sector Response to GBV

In 2012 UNFPA conducted an assessment of services provided to GBV survivors by state and non-state agencies in three provinces<sup>6</sup>. The assessment found that most service providers did not have units responsible for addressing the needs of GBV survivors. Most healthcare providers lacked necessary policies, standard operating procedures and ethical safety guidelines, and staff lacked specialized knowledge and skills to respond to GBV survivors' needs. Especially the lack of female staff had a negative effect on GBV response of public agencies (health-care, police and prosecutor). The assessment also found that healthcare facilities in rural and urban areas were often the only chance for GBV victims to seek assistance, although the ability of the facilities to respond was seriously undermined by the vulnerability of staff to pressure from family members and local communities. In all locations healthcare facilities, Ministry of Women's Affairs (MoWA) offices and Afghanistan Independent Human Rights Commission (AIHRC) offices served as entry points for GBV survivors, while police departments served as entry points in some locations. The assessment also showed weak communication and coordination between the agencies, resulting in various problems in the referral system.

In mid-2013, a Knowledge, Attitudes and Practices (KAP) study relating to health personnel working in GBV case management was carried out by UN Women in six provinces for the purpose of acquiring a better understanding of healthcare provider capacity to identify, treat, document and refer GBV survivors. The study helped to identify existing gaps in health facilities and determine an appropriate level of support required to ensure a qualitative and appropriate management of GBV cases by the health sector. According to the results of the study, an average of 22 GBV survivors had visited the health facility during the month prior to investigation (77 percent were victims of physical violence, 83 percent of emotional violence and 29 percent of sexual violence). Half of the healthcare personnel interviewed were well-informed about the health consequences of GBV. Slightly more than half of the respondents claimed to have queried their patients on the possibility of being a victim of GBV, but highlighted that several barriers to a proper consultation existed, including time limitations, lack of space in the clinic to ensure privacy, little or no service facility for GBV victims in the facility, greater emphasis on other health issues, fear of police proceedings, lack of training to handle such issues, and a lack of referral facility in the province for GBV victims.

Although most respondents in the KAP study felt that it is appropriate for healthcare providers to make queries of their patients regarding GBV, half of them expressed a view that they are uncomfortable when exploring such issues and the majority believed that women are themselves to blame for GBV. Further, the majority of respondents stated that they were capable of identifying GBV survivors. Approximately 20 percent admitted to having offered no care to GBV survivors. The majority stated a need for capacity building on GBV issues, indicators of GBV, GBV interview techniques, as well as clinical examination and the provision of services to victims. Approximately 30 percent of respondents also mentioned that visual privacy was not available at their health facility and a majority reported an absence of protocols and files to record and manage cases.

The results of the KAP study showed that there is an urgent need to include GBV into health sector



policies, develop guidelines to handle GBV cases and strengthen the capacity of health professionals on managing GBV cases. There results also pointed to a need to strengthen coordination and linkages with other non-health service providers, properly equip and organize health facilities and addressing cultural and social barriers to GBV. Health professionals can do much to help survivors of gender-based violence. Yet providers often miss opportunities to help by being unaware, indifferent or judgmental. The KAP assessment found that there is critical need to improve the knowledge level of health professionals, including doctors, nurses and midwives, to identify, assess and refer the GBV cases.

## Project Overview

## Objectives

The implementation of the GBV Treatment Protocol has the following key objectives:

### Objective 1:

#### **Improve the quality of care offered to GBV survivors**

- A) Strengthen the capacity and skills of healthcare providers on the GBV Treatment Protocol
- B) Strengthen health systems, e.g. institutional policies, referral mechanisms and availability of equipment, to enable the provision of quality GBV care

### Objective 2:

#### **Increase access and uptake of services by survivors of GBV**

### Objective 3:

#### **Integrate the GBV Treatment Protocol in various health and multi-sectoral GBV capacity strengthening packages and efforts**

## Expected Results

The GBV treatment protocol aims to achieve eight key results during the project's five years of implementation:

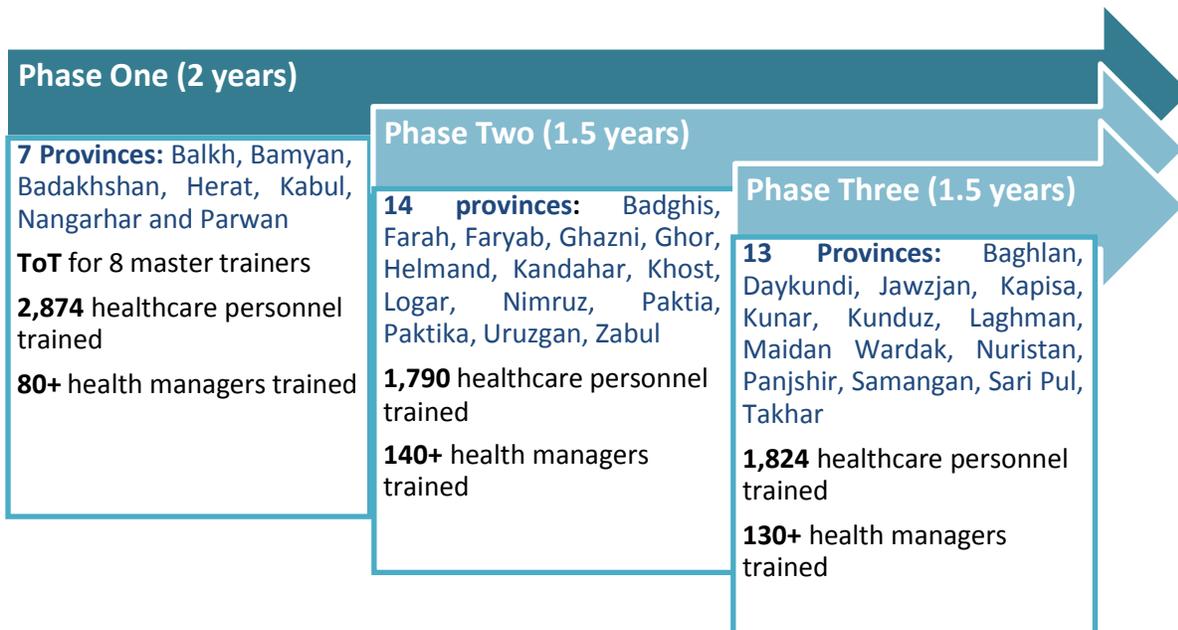


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- 1 •Care for GBV-survivors is **integrated** into the different levels of MoPH-system
- 2 •Trainers are **competent to train** on care for GBV-survivors
- 3 •Health facilities are **organized and equipped** to offer care to GBV-survivors
- 4 •Health-care providers are **skilled to offer care** to GBV-survivors
- 5 •**Facility policies** are in place to support provision of GBV care
- 6 •Providers are **supported, supervised and mentored** in providing GBV care and services
- 7 •**Monitoring and evaluation** system is functioning
- 8 •**Referral linkages** within the health services and with other services are strengthened

The GBV treatment protocol will be implemented in three phases. In Phase One seven provinces (Balkh, Bamyán, Badakhshan, Herat, Kabul, Nangarhar and Parwan) will be covered. Phase Two will begin after the evaluation of Phase One has been completed. At the end of the five-year project around 6,488 healthcare providers, including nurses, doctors and midwives as well as at least 350 health facility managers (10 per province, 20 from Kabul), will have been trained on the GBV Treatment Protocol.





### 3. Project Implementation

#### Overview of GBV Treatment Protocol Content

The GBV Treatment Protocol is a comprehensive handbook for health practitioners including detailed guidelines and step-by-step practical advice on how to administer quality care for GBV survivors.

The Protocol covers the following key areas:

#	Chapter	Description
1	<b>General Considerations for the Care of GBV Survivors</b>	Priorities, legal procedures, rights of the survivor, reporting, legal requirements with regards to forensic evidence, the setting of health clinics, organization of patient-flow, confidentiality, safety, rape treatment kits, documentation and reporting
2	<b>Survivor-centred Care</b>	Proper attitude, effective listening, gender-sensitive communication, supporting personal autonomy
3	<b>Primary Survey</b>	The first assessment carried out to identify life-threatening injuries such as airway obstruction, chest injuries with breathing difficulties, severe external or internal haemorrhage and abdominal injuries
4	<b>Identification</b>	Recognizing physical, psychological and behavioural signs, symptoms and clinical conditions associated with GBV for women, men and children
5	<b>First-Line Support</b>	Offering to all patients disclosing any form of GBV a minimum level of support and validation of the experience: being supportive, listening carefully but not pressuring, provide access to information and resources, safety planning
6	<b>History Taking</b>	Guidelines for taking medical history, interview, describing the incident, consent forms, history taking with children
7	<b>Medico-legal Evidence</b>	Referrals to forensic examinations, completing medico-legal certificates, documenting cases, describing injuries
8	<b>Physical and Genital Examination</b>	Determining the type of medical care to be provided to the survivor, physical examination for physical violence and rape
9	<b>Management of Wounds</b>	Controlling the bleeding, wound assessment, cleansing, wound closure, anaesthesia, antibiotics, follow-up care
10	<b>Management of Burns</b>	Types of burns, burn depth, extent of burns, burn management
11	<b>Management of Rape</b>	Clinical management of rape, HIV post-exposure prophylaxis (HIV PEP), prevention and treatment of sexually



		transmitted infections, prevention of pregnancy, Hepatitis B and tetanus prophylaxis
12	<b>Care for the Healthcare Provider</b>	Stress management techniques for healthcare providers

**Health Facility Readiness Assessment**

Before beginning capacity building and health system strengthening on GBV, a health facility readiness assessment will be carried out to gather information on the existing capacities and anticipated challenges of healthcare facilities to strengthen response to GBV. The information gathered will help determine what is needed to support and ensure health providers appropriately identify, treat, document and refer GBV cases. The assessment will first be carried out in the seven Phase One provinces to determine which provinces/districts/facilities are most ready to begin implementing the Protocol, and hence where beginning of implementation is most appropriate.

Five domains are included in the assessment to identify health sector readiness to scale up/strengthen primary response to GBV:

1. Existing practices
2. Challenges/barriers
3. Knowledge and attitudes
4. Institutional framework
5. Infrastructural readiness

The assessment will measure the level of willingness of health managers and providers to address GBV, the extent to which confidentiality, safety, operational facilities are in place and the extent to which referral linkages exist.

A WHO rapid assessment tool for this purpose already exists and has been piloted in Iraq – WHO will adapt the tool to the Afghan context and contract a third party company to carry out the assessment prior to implementation. The assessment will enable WHO and MoPH to begin implementation in areas and facilities that are likely to be more ready to implement the Protocol, enabling the project to build on successes instead of beginning in areas and facilities that are facing the biggest challenges in terms of implementation. Due to safety and security considerations, **it is necessary to ensure that services are not provided unless a minimum level of requirements is met** (such as existing basic equipment and medicine, systems of privacy and confidentiality).

At each level of the health system (basic and comprehensive health centers, district hospitals, provincial hospitals), it will be decided which package of services can be feasibly provided, and training will be tailored accordingly. For instance, all levels of services need to have a basic



awareness of GBV health consequences, GBV definitions and terms, provision of first-line support, stabilizing emergency cases, basic wound management, and when and how to inquire about GBV. However, at the provincial/district hospital level, modules on e.g. gathering medico-legal evidence, and complex management of wounds and burns are more relevant.

## **Criteria for Prioritizing Provinces in Phases**

A KAP study among healthcare providers has been conducted by UN Women in Balkh, Bamyan, Badakhshan, Herat, Nangarhar and Parwan, enabling analysis of changes in knowledge, attitudes and practices of healthcare providers after two years of the project when the KAP study is repeated. Other criteria that impacted the selection of provinces included security and access, existing health infrastructure (including female staff), and availability of partners already working in the provinces. The results of the health facility readiness assessment will help to further prioritize provinces in each phase.

## **Incorporating the GBV Treatment Protocol into Medical, Nursing and Midwifery School Curriculum**

Medical students, including doctors, nurses and midwives, will also be trained on GBV care. MoPH and WHO will work closely with the Ministry of Higher Education's curriculum committee to envision strategies for curriculum revision during Phase One of the programme. To ensure sustainability and continued effectiveness of the programme, WHO will work together with MoPH to include care for GBV survivors into the curriculum of medical, midwifery as well as nursing students across the country and ensure on-the-job mentoring of students takes place. Protocol materials will be further developed and adapted to ensure they are appropriate for higher education learning.

## **Sensitizing the Police and Other Multi-sectoral Stakeholders**

Sensitization sessions with the police and other stakeholders (e.g. Departments of Women's Affairs, Afghanistan Independent Human Rights Commission (AIHRC)) will be held on the links between health and GBV. WHO and MoPH will develop a half-day orientation module on the GBV Treatment Protocol, focusing on other sectors' respective obligations and roles. This module will be included in any on-going training for these sectors and also, where possible, WHO will bring in e.g. police and AIHRC staff to attend half-day sessions of the five-day workshops provided for healthcare providers.

## **Developing and Distributing Supportive IEC Materials**

WHO and MoPH will develop information, education and communication (IEC) materials such as brochures, posters and flyers, to be distributed in health facilities as well as general IEC materials (including radio and TV spots) targeting communities. The IEC materials will highlight GBV as a health problem and the links between GBV and health, focusing e.g. on the signs and symptoms for which healthcare is needed, the importance of seeking timely healthcare, and information on where help is available. This activity particularly supports Objective 2 on increasing access and uptake of services by survivors of GBV.



## Summary of Training Provided in Each Province<sup>7</sup>

No.	Province	Staff Trained	No.	Province	Staff Trained
1	Badakhshan	284	18	Kunar	152
2	Badghis	85	19	Kunduz	223
3	Baghlan	202	20	Laghman	135
4	Balkh	216	21	Logar	104
5	Bamyan	207	22	Maidan Wardak	153
6	Daykundi	132	23	Nangarhar	434
7	Farah	96	24	Nimruz	52
8	Faryab	183	25	Nuristan	60
9	Ghazni	251	26	Paktia	145
10	Ghor	143	27	Paktika	90
11	Helmand	141	28	Panjshir	53
12	Herat	386	29	Parwan	204
13	Jawzjan	158	30	Samangan	96
14	Kabul	1143	31	Sari Pul	131
15	Kandahar	244	32	Takhar	214
16	Kapisa	115	33	Uruzgan	86
17	Khost	96	34	Zabul	74
<b>TOTAL STAFF TRAINED: 6,488</b>					

## PHASE ONE

During the two years of Phase One of the implementation of the GBV Treatment Protocol, eight master trainers will be trained to cover trainings in seven provinces: Balkh, Bamyan, Badakhshan, Herat, Kabul, Nangarhar and Parwan. Training of healthcare providers will begin after the completion of training-of-trainers (ToT), and in total 2,874 healthcare personnel and 70+ health managers will be trained on the Protocol during this phase.

### *Preparatory Work*

Before the training of trainers commences, WHO will support the endorsement process of the Protocol at the Ministry of Public Health. The protocol will be translated to Dari and Pashto and 2,900 copies of both language versions will be made available for distribution to healthcare

<sup>7</sup> 2014 figures of the Health Management Information System (HMIS) database of the MoPH



providers and health managers in the seven provinces. WHO and MoPH, in cooperation with UN Women, organized an official launch event for the Protocol on 16 November, sharing the Protocol and implementation plan with key stakeholders such as NGOs, the donor community, media representatives and UN agencies.



*The GBV Treatment Protocol was officially launched in Kabul on 16 November 2014 by the Ministry of Public Health and WHO with the support of UN Women*

Coinciding with the official launch, a three-day workshop was organized to discuss the Protocol and the Clinical Handbook on healthcare for women subjected to intimate partner violence or sexual violence developed by WHO headquarters. Twenty-two healthcare providers, including nurses, doctors and midwives and MoPH staff, attended the workshop. The purpose of the workshop was to share the key content of the Protocol and Clinical Handbook, to generate discussions among participants and develop the direction of the forthcoming ToT and healthcare provider training by mapping out critical subjects needing more emphasis and exploring existing knowledge and capacity gaps to be addressed.

Before commencing trainings, all training materials and job aids will be finalized and translated into Dari and Pashto.

To identify a third party implementer for the project, a request for proposals (RFP) will be issued to seek out qualified NGOs/companies WHO and MoPH would partner with. The first training of trainers (ToT) will be organized once a suitable implementing partner has been identified by a selection panel consisting of WHO, MoPH and UNFPA programme staff.

### *Training of Trainers*

During Phase One, eight master trainers will be trained on the Protocol centrally in Kabul in a five-day training – these master trainers are then responsible for rolling out the training to the provinces and carrying out on-the-job mentoring and support. WHO, in coordination with MoPH, will develop comprehensive training materials based on the Protocol, including the training manual, hand-outs, in-



class activities, worksheets, PowerPoint presentations, pre and post-tests and training evaluation forms.

### *Training of Health Managers*

WHO will organize orientation workshops for health facility managers on how to best implement and administer GBV care, focusing on organizational and management aspects and staff sensitization. Workshops will be organized in all seven provinces, coinciding with healthcare provider trainings.

Training for healthcare managers will focus on organizational aspects, such as ensuring that the consultation room is set up in a proper way that ensures patient confidentiality and privacy. Health manager training will also focus on issues dealing with equipment procurement as well as referrals. Healthcare managers will also be trained on how to maintain patient-flow: when organizing care for GBV survivors, special attention should be given to the development of adequate patient-flows in order to uphold confidentiality and privacy. To avoid stigmatization of patients, a complete care package should be offered in a single consultation room and this room should not be identifiable as such. Moreover, the patient-flow should permit priority access for survivors of sexual assault, whilst mitigating the possibility of exposing them as such. Training for health managers will also emphasize ways to sensitize staff on the issue of GBV and proper treatment of survivors.

### *Training of Healthcare Providers*

During the first phase of the project's implementation, around 2,874 healthcare providers, including doctors, nurses and midwives, will be trained on the Protocol by master trainers who received a comprehensive ToT. These healthcare personnel will then act as GBV focal points in their respective clinics. Trainings will be organized at the provincial level and decisions on who to train will be made in close coordination with MoPH and UNFPA. During the first phase, a total of 141 workshops with around 20-25 participants in each will be organized.

During the five-day training, healthcare providers will be trained on the contents of the Protocol, including how to administer survivor-centered care, conducting primary surveys, the correct procedures for the identification of GBV, medical history taking, collecting medico-legal evidence, conducting physical and genital examinations, managing wounds, burns and rape cases and basic counseling skills and referrals. Training packages will be tailored to suit the needs of different levels of health facilities.

### *Evaluation of Phase One*

After the first phase of the programme, an evaluation will be carried out to gauge lessons learned and areas for improvement for the second and third phase. The programme will be evaluated against the indicators set out in the Tentative Performance Measurement Framework (Annex II). An external evaluation company will develop an evaluation strategy which will include in-depth interviews with healthcare providers, focus group discussions and survey data. The results of the evaluation report



will be presented and discussed in a workshop in Kabul with around 60 key stakeholders before launching Phase Two of the programme.

The evaluation will not only focus on individual trainees and the capacities of healthcare providers but it will adopt a systemic approach to assess how well systems have been modified to enable high-quality provision of GBV services. The assessment will look into whether services are being provided, procurement systems and referral mechanisms are in place and operational procedures and policies for safety, confidentiality, privacy as well as supervisory, mentoring and supportive efforts are in place and implemented. The assessment will also look into whether service uptake has increased.

The evaluation following Phase I will also include a Knowledge, Practices and Attitudes study to measure any improvements that have occurred since the first KAP study was conducted in six provinces. The KAP study will generate information on the effectiveness of training and partly assess the programme's impact. The KAP assessment will gather more information on the capacity and anticipated challenges of healthcare facilities to strengthen their response to GBV. The information gathered in the assessment will determine what is further needed to ensure health providers appropriately identify, treat, document and refer cases of GBV. The KAP study will be conducted through a comprehensive survey with qualitative and quantitative components in a face-to-face interview with a representative sample of healthcare personnel who were trained on the Protocol, selected through a random systematic sampling technique.

## PHASE TWO

### *Overview of Phase Two*

Similar to Phase One, the second phase begins with a health facility readiness assessment in 14 provinces to determine the structure and timing of implementation in each province, district and facility.

During the 1.5 years of Phase Two, around 1,790 healthcare providers and 140 health managers will be trained in 14 provinces, including Badghis, Farah, Faryab, Ghazni, Ghor, Helmand, Kandahar, Khost, Logar, Nimruz, Paktia, Paktika, Uruzgan and Zabul. Nurses, midwives and doctors as well as health facility managers will be trained on the Protocol.

Following the pattern of Phase One, this phase will also focus on health system strengthening on GBV management, including strengthening procurement systems for necessary equipment, integration of GBV training to existing trainings and education packages, police and multi- sectoral sensitization on GBV and health, distribution of IEC materials and the development of facility policies and procedures to create an enabling environment for the provision of GBV care.

In Phase Two, a total of 72 workshops of around 25 participants will be organized for healthcare



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providers. Orientation workshops for 140 health managers will be organized in 14 provinces. Training workshops will be organized at the provincial level with a mix of male and female participants selected in cooperation with MoPH, provincial health directorates, BPHS and EPHS implementing NGOs and other relevant stakeholders

## *Evaluation of Phase Two*

An evaluation of Phase Two will be carried out to identify lessons learned and areas for improvement for the third and final phase. The programme will be evaluated against the indicators set out in the Tentative Performance Measurement Framework (Annex II). An external monitoring and evaluation company will repeat the evaluation strategy used in Phase One, carrying out in-depth interviews with healthcare providers as well as conducting focus group discussions and utilizing survey data. An evaluation report with findings and recommendations will be distributed to all stakeholders and will be presented at a stakeholder workshop at the end of Phase Two.

## **PHASE THREE**

### *Overview of Phase Three*

Phase Three is the final phase of the programme covering the remaining 1.5 years. Before commencing trainings, a health facility readiness assessment will again be conducted in 13 provinces to determine the provinces/facilities from where to begin implementation.

In the final stage, around 1,824 healthcare providers and 130+ health managers will receive training on the Protocol from 13 provinces, including Baghlan, Daikundi, Jawzjan, Kapisa, Kunar, Kunduz, Laghman, Maidan Wardak, Nuristan, Panjshir, Samangan, Sari Pul and Takhar. Overall around 73 seven-day workshops will be organized in 13 provinces, with around 25 healthcare providers in each. For health managers, orientation workshops will be organized in all 13 provinces to focus on organizational and management aspects of GBV care as described above.

Phase Three follows the pattern of earlier phases and consists of a combination of health provider trainings, health system strengthening interventions (procurement issues, facility policies, equipment, referrals, set-up), distribution of IEC materials and sensitization sessions and collaboration with stakeholders from multiple relevant sectors.

