# HUMANITARIAN RESPONSE PLAN

## AFGHANISTAN

**2018 - 2021**

**HUMANITARIAN PROGRAMME CYCLE**

**2020 MID-YEAR REVISION**

ISSUED JUNE 2020

# About

This document is consolidated by OCHA on behalf of the Humanitarian Country Team and partners. It provides a shared understanding of the crisis, including the most pressing humanitarian needs and the estimated number of people who need assistance. It represents a consolidated evidence base and helps inform joint strategic response planning.

*The designations employed and the presentation of material in the report do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.*

**PHOTO ON COVER**
*Photo: Jim Huylenbroek*

## Get the latest updates

OCHA

OCHA coordinates humanitarian action to ensure crisis-affected people receive the assistance and protection they need. It works to overcome obstacles that impede humanitarian assistance from reaching people affected by crises, and provides leadership in mobilizing assistance and resources on behalf of the humanitarian system.

**www.unocha.org/afghanistan**
**twitter.com/ochaafg**

Humanitarian RESPONSE

Humanitarian Response aims to be the central website for Information Management tools and services, enabling information exchange between clusters and IASC members operating within a protracted or sudden onset crisis.

**afg.humanitarianresponse.info**

Humanitarian InSight

Humanitarian InSight supports decision-makers by giving them access to key humanitarian data. It provides the latest verified information on needs and delivery of the humanitarian response as well as financial contributions.

**www.hum-insight.info**

fts Financial Tracking Service

The Financial Tracking Service (FTS) is the primary provider of continuously updated data on global humanitarian funding, and is a major contributor to strategic decision making by highlighting gaps and priorities, thus contributing to effective, efficient and principled humanitarian assistance.

**fts.unocha.org**

# Table of Contents



**HIRAT, WESTERN AFGHANISTAN**

*March 2020. Returnees from Iran receive assistance at a transit centre in Hirat. Photo: OCHA*

# Foreword by the Humanitarian Coordinator

The arrival of COVID-19 in Afghanistan has brought heartache to millions of people who are now battling a deadly pandemic while simultaneously fighting for their survival amid poverty, disaster and war. Over my three years as Humanitarian Coordinator, I have marvelled at the resilience of the people of this country to cope with the hardships of life in the world's deadliest conflict – but even this remarkable strength is now being tested by the health, social and economic consequences of COVID-19. The virus is spreading across the country with frightening speed. Every province is now impacted, and people are understandably frightened.

A massive health response has swung into action under the leadership of the Government of Afghanistan. This work has been guided by health-focused prevention and response plans developed by the Ministry of Public Health with support from the World Health Organization (WHO), a wider government 'Master Plan' for responding to the impacts of COVID-19 and an initial three-month Multi-Sector Humanitarian Country Plan. Ten testing laboratories are now up and running, thousands of additional isolation and intensive care beds have been made available, training of health staff in infection control is being scaled-up, more than a million people have been reached with water and hygiene assistance to stymie the spread of the virus and safety messages are reaching millions of people in every corner of the country.

This decisive early action lays a strong foundation for the response, but the sheer scale and likely duration of the crisis gripping the country requires us all to step up and give more.

In a country where more than 90 per cent of the population is living in extreme poverty and 80 per cent rely on informal labour to survive, the economic consequences of COVID-19 could outstrip the direct health impact from the virus itself, sending people spiralling into financial insecurity and, in some cases, acute humanitarian need. For this reason, we have revised the Humanitarian Response Plan (HRP) for 2020 and now estimate a staggering 35 million people are in need of a social safety net, 14 million of whom are now in acute humanitarian need. This is up from 9.4 million at the start of the year.

A key driver of this increase is hunger. COVID-19 has put the world on the brink of a hunger pandemic and Afghanistan is on the front line. A third of the country is facing acute food insecurity including almost 4 million people at the emergency level – one of the highest figures in the world. COVID-19, movement restrictions, the inability to work and rising food prices are also pushing this food crisis into urban areas on a scale not previously seen. Further adding to this increased estimate of need is a frightening protection outlook, particularly for women and children, in light of COVID-19. Gender-based violence (GBV) is increasing and could soar. Worsening poverty is expected to place increasing numbers of children at risk from negative coping strategies such as early marriage and child labour.

People's survival will depend on the 161 dedicated humanitarian organisations operating in Afghanistan staying and continuing their hard work in support of the Government, under the most difficult conditions. For that we will require generous support from donors, in a demonstration of solidarity with the people of Afghanistan. The revised HRP requests $1.1 billion to reach 11.1 million of the most vulnerable people with life-saving assistance until the end of the year. A comprehensive programme of assistance is planned to address not only new needs arising from COVID-19 but also pre-existing needs that are just as pressing, if not more so, in the context of the pandemic.

In 2020, the unprecedented scale of need demands that we aim higher and do more to relieve suffering, including finding more durable solutions that help in rebuilding people's lives and connecting them with longer-term development programmes that give communities – girls and boys, women and men – the best chance of recovery. The 2018-2019 drought response demonstrated that the international community has room to improve in terms of connecting humanitarian and development work on both sides of the house. I am pleased to see that the COVID-19 response has already shown a change in approach with common analysis and complementary planning now underway, in particular with the World Bank.

The stakes for the response could not be higher at such a sensitive and fragile moment in the country's conflict-ravaged recent history. While the potential for peace has not yet been fully realised, and fighting continues, moves towards reducing hostilities are an encouraging signal of hope. Peace remains the most important step in breaking the cycle of aid dependency, alleviating suffering and getting Afghanistan back on its feet. Until that happens, the humanitarian community remains steadfast in its support of the people of Afghanistan as they navigate the turbulent times.

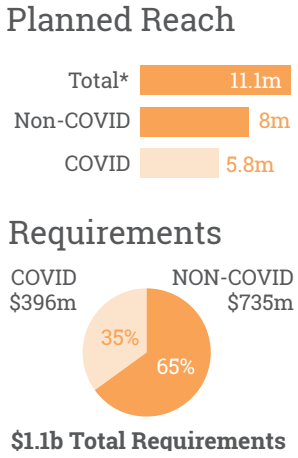
I am confident that with the ongoing support of donors and continued commitment and investment of partners – humanitarian and development – and the Government's lead - we can ensure that timely assistance reaches the growing number of people in need as a result of conflict, disaster and COVID-19. The people of Afghanistan are counting on us all.

**Toby Lanzer**

Humanitarian Coordinator in Afghanistan

# COVID-19 and the Afghanistan Response HRP Revision – June 2020

After 40 years of war, annual natural disasters and persistent poverty, the people of Afghanistan have been dealt another deadly blow from COVID-19. Less than six months since the virus' emergence, its humanitarian consequences are now affecting every aspect of life and threatening the survival and well-being of the most vulnerable by creating new needs and exacerbating existing ones. The virus has also reshaped the humanitarian operating environment in Afghanistan, demanding a deeper and wider response from aid agencies, using flexible new approaches to expand reach and ensure life-saving support is not interrupted. With this in mind, the Humanitarian Country Team (HCT) and the Inter-Cluster Coordination Team (ICCT) have revised the multi-year HRP with 14 million people now estimated to be in humanitarian need and a planned reach of 11.1 million people. For this work, the humanitarian community requires US$1.1 billion. Projections of key population groups (e.g returnees, people affected by natural disaster) have been adjusted to reflected new ground realities.




** Some people will receive both COVID and non-COVID-related assistance under the HRP*

This HRP revision comes at a time when the country's fragile health system, under extreme stress even before the pandemic, is straining to find the resources necessary to prevent, contain, and treat the virus. While acknowledging the initial funding already released by generous donors and through global pooled funds, health partners are operating in an environment where approximately one-third of the population (mostly those living in hard-to-reach areas) do not have access to a functional health centre within two hours of their home. These access gaps are a critical impediment to the fight against COVID-19, as well as people's general well-being and survival from other threats. Seventy nine per cent of adults and 17 per cent of children are estimated to live with some form of disability. Constant exposure to high-stress, conflict situations, movement restrictions and financial pressure, as well as repeated loss of friends and family members from sickness and war, are also taking their toll on the mental health of people living in Afghanistan. Hunger and malnutrition remain at dangerously high levels despite the passing of the drought with 12.4 million people forecast to be in crisis or emergency food insecurity between June and November of 2020.

People's living conditions, emotional and physical reserves, and their overall resilience in the face of recurrent shocks have been eroded by decades of hardship. Inability to access basic services is a key consequence of the ongoing crisis and is a product of a range of factors including conflict, insecurity and fear, poverty and under-investment in critical infrastructure and human resources. The country is also facing a protection crisis where people's rights to safety, security and well-being are regularly threatened not only by the conflict, but also by the economic implications of COVID-19. Afghanistan carries the terrible burden of being the world's deadliest conflict for children and now the virus is presenting safety risks for women both in terms of poor access to treatment and a surge of gender-based violence. Conflict and displacement have resulted in internally displaced persons (IDPs) and vulnerable people resorting to severe negative coping mechanisms such as early/forced marriages, child labour and begging – a situation that is only exacerbated by COVID-19. Women and girls are deprived of basic rights, particularly education. Afghanistan is littered with landmines and other explosive hazards (new and old), presenting daily risks to civilians, particularly the higher than normal numbers of returnees. Insecure housing, land and property rights are a key source of vulnerability for many people in Afghanistan, particularly IDPs, returnees and women. The risk of eviction is especially real for both returnees and those unable to pay their rent because of COVID-19.

This mid-year revision builds on efforts initiated by the Government, the Ministry of Public Health and the World Health Organisation and an initial Multi-Sector Humanitarian Country Plan (March-June). The revisions recognise the likely long-term nature of the pandemic, the need to continue to respond to pre-existing and emerging non-COVID priorities simultaneously, and the opportunity to work more closely with development actors to keep additional vulnerable people from falling into acute humanitarian need. Renewed engagement with development partners is critical to providing a response that promotes not just survival but recovery.

# Response Plan Overview

**PEOPLE IN NEED OF A SOCIAL SAFETY NET**
**35M**

**PEOPLE IN HUMANITARIAN NEED**
**14M**

**HRP PLANNED REACH**
**11.1M**
COVID-19: **5.8M**
NON-COVID-19: **8M**

**REQUIREMENTS** (US$)
**1.1B**
COVID-19: **396M**
NON-COVID-19: **735M**

The mid-2020 update to the Afghanistan multi-year Humanitarian Response Plan 2018-2021 requests US$1.1 billion and aims to reach 11.1 million people who are acutely affected by the humanitarian consequences of the COVID-19 pandemic, the country's four decades-long conflict, as well as natural disasters and other vulnerabilities. The complexity of needs and response in this environment cannot be underestimated with every one of the cross-cutting problems identified in the 2020 Global Humanitarian Overview[1] currently affecting the people of Afghanistan.

The revised response strategy reflects the wider scope of humanitarian action for Afghanistan that was adopted in September 2019 to include vulnerable people with ongoing needs for support, such as protracted IDPs, and people with specific needs such as women who are heading households, people with disabilities and those experiencing mental health issues. The Plan also provides some support for people who require resilience and recovery assistance to prevent them from slipping into more serious humanitarian need. Several sectors have included a range of resilience and recovery activities which, while more expensive in the short-term, will create savings and reduced suffering for beneficiaries in the long-term.

The need to respond to the multi-faceted impacts brought on by the pandemic has also spurred on accelerated planning between humanitarian and development actors, resulting in agreement on the number of people in need of an emergency social safety net. Organisations including the World Bank, the Asia Development Bank, UNDP, UNICEF and ILO, as well as OCHA and the Food Security and Agriculture Cluster worked together to develop this concept which establishes common planning parameters and visualises need in an innovative way to ensure that no one is left behind. These 35 million people (93 per cent of the population) are living below the international poverty line of $2 per day. About one-third of this group (11.1 million people) will be assisted by humanitarian organisations but the rest remain outside of the scope of the HRP and are in urgent need of a broader response through development assistance. This underlines the reality that humanitarian action is just the first part of a more comprehensive package of measures needed from the Government and development organisations. If these development needs are not met in a timely manner, people risk falling into humanitarian need, threatening hard-fought development gains and requiring a more expensive humanitarian response.

Cross-cutting response priorities for 2020 include continued action on prioritised recommendations from the 2019 Peer-2-Peer mission; an expansion of in-country cash capacity and improved decision-making on

**Revised definition of humanitarian action in Afghanistan**

Humanitarian action in Afghanistan provides life-saving emergency assistance to people in need, whether they are displaced or not. It also supports the most vulnerable people who are unable to access basic services or ensure their own survival, aspiring to leave no one behind. It aims to preserve people's dignity, improve their living conditions, and strengthen their coping capacity and resilience. Humanitarian action also assists host communities to cope with accommodating IDPs, refugees and returnees.

Humanitarian action in Afghanistan aims to protect people's rights and safety under international law and support those with special needs. The humanitarian community responds to people with physical and psychological trauma to foster their recovery and ability to play an active role in society.

Humanitarian action opens the way for recovery of vulnerable people through livelihood, asset-creation, cash-for-work and system-strengthening programmes, bridging people to more sustainable development assistance.

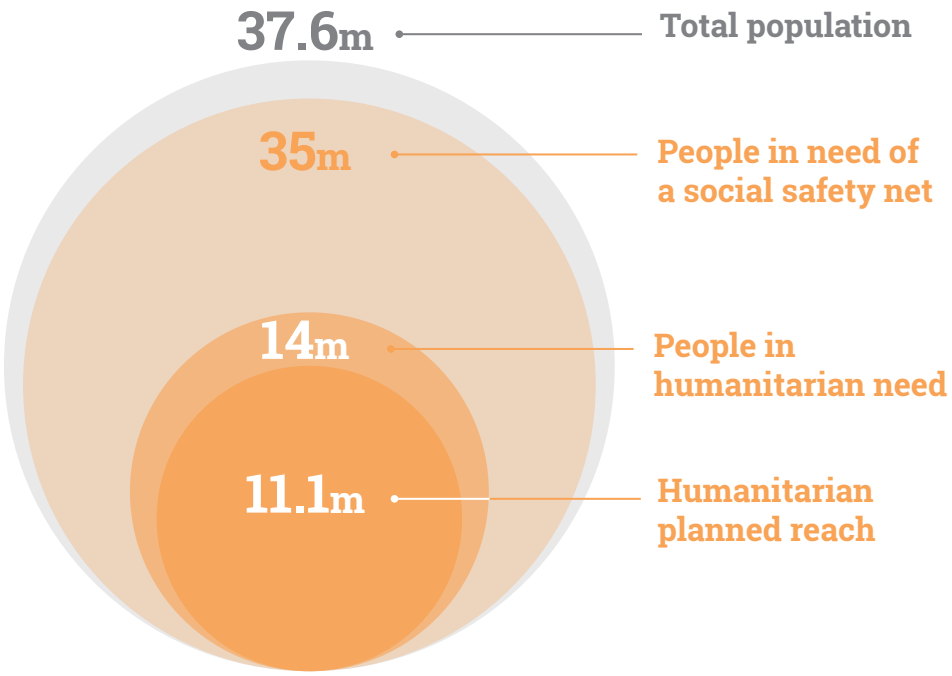
Humanitarian action aims to be integrated, coordinated, principled, rapid, effective and accountable, and guided by multi-year planning. It includes the use of cash where appropriate and aims to address people's needs across all sectors. The humanitarian community supports affected people to make decisions about the assistance they receive and to safely access complaints mechanisms.

the use of cash; expanded thematic preparedness planning; a focus on Accountability to Affected Populations (AAP), including through expanded Risk Communication and Community Engagement (RCCE); improved monitoring of response coverage; and better analysis of the gender, disability and mental health dimensions of the response.

This mid-year revision has also included the reinsertion of a refugee chapter at the recommendation of UNHCR. While progress had been made since the 2018 decision to transition coordination of the response for the 72,000 refugees in Khost and Paktika to the Government, the need for aid agencies to provide ongoing support and assistance has led to its re-insertion in the HRP. Refugee response activities are incorporated into each cluster's plans but the refugee chapter consolidates these plans allowing for better overall visibility of refugee needs and responses. The mid-year revision has also provided an opportunity for clusters to revisit activity costing, with general maintenance of the existing cost-per-beneficiary ($102 for mid-2020 compared to $103 originally planned for the year) despite an arguably more challenging response environment. While specific activity costs for the majority of clusters have reduced or maintained, activity costs for the Protection Cluster have increased significantly. This is mainly due to a revised methodology which corrects severe under-estimations in previous approaches.

Given the dynamic nature of the context, projected figures for people in need and planned reach in 2021, at 9 million and 6.6 million people respectively, have not been updated during this revision. Forecasts for 2021 will be revisited later in the year when more information is known. It is expected these will be substantially higher than originally forecast.

**People in Need 2020**



# Strategic Response Objectives

The three strategic objectives (SOs) of the HRP have been adjusted to reflect the new scope of action for 2020 and 2021. These encompass all four humanitarian consequences elaborated in the Humanitarian Needs Overview (HNO).[2] It should be noted that multiple consequences are addressed under each objective and are thus overlapping. As resilience and recovery programming is new to the HRP this year, activities remain modest and will be further developed over time. The changes to the strategic objectives have required a corresponding reorganisation of the HRP logframe at the back of this document (pg 111).

### 1. Lives are saved in the areas of highest need

This strategic objective is focused on the provision of urgent, emergency assistance to ensure people's survival and prevent mortality. This objective now combines life-saving responses to all kinds of shock under a single category (disaster, COVID-19 and conflict). This is in line with the HCT's desire to move away from status-based language which previously emphasised the cause of displacement and resulted in different levels of response to different groups. Coordination activities now also fall under this objective. This strategic objective is concerned with addressing critical problems related to physical and mental **well-being**, as well as critical problems related to **living standards**.

### 2. Protection violations are reduced and respect for International Humanitarian Law is increased

This strategic objective remains unchanged in 2020 and encapsulates responses to the extreme violence, fear and rights violations faced by people in Afghanistan every day. This strategic objective is concerned with addressing critical problems related to physical and mental **well-being**, as well as critical problems related to **protection**.

### 3. Vulnerable people are supported to build their resilience

This new objective prioritises action to assist the most vulnerable in the community, irrespective of shocks. It also recognises the struggle faced by people in Afghanistan to pull themselves out of trouble due to repeated displacement and their depleted psychological and financial reserves. This strategic objective is concerned with addressing critical problems related to **living standards** and critical problems related to **resilience and recovery**.

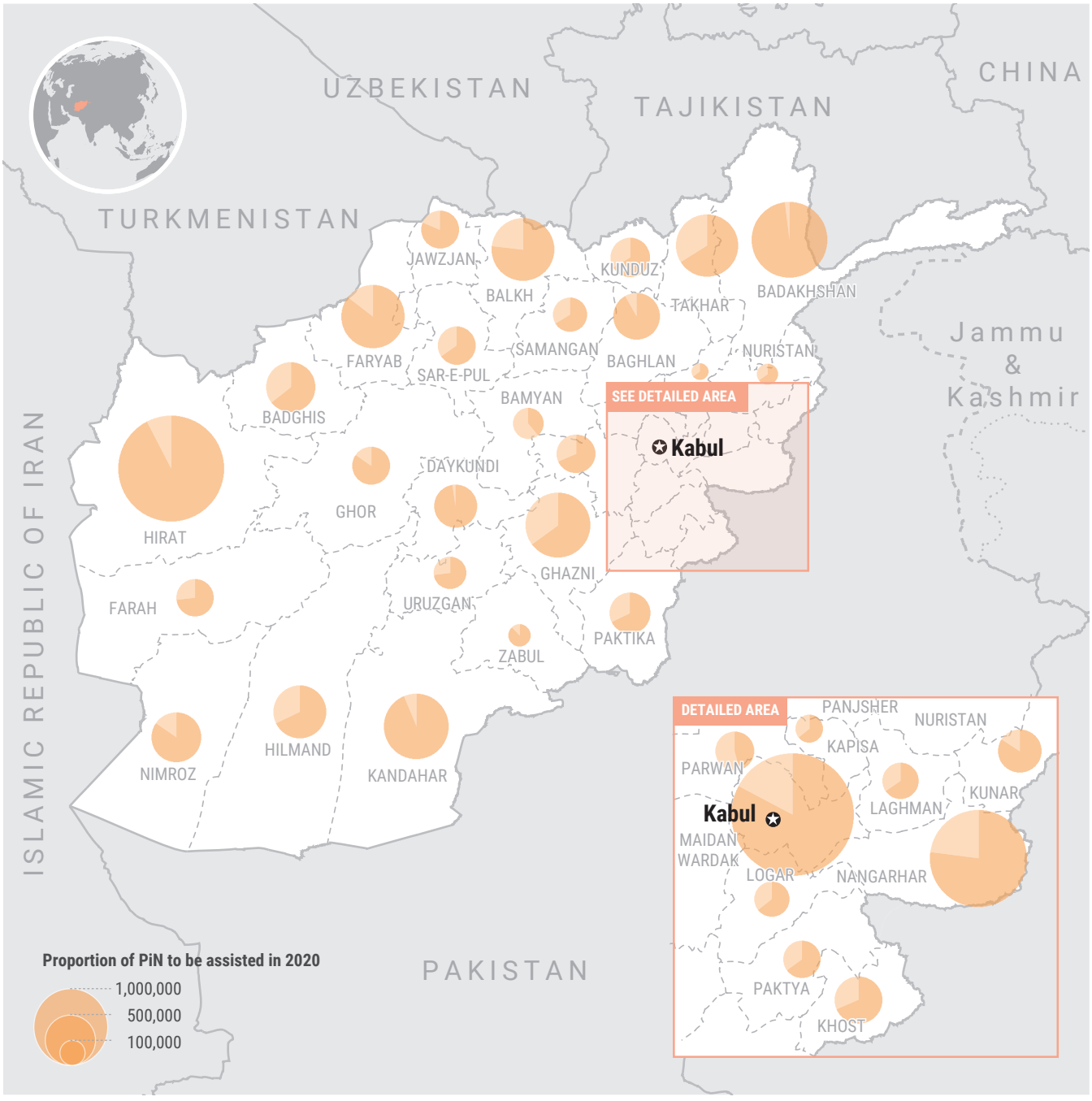
**MAZAR-E-SHARIF, NORTHERN AFGHANISTAN**

*Children play at Nahr-e-Shahi village outside of Mazar City where hundreds of families have settled after fleeing from conflict-affected areas of Faryab and Balkh. As the conflict is still ongoing, they have not been able to return home. Photo: OCHA/Charlotte Cans*

# Needs and Planned Response

| PEOPLE IN NEED OF A SOCIAL SAFETY NET | PEOPLE IN HUMANITARIAN NEED | HRP PLANNED REACH | WOMEN | CHILDREN | WITH SEVERE DISABILITIES |
|---|---|---|---|---|---|
| 35M | 14M | 11.1M | 22% | 53% | 8.4% |

## Overview map




*The designations employed and the presentation of material in the report do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.*

# HRP Key Figures 2020

## Humanitarian Response by Population Group

| POPULATION GROUP | PEOPLE IN NEED | PLANNED REACH | % TO BE REACHED |
|---|---|---|---|
| Acutely vulnerable people with humanitarian needs | 12.8 M | **10.1 M** | 79% |
| People affected by shocks in 2020 | 181 K | **181 K** | 100% |
| People displaced in 2020 | 500 K | **405 K** | 81% |
| Returnees in 2020 | 570 K | **460 K** | 81% |
| Refugees living in Afghanistan | 72 K | **72 K** | 100% |

## Humanitarian Response by Sex

| SEX | PEOPLE IN NEED | PLANNED REACH | % TO BE REACHED |
|---|---|---|---|
| Girls | 3.5 M | **2.8 M** | 80% |
| Women | 3.1 M | **2.5 M** | 74% |
| Boys | 3.8 M | **3 M** | 79% |
| Men | 3.5 M | **2.8 M** | 80% |

## Humanitarian Response for People with Disabilities

| | PEOPLE IN NEED | PLANNED REACH | % TO BE REACHED |
|---|---|---|---|
| People with severe disabilities | 1.2 M | **931 K** | 79% |

## Humanitarian Response by Age

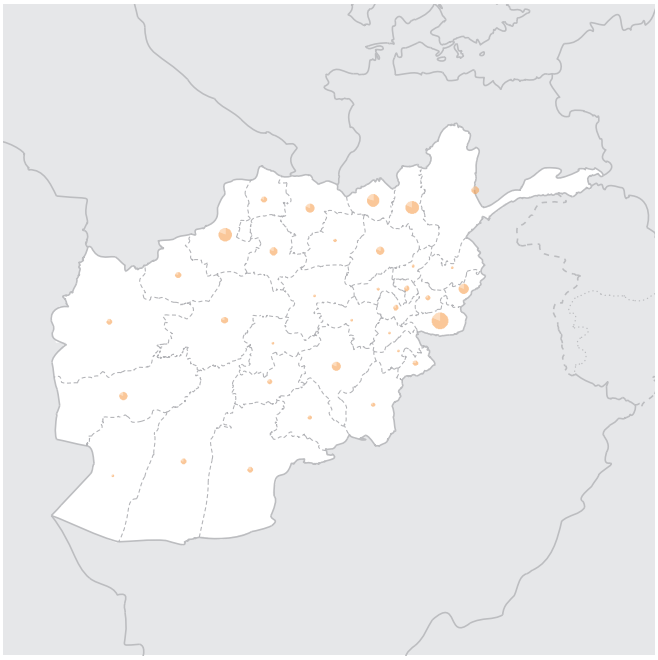
| AGE | PEOPLE IN NEED | PLANNED REACH | % TO BE REACHED |
|---|---|---|---|
| Children (0 - 17) | 7.4 M | **5.8 M** | 79% |
| Adults (18 - 64) | 6.1 M | **4.9 M** | 79% |
| Elderly (65+) | 395 K | **314 K** | 79% |

## Financial Requirements by Sector

| SECTOR | REQUIREMENTS (US$) |
|---|---|
| Education in Emergencies | **$68.1 M** |
| Emergency Shelter and NFI | **$122.9 M** |
| Food Security and Agriculture | **$370.3 M** |
| Health | **$171.1 M** |
| Nutrition | **$114.6 M** |
| Protection | **$91.9 M** |
| Water, Sanitation and Hygiene | **$152.2 M** |
| Aviation | **$25 M** |
| Coordination | **$14.9 M** |
| **TOTAL** | **$1.1 B** |

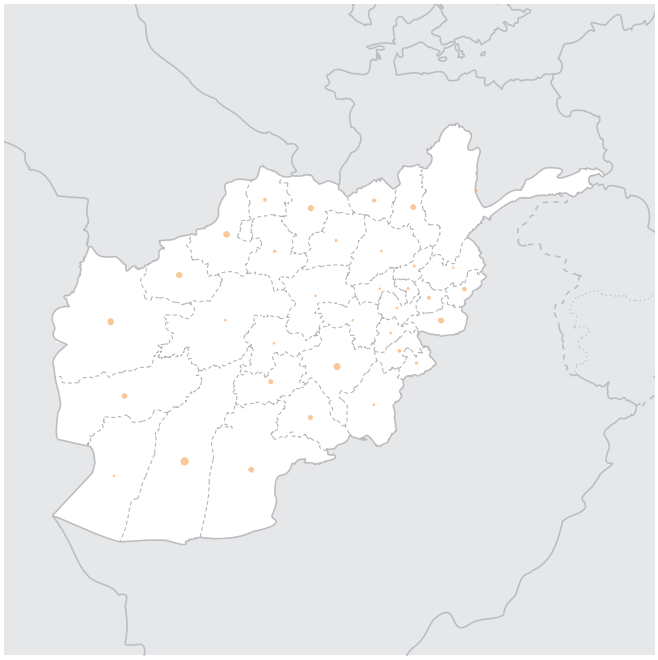
## People Displaced in 2020

| PEOPLE IN NEED | PLANNED REACH |
|---|---|
| 500K | 405K |



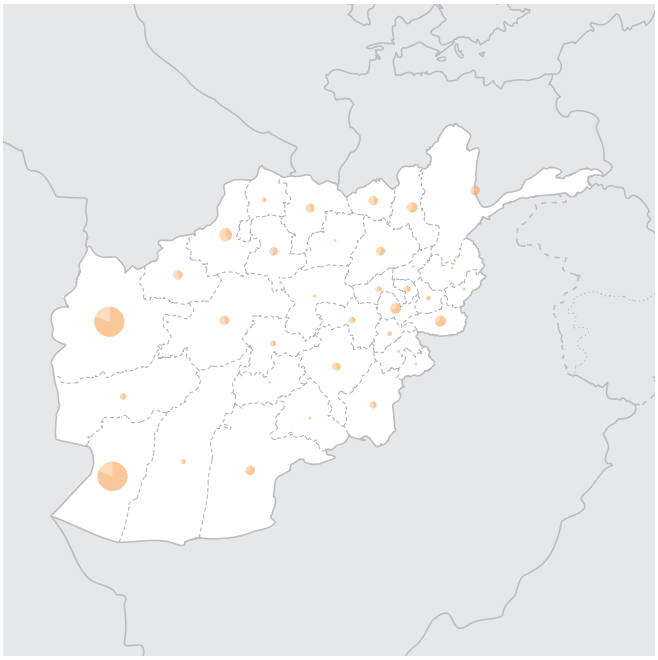
## People Affected by Shocks in 2020

| PEOPLE IN NEED | PLANNED REACH |
|---|---|
| 181K | 181K |



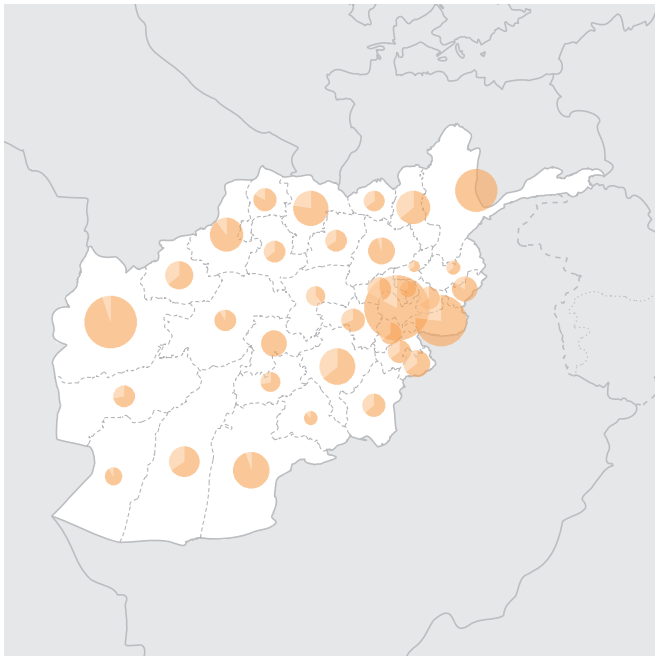
## Returnees in 2020

| PEOPLE IN NEED | PLANNED REACH |
|---|---|
| 570K | 480K |



## Acutely Vulnerable People with Humanitarian Needs

| PEOPLE IN NEED | PLANNED REACH |
|---|---|
| 12.8M | 10.1M |



# People in Need

The humanitarian consequences of the crisis now touch all corners of the country. In 2020, the people of Afghanistan are spending their 40th year grappling with the safety, security, financial and emotional consequences of war. Conflict now shapes all aspects of everyday life, posing terrifying protection risks but also having a devastating impact on the country's development. Political uncertainty, grinding poverty, escalating personal debt and repeated exposure to natural disasters have eroded coping capacities and pushed vulnerable people into dire humanitarian need. Added to this are now the overwhelming needs caused by COVID-19 that are wreaking havoc not only on people's physical health but also their mental and financial well-being. The pandemic has left some existing beneficiaries with more complex, deeper needs, while pushing others into humanitarian need for the first time. It has also necessitated the application of a wider lens that positions the humanitarian effort to acute needs within a broader supportive response by development actors.

**Revised parameters 2020**

A mid-term review of the four-year HRP in the final quarter of 2019 concluded that the scope of humanitarian analysis and action during the past two years in Afghanistan was too restrictive and inadequate for addressing the current trajectory of needs. Decades of war have eroded people's capacity to cope with constant shocks, pushing them into need faster and making them vulnerable for longer. This, combined with the impacts of the devastating 2018/19 drought, drove the Humanitarian Country Team to re-think the parameters for action in 2020 and 2021. The result was an extension in the scope of humanitarian action, in keeping with international approaches, to better address the nature and extent of needs in 2020 and beyond. The revised definition prioritises three main groups of people in need – shock-affected people in need of emergency assistance (including new IDPs, cross-border returnees, people affected by natural disaster), vulnerable people with ongoing requirements for support (including protracted IDPs, refugees in Afghanistan, people with specific needs such as people with disability, the elderly, female-headed households) and people who require resilience and recovery assistance to prevent them slipping into worse humanitarian need.


Given the shock of COVID-19 and its catastrophic economic consequences, the HCT has recognised that original projections from the start of the year are no longer valid and has embarked on a revision to more accurately reflect needs from June through until the end of the year. This process included cluster reflections on trends in a series of needs indicators set out in the HNO. This has resulted in the number of people in need of humanitarian assistance increasing to 14 million, largely as a result of the inclusion of all people in crisis or emergency food insecurity (IPC 3 and 4). Upward adjustments have been made across every sector with Health, Protection and FSAC showing the largest proportional increases in their needs.

**People in need of a social safety net**

An estimated 93 per cent of households in Afghanistan are in immediate need of an emergency social safety net in 2020, as they earn less than $2 per day and are particularly vulnerable to the economic shock of COVID-19. Large shares of the population depend on activities that are vulnerable to lockdowns and physical distancing measures. More than 80 per cent of workers are in the informal economy, which makes them more vulnerable with insecure, unstable and inadequate earnings — problems that are exacerbated by low productivity and a lack of safety nets that guard against income loss during economic hardship. Spikes in food prices due to border closures and disruptions to supply chains will also affect the purchasing power of households across the entire income distribution chain. These impacts are compounded for households dependent on remittances, as well as for the rapidly increasing numbers of returning returnees and IDPs. Without support from the Government and development actors, such income shocks can push vulnerable households deeper into persistent poverty and food insecurity. A household losing half its income usually reduces food consumption by an average of 30 per cent. In times of economic distress and rising prices, urban households are forced to reduce their consumption of nutritionally diverse foods for cheaper nutritionally-poor food items such as wheat flour. This has corresponding impacts on children, and pregnant and lactating mothers.

Rural areas will also experience negative impacts as farmers and agricultural seasonal workers see their livelihoods plummet as supply chains are interrupted. This vulnerable group of 35 million people includes men and women, children, rural, urban, and nomadic communities, and only excludes the small minority of wealthy households. Among these, the elderly, households headed by women, pregnant women, victims of domestic violence, refugees, orphans

or children living or working on the streets, and people with physical or mental disabilities, are especially at risk. This social safety net estimate is a broad and exceptional calculation, specific to the COVID-19 situation, and is applicable from June through the end of the year.

In the immediate-term, those falling outside the scope of the Humanitarian Response Plan must be reached with enhanced social protection measures with the intent of:

- Enabling access to minimum food requirements
- Enabling access to some form of health care
- Maintaining some level of job and income security
- Contributing to preventing greater poverty, unemployment and further informality; and
- Sustaining some form of economic and social stability

Lessons learned from previous epidemics, such as SARS-2003, MERS-2012 and Ebola-2018 highlight the need to combine effective health activities with broader social protection measures as part of government policy responses. With the COVID-19 crisis, strengthening resilience of health systems and rapidly reorganising service delivery has become more important than ever. Effective responses depend on inclusive community dialogue and the participation of the private sector as well as other stakeholders in tackling the causes and consequences of the crisis and promoting recovery and social stability.

In the longer-term, a broader range of social protection measures will be required to curb the spread of the virus, stabilise household income and demand, as well as contributing to recovery. The following social protection approaches may be considered:

- Income support through social assistance and cash transfers, including food vouchers, to ensure continued consumption of goods and necessities, thus having an income multiplier effect. Cash transfers can be particularly effective since they can take effect with less delay than other discretionary fiscal measures.
- Easier access to public and privately available health care. This implies providing immediate and significant additional financial and material resources to the health sector, noting the challenges of high out-of-pocket expenses and readiness for health insurance.
- Temporarily modifying tax payments for enterprises to alleviate liquidity constraints.
- Unemployment protection. Preventing job losses and supporting those who have lost jobs through temporary state-organised partial unemployment and/or tax benefits that allow employers to retain their workers during the crisis, thereby allowing for a quick recovery. This could be complemented by subsidies or reductions in rent and utilities. It is limited by the high level of workers in the informal economy.
- Increases in old age, survivor, and disability benefits (pensions) to support households where other incomes have been lost. Presently pension benefits are limited to retired government employees and survivor/ disability benefits to government security personnel.
- Adapting administrative procedures and delivery mechanisms, such as waiving requirements for in-person visits, using mobile money options, fee waivers, and exemptions for health care and utilities, to speed up the treatment of requests or the processing of claims and subsequent disbursement of benefits.
- Labour incentives for people to work, such as cash- and food-for-work programmes that could support domestic food production or other public goods and infrastructure.

Looking forward into 2021 after the expected peak of the COVID-19 impact, it is likely that the scope of this social safety net calculation will change with a more targeted focus on the people experiencing chronic food insecurity. As the crisis unfolds and more data is collected, there will be more insights into the longer-term consequences of COVID-19 on the economy. This will enable adjustments to be made to this figure in 2021. Uncertainty over how this crisis will evolve globally, and within Afghanistan, requires those providing social safety nets to remain adaptable and flexible enough to deliver timely support based on needs at the time, especially for those most vulnerable to chronic food insecurity.

# Context of the Crisis

### Operating context

The humanitarian response in 2020 has been reshaped by the COVID-19 pandemic. The pandemic has touched every facet of life for the people of Afghanistan, in many cases exacerbating complex, existing humanitarian and development needs. High internal displacement and overcrowded housing, low coverage of vaccination required for stronger immune systems, in combination with weak health, water and sanitation infrastructure, cultural practices that make physical distancing challenging, and a huge informal labour-market have left the people of Afghanistan reeling. COVID-19 requires the continued delivery of assistance, while safeguarding affected people and humanitarian staff from the virus. This is being done as responders contend with limited global supplies of critical medical equipment and work to remain responsive to people's worsening economic situation that lockdown measures have caused. Political and security volatility has compounded the pandemic's impact. Afghanistan remains one of the most dangerous places to live on Earth. People face daily risks from Improvised Explosive Device (IED) attacks and air strikes. Fear, violence, repeated displacement, escalating debt and, now, the pandemic, have gradually eroded people's coping capacity and crippled the economy, risking development gains and leaving people in extreme poverty. Humanitarian responders also face deadly risks and complex access challenges amid this highly-charged environment but are committed to delivering lifesaving assistance to people in need. For further analysis of the crisis context, please refer to the 2020 HNO.[3]

### Security and political environment

While the overall situation is uncertain, the security outlook for the immediate future remains characterised by high levels of civilian casualties due to suicide and non-suicide IED attacks in civilian populated areas, continued air strikes, indirect fire during ground engagements, and deliberate attacks against civilians and civilian sites. Resumption of offensive military postures of Government and Taliban forces in May 2020 and uncertainty around the agreement negotiated between the US and the Taliban in late February 2020, suggest potential for volatility in the security environment over the remainder of the year.

UNAMA documented 1,293 civilian casualties (533 killed and 760 injured) in Afghanistan in the first three months of 2020.[4] Violence continues to disproportionately impact children and women. From 1 January to 31 March 2020, UNAMA documented 417 child casualties (152 killed and 265 injured) and 168 women casualties (60 killed and 108 injured). This includes an especially disturbing increase in violence during March, when it was hoped that the Afghanistan Government and the Taliban would begin formal peace negotiations and defuse the conflict to help protect citizens from COVID-19. UNAMA's preliminary figures indicate a trend of escalating civilian casualties in April 2020, with a 25 per cent increase compared to April 2019. UNAMA has raised further concern about the levels of violence recorded in the first half of May, including attacks claimed by Islamic State of Khorasan (ISK).

Fighting creates an immediate and long-lasting burden for civilians and exposes them to sudden and terrifying violence that leaves them vulnerable to unexploded ordnance, permanent disability and significant trauma-related needs. Fighting between Non-State Armed Groups (NSAGs) is also is generating new humanitarian needs and is likely to further complicate developments over the year ahead. Violations of international humanitarian law, including attacks on health and education facilities, are now commonplace with students and the sick paying a heavy price in terms of missed classes and medical services.

### Economic, socio-cultural, demographic profile

People are finding it increasingly difficult to cope with the daily hardships they face due to the direct impact of lockdowns intended to slow COVID-19's spread, the lingering impacts of the drought, continued insecurity, a contraction in economic growth and a labour market that is unable to absorb the available workforce. A full picture of the economic calamity facing the country may not be known until later in the year. However, preliminary World Bank estimates show major economic and fiscal shock in Afghanistan. The virus and related containment measures, including border closures and the recent lockdown of major cities, have led to: (i) massive disruptions to productive economic activity and consumption; (ii) disruptions to imports, including of vital household items, leading to rapid inflation; (iii) reduced exports due to disruptions at border points; (iv) a sharp decline in remittances. The same analysis suggests an indicative revenue loss of up to 30 per cent ($800m less than 2019) and at least a 5-7 per cent contraction in GDP (compared to the 3 per cent growth that had been originally predicted). This will have significant impact across the board but will be particularly challenging for people already living in poverty, including those who are displaced long-term. Even before COVID-19, an estimated 93 per cent of people were living on less than $2 per person per day[5] (based on 2016/17 data adjusted for current exchange rates); approximately twice the official national poverty line which is close to $1 per person per day. These 35 million people struggle to meet their needs, undermining the dignity of their living conditions and eroding the community's resilience to shock. This indicates little capacity to absorb the economic shock of COVID-19 and the associated loss of livelihoods.

Regional geo-political issues may continue to have a significant impact on Afghanistan's economy over the year ahead. These issues

include the reduction of available jobs and thus remittances due to the weakened economic situation in Iran and the steep drop in the price of oil. Inbound remittance flows for 2020 were estimated at between 3-7 per cent of GDP, and mainly came from Iran, Pakistan and Gulf countries. This is expected to substantially decline with the contraction of global economic activity as well as plummeting employment opportunities in Iran, where a large number of Afghanistan citizens work in a country that has been a virus hotspot.

Afghanistan's population is estimated to be 37.6 million people in 2020[6] of whom 51 per cent are men and 49 per cent women.[7] The country has a population growth rate of three per cent per annum,[8] which is among the highest in the world.[9] The most striking feature of Afghanistan's population profile is its very young average age. Almost half of the population (48 per cent) is under 15 years old, which is the highest proportion on Earth. Rapid population growth, rural-urban migration, continued displacement and now COVID-19 further compound the stress on urban centres while increasing competition for local resources and basic services. According to IOM's Displacement Tracking Matrix (DTM) Baseline Mobility Assessment for 2019, 4.1 million people who have been displaced since 2012, many into urban areas, show no signs that they intend to return to their places of origin.[10]

**Infrastructure and access to services**

The challenges from COVID-19 are layered on top of years of under-investment in basic services, inefficiencies and economic stagnation. Active conflict, large-scale population movements and limited livelihood options continue to deprive people of access to services that are especially urgent in a pandemic, including health, clean water and sanitation. A comprehensive social protection system remains critical but elusive in the current economic climate. In the absence of something more comprehensive, approximately 35 million people will need an emergency social safety net in 2020 as a result of COVID-19 and its economic consequences.

Afghanistan's fragile health system is thinly spread across the country due to ongoing insecurity and infrastructure challenges. Around 30 per cent of the population has limited access to basic health services within a two-hour travel radius and the maternal mortality rate is among the highest in the world. Only 50 per cent of children under five have received the full suite of recommended vaccinations to keep them safe and healthy. The health system is further overburdened by mass casualty incidents and recurrent outbreaks of communicable diseases, especially among internally displaced people. Where access to health services does exist, fear of catching or being perceived as having COVID-19 has kept people from seeking routine care or preventative treatments. Prior to COVID-19, antenatal care was accessible only to a limited portion of the population – up to 32 per cent of IDPs report unavailability of antenatal care where they live. Women, yet again, are likely to be disproportionately affected by the impact of the virus. The increased care-burden of women is likely to expose them to increased risk to contracting COVID-19. At the same time, if they do become ill, cultural limits on their movement in combination with a lack of female medical staff are likely to restrict their access to health care (both COVID-19-related and non-COVID-19-related).

Gender-Based Violence was already at disturbing levels before COVID-19. Strong evidence exists that Afghanistan is following global trends during lockdowns with a jump in GBV risks, for which support services are limited. Nutrition services, that are often co-located in health centres, are also affected by COVID-19. Analysis from UNICEF's nutrition database shows that as of April 2020 there has been a 40 per cent decrease in admissions for inpatient treatment of severe acute malnutrition within health centres at the national level, with some regions seeing as high as a 59 per cent decrease.

Of the 871 health care workers who have been confirmed to have the virus as of 1 June 2020, 13 have died. As of 1 June, more than five per cent of the total confirmed COVID-19 cases in Afghanistan are among healthcare staff. Lack of familiarity with protection measures and shortages of Personal Protective Equipment (PPE) are likely factors. These figures are expected to increase with escalating community spread of the virus that further weakens the healthcare workforce.

The country has struggled to cope with the urban planning challenges resulting from massive internal displacement. WASH and Shelter needs are extreme with over one-third of households displaced for more than six months (1.4 million people).[11] Displaced people still live in makeshift shelter or tents in overcrowded conditions, with little access to services. Overcrowding is likely to have a severe impact on fighting the spread of COVID-19 in terms of hygiene and physical distancing. Electricity is unreliable across the country as a result of both infrastructure deficiencies and conflict; access to the Internet is limited in many areas. These gaps make it harder for office-based staff to work from home and for schools to shift to technology-based learning platforms during the COVID-19 shutdown. Roads in more remote areas are often poor quality and regularly close due to flooding, landslides, snow or avalanches in high altitude areas, in addition to conflict-related closures. The 2019 Hard-To-Reach Assessment found that "inaccessibility due to physical constraints" was strongly linked to lower access to education, health, and WASH facilities, as well as to markets with basic supplies.

COVID-19 has also now spread into the prison system where two-thirds of facilities are still operating at over their 100 per cent capacity, despite the recent prisoner releases. Limited space,

availability of sanitation and hygienic materials, as well the absence of regular medical examinations make prevention a challenge. Some officials have raised concern about many prisoners already having underlying health conditions which make them further vulnerable to the virus. Female prisoners and their accompanying children face further challenges, including insufficient post-release support.

**Existing legal and policy frameworks**

Ownership of identity documents is a key determinant of people's ability to access the limited government services that do exist. It is estimated that 90 per cent of men and only 38 per cent of women have a Tazkera, or ID card.[12] While limited access to essential services affects everyone, IDPs and returnees (particularly female IDPs) are especially disenfranchised due to either their loss or lack of appropriate civil documentation. Refugees also face legal challenges when it comes to accessing government services. The ability to support people through these legal challenges will be limited during the pandemic due to disruptions to the legal system. An estimated 2.2 million returnees and IDPs[13] also are living at constant risk from insecure land tenure and the threat of eviction from the private land on which informal settlements have been established around the country. The risk of eviction is likely to increase during the COVID-19 crisis as people struggle to earn the income they need to pay their rent.

Enforcement of legislation meant to protect women from violence remains a challenge. Women's access to justice is limited and women still face inequality before the law. Complex bureaucracy makes it difficult for vulnerable people, particularly those with disabilities, to access government services. These challenges have been further heightened as government facilities and many courts are closed or have greatly reduced working hours due to COVID-19. Despite efforts to improve governance through the adoption of a new anti-corruption law in 2017 and the planned establishment of the Independent Anti-Corruption Commission, Afghanistan continues to rank poorly (172 out of 180 countries) on the global corruption perception index.[14]

The complex petition system implemented by the Government to verify IDPs over recent years was time consuming and had been causing significant delays in the delivery of assistance. After several years of negotiations by OCHA on behalf of the humanitarian community, the Government and the Humanitarian Coordinator signed new Standard Operating Procedures (SOPs) in May 2019. The new SOPs confirm that the petition system is no longer the primary entry point for IDPs to receive humanitarian assistance, making the process of verifying and responding to displacement more efficient and flexible.

**Environmental profile – natural disaster risk**

Conflict remains the main driver of displacement, although natural hazards (both slow and sudden onset) also contribute to population movements and humanitarian needs. Afghanistan is highly prone to natural hazards, the frequency and intensity of which are exacerbated by climate change's effects. Afghanistan has an INFORM Risk Index[15] of 8 – the fifth highest risk country out of 191 profiled. At the same time, the Notre Dame Global Adaptation Index[16] ranks it as one of the least prepared countries against climatic shocks. Drought was a major driver of humanitarian need over the past two years, and recent food security assessments have confirmed that hunger and malnutrition remain disturbingly high with approximately 12.4 million people, or one-third of the population, projected to be in 'crisis' and at 'emergency' levels of food insecurity between June and November 2020.

The country remains highly susceptible to the risk of earthquakes with potentially catastrophic consequences if a major tremor occurred near a population centre. Each year, freezing winter temperatures, especially in high altitude locations and areas of concentrated displacement, drive needs because a large proportion of shelters do not protect against the cold and many people are unable to afford heating, even in a normal year. In 2020, the school year may also extend into winter to allow catch-up classes for those missed during COVID-19 lockdowns. This will mean additional resources to keep children warm at school.

Part 1

# Strategic Response Priorities

**JALALABAD, EASTERN AFGHANISTAN**

*November 2019. Children outside a Jalalabad trauma centre, which operates with the support of the Afghanistan Humanitarian Fund. Photo: OCHA*

# 1.1 Response Analysis

**Multi-year planning and approach**

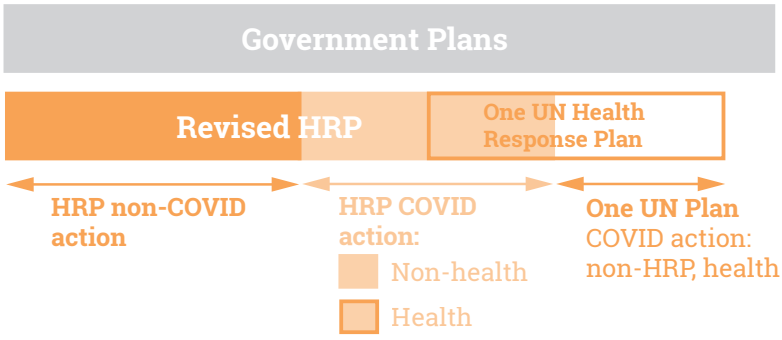
A mid-term stock-take of the multi-year HRP towards the end of 2019 confirmed that the trajectory of needs and the corresponding response did not align with projections that originally had been framed during more predictable times at the end of 2017. The mid-term assessment also indicated that the cumulative impact of decades of war took a more severe toll than originally anticipated, with people exhibiting signs of worsening coping capacities despite years of humanitarian support. The impact of the COVID-19 outbreak in Afghanistan has necessitated a further reorientation of response priorities and approaches. Initial support to the Government's efforts in fighting the virus includes investing heavily in community engagement to support awareness raising and sensitisation on COVID-19 prevention and resources to supplement government-led surveillance, tracing and treatment. Recognising that the pandemic will require a longer-term response, and aligning with the Global HRP, COVID-19 response approaches have now been fully integrated into the broader Afghanistan HRP for 2020. This revision echoes the emergency elements of the Government's health planning and ensures that these efforts are fully aligned and complementary. As a result, while the majority of needs identified at the end of last year remain in this revision, some of the priorities established may no longer be relevant or have been rescheduled in light of urgent needs now facing the country. The activities and requirements outlined in the revised HRP will be fully reflected in the next edition of the Global HRP and on the Financial Tracking Service, while partners will regularly monitor responses against the new priorities through ReportHub.

The revised HRP recognises that the country's limited emotional and financial resilience to disaster and conflict (noted at the beginning of the year), has been further eroded or altogether depleted by the COVID-19 pandemic and the measures put in place to limit its spread. Increasing numbers of people are now unable to survive or recover without assistance. The HCT's decision in late 2019 to broaden the parameters for humanitarian action in Afghanistan to be more inclusive of those with severe vulnerabilities is reinforced in the current context. In preparing this revision, clusters conducted a review of their strategies and capacities through a COVID-19 lens. For some clusters, this has resulted in the temporary scale back of activities that had originally been prioritised for 2020, the development of new programming to respond to emerging urgent needs, expansion of the volume of assistance to people already receiving assistance and/or the development of alternative methods of assistance delivery. Recognising that there is significant overlap in needs within each population group to be assisted, in this revision clusters have structured their requirements to reflect COVID-19-specific activities and those that are ongoing responses. Thus, within the $1.1 billion ask, $396 million (35 per cent) is for COVID-19-specific activities; $735 million (65 per cent) is for non-COVID-19 activities. The revised HRP will be monitored against an updated logframe which further delineates COVID-19 and non-COVID-19 activities and will support transparent FTS reporting.

Given the dynamic nature of the context, 2021 projected figures for both people in need and planned reach have not been updated in this revision and remain at 9 million and 6.6 million people respectively. Given the unprecedented nature of the situation, forecasts for 2021 will be revisited when more information is known. These numbers will most likely be substantially higher than originally forecast.

**Planning parameters, assumptions and possible risks**

Planning for 2020 is based on a common outlook that considers the widespread impact of COVID-19, an updated IPC analysis indicating worrying food insecurity, and a security outlook that anticipates continued political uncertainty. Planning also acknowledges that the current situation is volatile due to political instability, uncertainty around the future of the US-Taliban peace agreement negotiated in late February 2020, potential intra-Afghan talks and fragmentation of the conflict. Thus, it remains possible that the situation could spiral due to a range of factors, including escalation in the number of COVID-19 cases, impact from regional and global responses to the pandemic (including but not limited to global supply shortages, border closures, economic downturn) and the withdrawal of international military forces. Alternatively, an intra-Afghan peace agreement could reduce



hostilities and improve humanitarian access to people in hard-to-reach areas. In this event, there may be a much greater demand for humanitarian action and funding to respond in new locations, including activities that bridge to development assistance. In preparation for that possibility, the humanitarian community developed an integrated response plan for a reduction in hostilities in 2019 identifying priority areas where access was previously limited and where there are willing responders and likely needs. This will need to be updated to reflect the COVID-19 landscape. Given these uncertainties, regular monitoring of needs and response will remain critical throughout the year.

Activities for 2020 have been revised with an initial focus on areas most directly affected by COVID-19, including but not limited to border areas. Beyond the pandemic, clusters have used the HNO analysis to prioritise specific areas of the country with the highest sectoral needs and vulnerabilities. Based on an analysis of sectoral needs, severity and scale, as well as overlapping inter-sectoral needs, clusters have designed responses that are tailored to the needs expressed by affected people, while factoring-in the availability of partners in each location and the access challenges they face (See cluster pages for more details of geographical prioritisation).

Given that Afghanistan is in the middle of a multi-year HRP, the HCT has opted not to adopt all elements of the new global Humanitarian Programme Cycle (HPC) approach introduced in late 2019 for the HNO and HRP for 2020. Instead, a hybrid approach has been used reflecting the spirit of the new analysis in the narrative, while still aligning with the structure and broader goals of the ongoing multi-year HRP. For the first time, HNO 2020 presents a new way of framing the primary humanitarian needs facing the people of Afghanistan on the basis of four humanitarian consequences of the crisis. This new approach promotes collective thematic action and supports inter-agency cooperation around commonly agreed critical problems. It is hoped that this model, which is reflected in the HNO and HRP and is aligned with new global standards, will help deliver more integrated responses in 2020.

**Population groups**

The revised definition of humanitarian action adopted in late 2019 required changes to the population groups prioritised in the HRP. The scope of these groups has been further tweaked in this revision to accommodate COVID-19 needs. Some people who in the past largely fell outside humanitarian planning categories but who still needed life-saving support and protection, are now in the list of populations of concern for 2020. There also has been a substantial effort to move away from status-based language in the expression of displacement in the HNO. The list of population groups has been fine-tuned to five core categories:

- People displaced in 2020;
- People affected by shocks in 2020;
- Returnees in 2020;
- Refugees living in Afghanistan;
- Acutely vulnerable people with humanitarian needs.

A key change is that the category for acutely vulnerable people with humanitarian needs will now include all 12.4 million people living in IPC phase 3 (crisis) and 4 (emergency). This expansion is based on updated analysis revealing persistently high levels of food insecurity, the likely longer-term impact of COVID-19 on the economy and people's ability to recover, even after the harvest season. Heightened humanitarian needs from, and vulnerabilities to, the pandemic also require the inclusion of those who are expected to become seriously ill and are likely to need hospitalisation due to the virus (300,000 people, 80,000 of whom may die), as well as some people in prisons and other detention facilities who require specific WASH support due to the pandemic.

**A new way of working**

Even before COVID-19's arrival, the growing global price tag of humanitarian appeals was outstripping available funding. It is more urgent than ever that all actors – humanitarian, development and peace – come together and work in a systematically cohesive manner to invest in the resilience of communities, reducing their reliance on costly short-term and unsustainable assistance and facilitating a more dignified existence. The COVID-19 crisis makes the case for a new way of working not only more compelling, but also more urgent.

In spite of the vast amount of aid money that has been spent in Afghanistan, key development indicators are stagnating or reversing. Current resources are simply too meagre for the scale of action required for positive life-changing programming to benefit the majority of people who need it, at least through the current approach. While there have been numerous discussions at the global and local levels about joined-up humanitarian-development programming, the operational reality has shown significant gaps. The 2019 Peer-2-Peer mission to Afghanistan highlighted how humanitarian and development needs frequently exist side-by-side and are mutually reinforcing. The mission emphasised that the capacities and resources of the humanitarian and development community (and peacebuilding organisations where feasible) need to be better leveraged to respond comprehensively to immediate chronic needs, and work on longer-term solutions to crises.

The 2018-19 drought response clearly demonstrated the current challenges in ensuring that both the humanitarian and development needs of shock-affected people are met. Few, if any, pathways to sustainable assistance were available to displaced people in the west once humanitarian assistance had phased down at the end of June 2019. No comprehensive mapping was available to visualise what development assets and responses were available in affected areas. Additionally, development actors were insufficiently engaged in local

**Peer-2-Peer mission**

In March and April 2019, Afghanistan hosted a Peer-2-Peer mission that reflected on whether the existing coordination arrangements were fit-for-purpose. The team made 73 recommendations, of which the HCT prioritised 10 for urgent action before the end of 2019. The prioritised Peer-2-Peer recommendations are aligned with the commitments made under a newly developed HCT Compact. The HCT has been diligent in regularly reporting on its activities towards the recommendations, ensuring that agencies responsible for leading on prioritised issues are held accountable. The HCT has found the Peer-2-Peer recommendations to be extremely useful for strengthening the humanitarian system in Afghanistan and has built strong momentum on implementation in the year since the mission. The Peer-2-Peer team has praised the extensive progress made in such a short period. Implementation of the recommendations will continue in 2020.

**Key achievements**

- HCT Compact: A new HCT Compact with 12 priority areas of commitment has been developed and is being implemented.
- Alignment between ICCT and HCT agendas: A series of joint ICCT-HCT meetings has been held in 2019 and 2020 featuring fruitful discussions about humanitarian strategy in Afghanistan and supporting development of the HNO and HRP, as well as this revision. Regular ICCT reports are now provided to the HCT, while HCT discussions and taskings are systematically reflected on the operational ICCT agenda.
- HCT cluster presentations: A calendar is in place that sets out a regular programme of Cluster presentations to the HCT throughout the year. OCHA has been working with Clusters and technical experts to improve the strategic direction of these presentations and has produced a guidance note to ensure they are useful in HCT decision-making.
- Protection and cross-cutting issues: As part of the HCT calendar, a short thematic update on one of five cross-cutting workstreams (Accountability to Affected Populations (AAP), Gender-Based Violence (GBV), Gender, Protection, and Protection from Sexual Exploitation and Abuse (PSEA) is being made every week.
- Sub-national coordination: A Mutual Accountability Framework has been developed to set minimum expectations and agreed priorities for improvement.
- ICCT field missions: The ICCT is now conducting quarterly field missions and has visited Balkh, Kunar and Nangahar provinces since the Peer-2-Peer mission took place. Large group field missions may not be possible in 2020 as a result of COVID-19, but cluster coordinators are individually being encouraged to get to the field as often as possible to engage with operational counterparts.
- PSEA Taskforce: A rejuvenated PSEA taskforce is now meeting regularly, co-chaired by UNHCR and IRC, with a coordinator also based at WFP. Mapping of the current PSEA architecture and landscape is complete, and an action plan is being implemented.
- IDP SOPs: After years of negotiations, the Government and the Humanitarian Coordinator signed new SOPs in May 2019.
- HCT Key Messages: These are now produced regularly and have helped cement common advocacy priorities for the HCT.

planning processes to quickly connect individuals to their support where it did exist. The absence of such pathways has resulted in prolonged humanitarian needs among vulnerable people.

Even before COVID-19, 2020 had already been shaping up as a landmark year in turning this situation around. At the operational level, the ICCT held a technical workshop in the first quarter of 2020 aimed at engaging better with counterparts working on development planning and implementation. This helped start a tangible, operational dialogue and laid the foundations for better coordination of response in areas where both humanitarian and development actors are active.

The ICCT also has engaged development actors in planning for new, integrated Area-Based Response pilots aimed at improving the quality of assistance by breaking down sectoral silos and applying a more people-centred approach to service delivery. The World Bank and UNDP continue to be observers at the HCT to encourage common situational awareness and sharing of best practices. Furthermore, the revised scope of humanitarian action for 2020 will see more investment from the humanitarian side on a modest range of costlier activities supporting transitional and durable solutions across sectors. The inclusion of these more sustainable activities is expected to reduce the cost of humanitarian assistance in the medium- and

long-run, build resilience and provide new bridges to development support. This approach is underpinned by the 'UN Common Guidance on Helping Build Resilient Societies',[17] which strongly promotes risk-informed programming and risk management, especially for prevention and recovery.

Aspirations for more refined humanitarian-development thinking have really come to the fore with the arrival of the COVID-19 which has made urgent the need for common needs analysis, aligned programme design and complementary delivery of assistance. Humanitarian and development actors are collaborating on an integrated and holistic response to COVID-19. The UN country and humanitarian teams have developed collaborative programming corresponding to the Government's plan 'Responding to the Corona Virus: An Invitation for Discussion', as well as the 'United Nations Framework for the Immediate Socio-Economic Response to COVID-19'. The thematic working groups on the development side and the clusters/sectors on the humanitarian side have been meeting regularly throughout their respective planning processes to ensure alignment of the response. The humanitarian community has been working closely with the World Bank, which is planning a comprehensive emergency social safety net response to the crisis (see box text pg 22) and leads agencies on the post-COVID-19 development process in support of the Government. A specific outcome of this improved collaboration across humanitarian and development work has been the articulation of a number of people in need of an 'Emergency Social Safety Net' response in Afghanistan (35 million people) as a result of COVID-19. It is hoped that this initial work will be further built on for 2021 to provide greater analysis and a more coherent response to needs across humanitarian and development workstreams (see People in Need, pg 13 for more details).

**World Bank Response to COVID-19 in Afghanistan**

Afghanistan is facing an unprecedented health and economic crisis driven by COVID-19. To support the Government's plan, 'Responding to the Corona Virus', the World Bank is developing a package of immediate relief measures and preparing for recovery so that Afghanistan can reignite its economy, generate much-needed, short-term employment, and build its resilience to shocks in the longer term. This work has been developed in collaboration with humanitarian actors to maximise coverage and ensure people get the right assistance, at the right time, based on their needs.

In 2020, existing funds and activities are being reprogrammed to assist vulnerable households to meet their needs during the relief phase of the COVID-19 outbreak. This includes leveraging the existing Citizens' Charter project to provide food (or cash) support to rural communities using partners for delivery. This support would be extended to other rural areas, where possible, through a proposed emergency operation (Relief Effort to Afghan Communities and Households, REACH). The World Bank is also exploring how the REACH operation can deliver basic food or cash baskets in urban areas (including Kabul) through similar community platforms. In urban areas, two tranches of support would be provided, with plans for the second round to be delivered through mobile/digital money transfers to the extent possible.

In the recovery phase, the Early Warning, Early Finance, Early Action (ENETAWF) operation will establish a system to provide routine support to 500,000 of the most chronically and seasonally food- and nutrition-insecure households in 78 drought-prone districts across Afghanistan. It is envisaged that this programme will also support the same communities to cope with the shock of COVID-19. To increase community resilience, seasonal support will be provided through cash-for-work programmes and/or other activities that improve resilience, for example by strengthening agriculture productivity or water management in communities. The project will also provide unconditional cash transfers to chronically food insecure households in which there are no able-bodied people who can participate in the cash-for-work programme. The risk of malnutrition will be reduced through nutrition support to food insecure households with pregnant women and infants up to two years old. Additionally, a risk-based financing facility, connected to a drought early warning system, will enable pre-agreed financing to be released in anticipation of action plans that support the most vulnerable in the event of a drought. This would allow the social support system to expand horizontally and vertically.

An emergency food and water supply response project also is being considered that would cover support for: irrigated agricultural productivity for improved resilience; dryland farming and watershed management; seed production and distribution; food security-critical commercial supply/value chains impacted by COVID-19 and other shocks; and support to the implementation of emergency response and recovery plan; priority water supply facilities in selected locations; and developing a hygiene and handwashing campaign with a focus on vulnerable public spaces. This would be complemented by a broader private sector effort focused on market re-engagement and recovery. Grants would be provided to help enterprises engaged in critical food supply chains and important service sectors to retrofit and retool their operations to address COVID-19 constraints.

These measures form part of a broader package of support that includes a COVID-19 Emergency Response and Health Systems Preparedness Project ($100.4 million) approved by the Bank's Board in April 2020; budget support through planned and forthcoming emergency relief operations; and support for urban and rural livelihoods through cash-for-work programmes and support to informal and small shops and firms, as well as to small and medium enterprises in urban areas.

1.2

# Response Priorities by Strategic Objective

## Strategic Objective 1: "Lives are saved in the areas of highest need"

- Addressing Critical Problems Related to Physical and Mental Well-being
- Addressing Critical Problems Related to Living Standards

**Preventing the spread and responding to COVID-19**

With a fragile health system, a developing economy and underlying vulnerabilities driven by decades of political and social turmoil, the people of Afghanistan are facing extreme consequences from the COVID-19 pandemic. A fragile health system, limited access to water and sanitation, widespread food insecurity and high rates of malnutrition are all additional complicating factors for Afghanistan. Preventing and responding to the COVID-19 pandemic has been woven into all cluster and sector approaches for 2020, necessitating a reorientation of priorities, operational modalities and coordination structures. While humanitarian actors will continue to deliver core life-saving programming in response to ongoing conflict and natural disaster, additional focus on strengthening access to critical health services, supplementing WASH programming to improve hygiene, and responding to the multi-sectoral impact of the pandemic will be required throughout 2020.

**Safeguarding civilian safety and preventing disability**

Deteriorating and widening insecurity continues to expose increasing numbers of people to life-threatening harm and injury, undermining their physical and mental well-being. For the final two years of the multi-year HRP, partners will continue to provide immediate and effective assistance that prevents loss of life and alleviates human suffering. After four decades of war, Afghanistan is littered with explosive ordnance that poses daily threats to the safety of civilians, especially children and those returning or displaced to areas where they are not aware of local risks. In a bid to reduce these dangers, Mine Action partners will conduct survey, clearance and disposal activities in high risk areas. In 2020, Mine Action partners will also scale up Mine Risk Education to cover the increased numbers of returnees from Iran.

**Addressing acute food insecurity and malnutrition**

In 2020, efforts will be made to scale up operations to respond to food insecurity and avert extreme hunger and acute malnutrition. Food Security partners will aim to reach 9.8 million people with food and livelihood assistance, including support for vulnerable people whose needs have been aggravated by the COVID-19 pandemic and who may feel forced to engage in negative coping strategies. The response will focus on urban and rural areas, reaching the majority of those identified to be in 'crisis' and 'emergency' levels of food insecurity (IPC 3 and 4) throughout the year, although with different volumes of assistance. The anticipated respite resulting from the upcoming harvest season is expected to be offset by the spike in staple food prices (which have stayed at elevated levels since mid-March) and a decline in economic activity related to movement restrictions. These restrictions are severely affecting small traders and casual labourers in urban areas. Many people are expected to resort to negative coping strategies, including diminishing their household dietary diversity by shifting to cheaper foods (with less nutritional value); selling assets; and moving to seek employment opportunities. FSAC will, therefore, have a specialised focus on the urban poor who are or were in vulnerable employment.

The overall cost-per-person of the food security response is lower due to the different volumes of assistance being provided to some groups. However, the cost-per-person to deliver food and livelihood assistance is anticipated to increase due primarily to a spike in transportation costs linked to the cross-border disinfection, cross-docking and the additional administrative burden for food trucks coming from Pakistan. FSAC partners are carefully monitoring the increase in prices of staple and high value foods such as fruits. There are plans to re-evaluate the food basket price in June as the impacts from the intermittent border openings and the domestic production become clearer.

The nutritional status of children under five continues to deteriorate in most parts of Afghanistan. The Nutrition Cluster response will continue its focus on core nutrition services – treatment of severe acute malnutrition (SAM) for 'inpatient' and 'outpatient' care; treatment of moderate acute malnutrition (MAM) including blanket supplementary feeding, therapeutic supplementary feeding and micronutrient supplementation; infant and young child feeding

(IYCF) and counselling services. To mitigate against disruptions to ongoing assistance, the Cluster will revisit its delivery modality with an increased focus on Mobile Health and Nutrition Teams (MHNTs) to ensure nutrition services reach those who are unable or unwilling to access health centres due to COVID-related movement restrictions or fear of approaching health facilities. Geographic prioritisation for deployment of MHNTs will consider areas where nutrition services already have been affected by changes in health-seeking behavior and where 'inpatient' SAM treatment has been reduced. The cost of running mobile services is higher than delivering assistance through static facilities. The Cluster also plans to increase its investment in the preventative component of the nutrition response and provide transportation costs – through cash or voucher assistance – for vulnerable families travelling to seek 'inpatient' SAM care. This is a new approach for the Nutrition Cluster.

**Expanding life-saving services for physical and mental health care**

The Health Cluster continues to respond to people's immediate health needs by ensuring access to critical life-saving assistance for all population group. In 2020, the Health Cluster will scale-up both non-COVID and COVID health services and aim to use COVID-19 as an entry point for deeper access into hard-to-reach areas. In direct response to the pandemic, the Cluster will support the Government on screening at border points, surveillance, testing laboratories, establishment of isolation wards and intensive care units (ICUs), and extensive risk communication and community engagement. This will reach a new population group of those expected to require hospitalisation due to the pandemic.

Ensuring basic health services remains challenging in the face of the pandemic and widespread conflict. About one-third of the population (mostly those living in hard-to-reach areas) does not have access to a functional health centre within two hours of their home. To expand its reach, particularly in hard-to-access and NSAG-controlled areas, the Cluster aims to deploy more well-equipped Mobile Health Teams (MHTs) and pre-position medicine and supplies. This will not only extend COVID-19-related health care, but also mitigate disruptions to health services.

Health partners will also focus on expanding services through community-level health facilities (as opposed to hospitals), which will require providing specialised training and equipment to these locations. This will allow people to receive care closer to home and allay fears around the need to travel to receive basic health care. Disease surveillance campaigns will continue and MHTs will be augmented to include an additional vaccination component. The Health Cluster will support the Protection Cluster and channel Mental Health and Psychosocial Support (MHPSS) support through health services to meet increased need. The Cluster will link its COVID-19 activities with the polio eradication programme, which was paused due to physical distancing requirements. The linkage will provide additional resources to support COVID-19 surveillance, contact tracing and community awareness. As a result of the pandemic, a nation-wide polio vaccination programme, planned to reach 9.9 million children, has been suspended. This is particularly concerning as 11 cases of polio were reported since the start of the year, mostly in areas controlled by NSAGs and where house-to-house vaccination campaigns have been banned since May 2018.

The provision of trauma care continues to be a focus of the health response, particularly through first aid trauma posts that have been extended to areas most heavily affected by fighting. These have shown tremendous capacity to keep people alive who previously would have succumbed to their injuries or survived with life-altering disabilities that require added support.

**Extending access to sanitation, clean water and safe shelter**

Conflict and disaster are drivers of poor access to basic WASH services in communities across the country, including for those who are displaced. Lack of access to these services directly impacts the health of the most vulnerable people in communities, particularly young children. According to the 2019 Whole of Afghanistan Assessment (WoA), 39 per cent of shock-affected households had at least one child exposed to a diarrheal disease in two weeks preceding data collection.[18] In order to respond to COVID-19 hygiene needs, prevent additional disease outbreaks and improve quality of life, the provision of clean water and safe sanitation near people's homes remain priority activities for the WASH Cluster in 2020. In direct response to the pandemic, the Cluster will increase its provision of WASH infrastructure in approximately 94 priority health centres, isolation wards and other facilities. To ensure flexibility and rapid response, the Cluster plans to utilise mobile WASH teams that can deploy quickly and install mobile handwashing devices in areas where there is a sudden influx of people or a concentration of COVID-19 cases. These teams will provide rapid water treatment in health and nutrition centres. The Cluster will continue to provide sustainable WASH services, particularly in hard-to-reach areas. The WASH Cluster will now include prisoner populations in its activities in response to the intensified COVID-19 risks that people in detention face.

Emergency Shelter and Non-Food Items (ES-NFI) Cluster partners are responding to the pandemic. Partners will strive to continue ensuring that people impacted by new crises can get emergency or transitional shelter and relief items that ensure their privacy and dignity, and

that minimise protection and health risks, including COVID-19. The Cluster will expand its rental support to people with insecure tenure in informal settlements and will provide shelter extension kits in IDP sites and informal settlements to promote isolation and curb COVID-19 transmission. Also, as a virus mitigation measure, the Cluster plans to provide more non-food items to families to discourage sharing within households. The ES-NFI Cluster will work with other sectors to utilise prefabricated housing units as potential isolation places in IDP sites; storage spaces for pre-positioned stocks; additional space for health and nutrition activities; locations where psychosocial support is provided and information dissemination spaces.

Winterisation assistance to ensure the survival of vulnerable people and those living in high altitude areas will be enhanced in 2020-2021 in view of people's eroded coping capacities due to COVID-19. Together with the Education in Emergencies Working Group (EiEWG), the ES-NFI Cluster will develop an enhanced 2020-2021 Joint Winterisation Strategy. The Cluster will focus on household winterisation needs and has provided technical guidance to the EiEWG to plan for school winterisation should the school year be extended into colder months for catch-up classes.

**Enhancing coordination**

A range of enhancements designed to improve the quality and timeliness of life-saving services were proposed as part of an overhaul of coordination arrangements in 2020. In line with the recommendations of the 2019 Peer-2-Peer mission, these included: the implementation of a new Mutual Accountability Framework between Kabul and the field with clarified reporting lines and increased support for management of cross-cutting issues in the response; the development of a new Data Accountability Protocol; further improvements to and training on the new IDP SOPs implemented jointly with the Government in 2019; a scale-up of cash capacity and safe cash use; enhanced Civil-Military Coordination capacity in the field; and the roll-out of newly approved Joint Operating Principles through the Humanitarian Access Group. Some of these will be paused until 2021 given the current focus on the COVID-19 response and others still will be delivered but on a longer timeline. The ICCT will continue developing thematic preparedness plans for a range of emergencies (COVID-19, flooding and earthquakes). The ICCT began holding a series of capacity-building workshops planned for 2020 although some of those scheduled will be delayed until later in the year.

Actions completed so far in 2020 include:

- Multiple trainings – carried out both in person and online by the CashCap – to build cash capacity and support the safe use of cash;
- Two ICCT capacity-building workshops on monitoring and reporting, as well as operational engagement with development actors;
- An after-action review was held to reflect on the 2019 HNO/HRP process and a reflection exercise was conducted to examine the effectiveness of the existing HCT Protection Strategy. The latter has resulted in agreement that the strategy would be revised to reflect the new HCT Compact, under the leadership of the new ProCap;
- The publication in March of the three-month Multi-Sector Humanitarian Country Plan for COVID-19 to kick-start fundraising and coordinate the response. The quick release of AHF support against this plan has facilitated early action;
- The development of multiple training modules tailored for different audiences to roll out the Joint Operating Principles through the HAG;
- Establishment of a Logistics Working Group and a COVID-19 Gender in Humanitarian Action Working Group;
- Establishment of an UNHAS airbridge from Kabul to Doha.

While it may not be possible to complete all of the activities planned for 2020 due to the shift in focus towards COVID-19, a number of these focus areas have organically received attention as a result of the unprecedented situation brought on by the pandemic. Most notably, this includes increased communication and coordination with development actors, both in the development of a common needs analysis and articulation of the number of people in need of an 'emergency social safety net'. It is hoped that this joined-up planning approach will result in complementary programming that ensures no one is left behind.

# Strategic Objective 2: "Protection violations are reduced and respect for International Humanitarian Law is increased"

- Addressing Critical Problems Related to Protection
- Addressing Critical Problems Related to Physical and Mental Well-being

**Managing escalated protection risks due to COVID-19**

Conflict, poverty and repeated natural disasters have left an acutely vulnerable population with eroded emotional and financial capacity to cope with the unfolding COVID-19 crisis and the added protection risks it is causing. To respond to COVID-19-driven challenges, including more incidents of Sexual and Gender-Based Violence, protection partners will work to maintain core services, utilising more mobile teams to ensure broad reach within communities despite movement restrictions. The Protection Cluster will enhance protection monitoring, including by incorporating additional COVID-19-specific indicators, and will continue to provide psychosocial support and targeted assistance (including cash) to vulnerable community members who are struggling during the pandemic. Protection partners will respond to a rise in child protection concerns by expanding support for family tracing, reunification and psychosocial assistance, and by providing logistical and capacity support to caregivers.

**Mitigating attacks on education and health**

Evolving conflict and continued violations of International Humanitarian Law (IHL) have contributed to an alarming protection crisis affecting all people. Amid a culture of disrespect for IHL, attacks on health and education facilities continue to be commonplace. School children, along with sick and injured people, are paying a heavy price for these disruptions which have continued, even during the COVID crisis.[19] The 12 May 2020 attack on mothers, newborns, and healthcare staff at Sad Bistar Hospital in Kabul is an extreme but relevant example of the disregard showed for IHL and human life. While this attack is particularly heinous, deliberate assaults on health care in Afghanistan have increased overall since 2017; 18 incidents impacting healthcare personnel and facilities were recorded in the first quarter of 2020 alone.[20] In 2020, the Health Cluster will join with education colleagues to enhance monitoring of these violations. At the same time, these Clusters will work to strengthen advocacy to prevent such attacks.

**Reducing adoption of negative coping mechanisms**

Almost 40 million people face a pandemic-inspired economic lockdown that severely limits their access to employment and worsens pre-existing cycles of debt. Rising prices and job losses in the informal economy are leaving many families, especially in urban areas, in deeper crisis. In rural areas, any interruptions to the harvest season in June and July may have catastrophic consequences for incomes and food availability. Harmful traditional practices and coping strategies such as early and forced marriages, indebtedness, child labour and begging, as well as lack of access to basic health, psychosocial and legal services, make life for people even more fragile. In 2020, humanitarian actors will continue to deliver needs-based assistance that reduces reliance on negative-coping mechanisms, promoting the safety and dignity of the people they serve.

Key to identifying and supporting those most at-risk in 2020 is protection monitoring and risk analysis. This analysis will inform the protection response, including referrals and evidence-based advocacy. Cash assistance will be provided to families most at risk of using harmful practices to cope with COVID-19's impact. Protection responses will continue to be tailored to vulnerable people with specific needs such as people with disabilities. Community engagement will also be strengthened on child protection issues related to COVID-19 as well as on protecting children from violence, abuse, exploitation and neglect.

**Gender-sensitive response planning**

While the prevalence of GBV in Afghanistan is even more difficult to accurately quantify during the lockdown period, programme and anecdotal evidence suggests that GBV is widespread and growing, particularly during the pandemic. The HRP outlines plans for the provision of legal, safety, health and psychosocial assistance for at-risk IDP, returnee and non-displaced GBV survivors through a multi-sector approach. Community dialogues focusing on men and boys, including community and religious leaders, are also a key means through which culture change on GBV will be promoted. The distribution of dignity kits to women and girls – particularly those who are displaced – will continue. In designing their programmes, response approaches and targeting, clusters have paid particular attention to the unique vulnerabilities of children[21] and women. Vulnerabilities include more female-headed households struggling due to the loss of breadwinners from violence and now COVID-19; as well as the social and cultural norms that limit women's access to government and humanitarian services, particularly health care.

**Accountability to Affected Populations (AAP)**

In 2020, the HRP emphasises a rights-based approach to activities in response to the sheer scale of the protection crisis facing the country and will continue to prioritise mainstreaming protection throughout all programming with additional assistance from the

newly arrived ProCap. Improving accountability to affected people will be heavily emphasised including through a scale-up of resources to boost capacity, reintroduce the former Community Engagement Working Group as the Accountability to Affected Populations Working Group and support expansion of community engagement by all cluster partners. Strengthening community engagement, improving awareness of COVID-19 prevention and response through two-way communication, and tracking and correcting rumours are central priorities for the response to the COVID-19 pandemic. This urgent task will require a whole-of-community effort and be supported through dedicated and integrated outreach in 2020. Four integrated Area-Based Response pilots started in the first quarter of 2020 and will also support a more intense field-level focus on AAP issues. Continued support for the Awaaz Afghanistan inter-agency telephone feedback mechanism is critical to monitoring the views, complaints and preferences of affected people alongside regular multi-sector needs assessments such as the Whole of Afghanistan (WoA) Assessment, community perception surveys, and individual agency feedback mechanisms. The revitalised PSEA Task Force will also continue its work on system-wide improvements to awareness and referral processes in the humanitarian response. (See AAP-PSEA Section, pg 45.)

# Strategic Objective 3: "Vulnerable people are supported to build their resilience"

- Addressing Critical Problems Related to Living Standards
- Addressing Critical Problems Related to Resilience and Recovery

**Strengthening fragile health systems amid war and COVID-19; supporting people with disability**

In light of the pandemic, the health response in 2020 will be accelerated, including system-strengthening for health services in areas facing a heavy humanitarian burden and expanding health access to underserved and hard-to-reach communities. Health partners will also specifically focus on better equipping health facilities and building the capacity of health personnel. They will work with the WASH Cluster to improve availability of water and sanitation facilities and hygiene options in top-priority health facilities. Efforts also include ensuring nutrition treatment facilities are fit-for-purpose in the face of COVID-19 and have adequate space between beds to minimise the risk of virus transmission.

**Livelihood support to people affected by COVID-19 and enhanced linkages with development actors**

Threats to living conditions, including access to affordable food, are another consequence of the COVID-19 pandemic. Market monitoring reports indicate that due to initial panic buying in major cities, limited movement of commercial goods across borders, and opportunism among some retailers, prices for key commodities have sharply increased while the purchasing power of millions has plummeted. In response, humanitarian partners will continue to deliver programming which aims to meet livelihood needs, including by maintaining and advocating to expand a range of asset-creation activities. These asset-creation programmes are expected to extend income-generation opportunities and allow vulnerable households to maintain self-reliance and earn a living. Anticipatory development funding and action, including through an emergency social safety net response, (see PiN section pg 13) are critical to avoiding preventable suffering and a more expensive humanitarian response to more people in the longer-term.

**Getting vulnerable children into school**

To mitigate the spread of COVID-19, the Ministry of Education (MoE) announced the suspension of all education activities on 14 March 2020. Approximately 10 million children have had their normal schooling interrupted. This is in addition to the 3.7 million children who were already out of school prior to the pandemic. It is anticipated that schools cannot realistically re-open until September 2020 at the earliest. Education partners fear that such a prolonged absence from classes will result in loss of skills, especially in literacy and numeracy, and declining commitment to learning. Urgent action is required to ensure this does not happen.

At the start of 2020, Education partners expanded their work to support not only shock-affected children but also vulnerable children who have been severely affected by the country's protracted crisis. Partners also will support the Ministry of Education to ensure that children whose needs are aggravated in the pandemic continue to learn through alternative methodologies and extended outreach. In preparation for when schools eventually re-open, likely with an extended school year, partners will focus on education recovery work. Education partners will work closely with the WASH and ES-NFI partners to ensure schools and Community Based Education (CBE) learning spaces are safe to re-open with appropriate hygiene facilities and adequate winterisation.

Education partners will continue to invest in the resilience of the education system by supporting the recruitment, training and deployment of teachers, particularly women. The inadequate number of female teachers has had a direct impact on girls' ability to benefit from schooling. Training of School Management Shuras on the importance of education, especially for girls, is another example of the EiEWG's contribution to community resilience-building.

**Providing durable shelter solutions**

Poor shelter and unhygienic conditions, particularly in displacement, leave people vulnerable to diseases such as COVID-19, and unable to cope with Afghanistan's harsh winters. During the first two years of this multi-year plan, emergency shelter assistance was provided to displaced people within an initial period of up to three months and was predominantly oriented towards items such as tents and basic household items. While such support has been vital to saving lives, to date it has not created opportunities for recovery or facilitated displaced people's reintegration and return. Many IDPs remain in a protracted state of displacement, unable to contribute to their own recovery and continuing to require costly annual winterisation support, amongst other unaddressed needs. The ES-NFI Cluster has re-evaluated the type of response provided by partners to make it more responsive to the evolving needs of communities, especially in the face of COVID-19. The ES-NFI Cluster aims to employ a more holistic approach in 2020 and 2021, with life-saving assistance at the onset of an emergency provided alongside carefully targeted support for expanded basic services and improved living conditions via transitional shelters. Transitional shelters not only contribute to security, safety, health and well-being, but also promote recovery among displaced and non-displaced people. To address the effects of COVID-19, the Cluster will additionally expand its rental support to people with insecure tenure in informal settlements.

**Early action to avoid severe malnutrition**

In 2020, the Nutrition Cluster will continue to address the needs of vulnerable, 'borderline' cases of acute malnutrition through prevention-oriented services such as counselling on optimal care practices to mothers of children who are 'borderline' in terms of their Mid-Upper Arm Circumference (MUAC). This approach has potential to reduce the risk of rapid deterioration of the nutritional status of children with a MUAC result of 12.5-13.5 cm. To address the nutrition needs aggravated by COVID-19, Nutrition partners will expand the age group of children targeted under its blanket supplementary feeding (BSF) programme, from children six-to-23 months to children up to 5 years old. The Cluster will also expand its reach of those receiving infant and young child feeding (IYCF) assistance to include children 'at risk' of malnutrition.

**Promoting recovery and strengthening coping capacity**

Vulnerability takes on many overlapping dimensions in Afghanistan and is driven by the sub-optimal living conditions and dire financial circumstances facing communities after decades of war, repeated displacement, drought and now COVID-19. If anything, the rapid spread of COVID-19 throughout the country has provided yet another example of how poor infrastructure, overcrowded shelters and weak health systems have eroded preventative capacities and exponentially compounded and extended vulnerability. In response, aid agencies will continue to attempt to respond to these needs more comprehensively in 2020 by building resilience through the creation of income opportunities; investment in more durable infrastructure (Shelter and WASH); the strengthening of service systems (Health and Nutrition); the design of more disability and gender-inclusive programming; and by supporting people to bridge to development assistance.

To address the needs of vulnerable people who are struggling to recover, several sectors have included a modest range of resilience activities which, while more expensive in the short-term, will create savings and reduced suffering for people in the long-term. An example of these more resilience- and recovery-focused activities is pursuing more durable WASH solutions that invest in stronger water systems for communities repeatedly affected by flooding. A life-cycle cost analysis of investment in durable water schemes shows that while the immediate cost per person is higher for a small piped water scheme than a hand pump-operated borehole,[22] maintenance issues associated with these two options differ over time. In the long run, small hand pump-operated water services have a tendency to wear out more easily and require more frequent maintenance, leaving the people they serve with only intermittent access to water.

# 1.3 Cross-Cutting Response Priorities

**Centrality of protection**

Among the 14 million people in need of humanitarian assistance across the country, the most vulnerable include the rural poor; minority groups; those exposed to forced, multiple and often extended periods of displacement; returnees and refugees; children; the elderly; households headed by women; and people with disabilities. Conflict, poverty and repeated natural disasters have left these acutely vulnerable people with reduced ability to cope with the COVID-19 crisis. People with physical disabilities will face additional challenges with cities shut down and limited transport options. Movement restrictions and self-isolation are disproportionately affecting people with specific needs and vulnerabilities, especially the elderly. Pregnant women and newborn babies are also vulnerable as pre- and ante-natal care has been de-prioritised by families for fear of catching the virus at health facilities. The closure of schools has exacerbated the burden of unpaid childcare work on women and girls. Already there are reports of higher incidence of child labour and early marriage as prolonged lockdowns have economically stressed families. Women and children face unique risks in a pandemic, including greater exposure to violence, sexual exploitation and abuse, as well as separation.

The HCT remains committed to ensuring that people are at the centre of humanitarian action and that all assistance is planned and implemented in such a way that their safety, dignity, rights and preferences are upheld. The Protection Cluster continues to take the lead on centrality of protection activities in Afghanistan. Humanitarian partners will be guided in their response by more robust analysis of protection risks and human rights abuses, supported through a new protection monitoring framework that has been further adapted to include COVID-19 specific indicators. Efforts by humanitarian partners will be complemented by the HCT Protection Strategy that was endorsed in 2018, reviewed in 2019 and will again be revised in 2020. To further boost strategic planning and policy setting on protection issues, a ProCap deployment began in May 2020. Amongst other duties, the ProCap advisor will support the revision and implementation of the HCT protection strategy and ensure the strategy remains responsive to current risks and responses in line with the HCT Compact. The adviser will also work with the Protection Cluster to enhance advocacy around protection issues and elevate protection mainstreaming across the response.

The response will continue to focus on implementing approaches that include affected people in the process of identifying the protection risks they face and understanding their vulnerabilities to those risks and their coping mechanisms. Increased outreach to enhance two-way communication with communities and identify best practices for understanding and integrating community preferences has already been rolled out. However, many pre-existing protection issues faced by affected people have been exacerbated by new economic, social, physical and psychological challenges brought on by COVID-19, requiring a mix of rapid-responses and longer-term durable solutions. This necessitates a shift in programme approaches and resourcing modalities and will require enhanced coordination between different sectors and with development actors.

The COVID-19 pandemic has reinforced the importance of strong engagement with affected communities to best understand community knowledge, attitudes and perceptions around the virus and how they shape humanitarian and protection needs for an effective response. It is hoped that the reactivation of the AAP Working Group, the COVID-19-specific RCCE Working Group and planned Area-Based Response pilots in four locations (see box on page 31) will also help improve responsiveness to protection needs and accountability to crisis-affected communities.

Escalating conflict in the context of an ongoing health pandemic demands that an agile and proactive advocacy approach be adopted. Indeed, with attacks on healthcare facilities and staff now a regular occurrence and civilian casualties already close to 1,300 in the first three months of the year,[23] activities that enhance the prevention of protection violations – as opposed to merely responding to their consequences – are critical. In this regard, the HCT continues to prioritise messaging that demands respect for IHL and International Human Rights Law (IHRL), as well as providing support to specific programmes that safeguard especially vulnerable people from harm.

In line with the recommendations of the Peer-2-Peer mission (see box on page 21), presentations on one of five mandatory areas of responsibility – Protection, AAP, GBV, Gender and PSEA – are provided to the HCT each week. These protection pillars are central to a new HCT Compact developed in 2019, elevating these issues in the HCT discussions and deliberations. The revitalisation of the PSEA Task Force in 2019 and the planned transformation of the former Communication and Community Engagement Working Group into the AAP Working Group will also ensure improved accountability on protection issues. (See Accountability section on page 43)

Protection-mainstreaming continues to be a mandatory consideration in approved country-based pooled fund projects across all sectors. The Protection Cluster supports with reviews of all projects to ensure that mandatory protection elements such as avoiding causing

harm, prioritisation of safety and dignity, AAP, and participation and empowerment of affected people are sufficiently reflected in project proposals.

**Gender, age, mental health and disability-sensitive programming**

COVID-19 comes at a time when the intersection of ongoing armed conflict, lack of access to services, poor employment opportunities, limited infrastructure, increased unemployment and high gender inequality are already negatively impacting Afghanistan's economic and social stability. The COVID-19 crisis is aggravating pre-existing vulnerability to violence and further limiting access to life-saving services. Women and girls who face multiple forms of discrimination, including internally displaced women, women living in conflict-affected areas, women of ethnic minorities, older women, women living with disabilities and those living in rural and remote areas, are at particularly increased risk of experiencing violence and are less likely to receive the support they need.[24] Social norms, including expectations that women and girls are responsible for doing domestic work and taking care of sick family members – can expose women and girls to a greater risk of COVID-19. At the same time, women's ability to access healthcare is seriously diminished due to limited availability of female health workers. This may mean women are less willing or able to get tested if they have symptoms.

The disruption to livelihoods, public services and freedom of movement can also exacerbate the risk of sexual exploitation and abuse (SEA) for groups who already are vulnerable because of poverty. Scarce resources and lower access to health and legal services may result in a concentration of power that could be detrimental to people in vulnerable situations. Food shortages, induced by the COVID-19 emergency, can also increase vulnerabilities and lead to negative coping strategies, and increasing risk of SEA.[25]

Global experiences have demonstrated that where women are primarily responsible for procuring and cooking food for the family, increasing food insecurity may place them at higher risk of intimate partner and other forms of domestic violence due to heightened tensions in the household.[26] Other forms of GBV also are exacerbated in crisis contexts. For example, the economic impacts of the 2014-2016 Ebola outbreak in West Africa placed women and children at greater risk of exploitation and sexual violence.[27] Emerging evidence is beginning to show that these trends also are playing out in Afghanistan. Hotlines receiving calls from women, recent surveys carried out by OXFAM[28] and Die Johanniter[29] and reports from NGOs show that, across Afghanistan, violence against women and girls has increased during this period of COVID-19 stress. At the same time, services for survivors, including healthcare, police, justice and social services, are particularly impacted by the crisis. Life-saving care and support to GBV survivors (i.e. clinical management of rape, and mental health and psycho-social support) may be disrupted when health service providers are overburdened and pre-occupied with handling COVID-19 cases. Where services exist, many women and girls surviving violence are now often unable to seek support due to the movement restrictions, disruptions of services, and lack of opportunity to get help because of cultural constraints. Women and girls may also now be confined inside a house with their abuser. This is particularly

**Strategic use of pooled funds and local empowerment**

Pooled funding was fundamental to addressing critical humanitarian priorities across Afghanistan in 2019. Overall, the OCHA-managed Afghanistan Humanitarian Fund (AHF) and Central Emergency Response Fund (CERF) disbursed a combined total of $79.9 million, to 35 partners (6 national NGOs, 22 international NGOs and seven UN agencies) through one AHF standard allocation, four AHF reserve allocations and one CERF under-funded second round allocation. These allocations enabled 66 projects that provided life-saving humanitarian assistance to 2.9 million people. Pooled funds contributed 14 per cent ($63.9 million) funding received for the 2019 HRP ($465.1 million). The AHF continued to play an essential role in supporting the 2019 response by launching life-saving activities included in the HRP. Support through the CERF also has been critical in supplementing assistance to under-funded emergencies. Starting in 2019, AHF funds helped kick-start funding for an integrated drought response pilot in Badghis province, aimed at preventing those currently experiencing crisis and emergency levels of food insecurity from deteriorating further, and supporting early recovery and resilience-building to protect affected communities from further shocks. Significant investments have been made by the humanitarian community in 2019 to enhance engagement with national NGOs, ensuring wider coverage by, and increased sustainability of, humanitarian action.

In early 2020, the AHF provided its first Standard Allocation with $20 million to support humanitarian partners to address both cluster-specific and overall HRP priorities, including by kick-starting funding for critical COVID-19 projects tied to the three-month COVID-19 Multi-Sector Humanitarian Country Plan. Pooled funding continues to be of critical importance to implementing both the Afghanistan and Global COVID-19-related response plans. As of May 2020, the AHF has disbursed $44.5 million to support the COVID-19 response ($26.5 m) and other life-saving humanitarian assistance ($18 m); in addition, the CERF disbursed $2.4 million to enable urgently required preparedness and response activities throughout Afghanistan.

true for women and girls living in rural and remote areas where services are not available or accessible.

On top of this, while both men and women have paid a heavy price in the ongoing conflict, the costs have been borne differently. Conditions for women in and outside the home have comprehensively deteriorated as suicide attacks, recruitment of male family members into the armed forces, and economic migration abroad have deprived them of breadwinners, social support networks and in some cases, security. Households headed by women are more likely to be food insecure than male-headed households, are less able to access healthcare, and more often rely on negative coping strategies to survive, such as using unsustainable income sources, borrowing/loans, selling assets, and gifts/remittances. Men and young boys face their own unique risk profile. Men and boys make up a majority of all trauma victims and are the majority of those who have tested positive for COVID-19, potentially as a result of multiple factors including their wider movement outside the home, their increased access to health care and higher likelihood of being tested and their predominance among returnees from Iran.

People with disabilities face higher risks and challenges in society, which are further exacerbated in conflict settings and amid a pandemic when resources are limited and subject to fierce competition.[30] A recent disability survey conducted in Afghanistan by the Asia Foundation found that disability prevalence among adults was 25.6 per cent for mild disabilities, 40.4 per cent for moderate, and 13.9 per cent for severe. Amongst children, rates were lower, with only 10.6 per cent presenting with moderate or severe disabilities. While there is limited data on the impact of COVID-19 on people with disabilities in Afghanistan, global data has shown that even under normal circumstances, people with disabilities are less likely to access health care, education, employment or participate in the community. They are more likely to live in poverty, experience higher rates of violence, neglect and abuse, and are among the most marginalised in any crisis-affected community. COVID-19 has further compounded this situation, feeding on pre-existing social and economic inequalities associated with disability and threatening to exacerbate them.[31] In this regard, people with disabilities are at greater risk of contracting COVID-19, developing more severe health conditions and dying from COVID-19, facing discrimination in accessing healthcare and life-saving procedures, and being disadvantaged by the socio-economic consequences of COVID-19 and measures put in place to control it.[32]

Ensuring that humanitarian assistance is appropriately tailored to meet the distinct needs of women, men, girls and boys in a way that accommodates their physical and mental well-being will not only be critical to their immediate survival, but also their capacity to meaningfully engage with and contribute to society in

**Area-Based Response**

As a continuation to the work started in 2019 on integrated response planning, Area-Based Response pilot projects in Kunduz, Badghis, Kandahar and Kabul provinces have been initiated through funding provided by the AHF. The pilot locations were chosen to reflect different contextual settings, including areas of protracted crisis, urban areas and conflict-affected sites. The pilots apply an Area-Based Response concept that utilises a multi-stakeholder, integrated service approach through community centres and integrated mobile teams.

Two humanitarian organisations were chosen to carry out the pilots. Each organisation defined a precise spatial area within which to deliver integrated assistance that seeks to address the humanitarian and protection problems specific to each area. Planning processes and responses place a significant emphasis on community and wider stakeholder engagement and are designed to be inherently integrated across sectors in order to address needs holistically.

Key services are co-located in one community centre space so as to make them more accessible to affected people. As a hub for basic services, the community centre is also a locus for humanitarian coordination and activities that serve to ensure AAP – two-way communication, feedback mechanisms and community engagement in all phases of humanitarian programming. Due to the COVID-19 pandemic, current pilots carried out by NRC and INTERSOS have been adapted to ensure the safety of communities seeking assistance. This includes limiting the number of individuals who can access the community centre spaces at any given time to avoid overcrowding, providing staff with PPE, and ensuring that all those who enter the centres utilise handwashing stations and undergo temperature checks. The community centres have been designed with community participation and engagement at their heart and early results suggest the model's success.

Since opening in April, the Kunduz community centre has made it possible for staff to engage with over 500 IDP households, providing critical assistance and utilising the engagement to carry out COVID-19 awareness and RCCE activities. The community centre in Badghis also has seen early positive inter-sectoral results, with 1,500 IDP households reached thus far with services and critical COVID-19 information. The strong engagement with the community has made the centres a hub for verified, accurate COVID-19 information as well as a place to receive community questions and feedback, which will continually inform age- and gender-specific COVID-19 RCCE activities.

An immediate priority in the pilot locations will be to see how community engagement approaches can be integrated into existing mobile health and other outreach teams to ensure that these teams can conduct effective mobile RCCE activities to reduce the spread of COVID-19 and other highly contagious diseases.

the future. At an operational level, humanitarian action in Afghanistan will remain committed to fully integrating gender, age and disability considerations into all components of the Humanitarian Programme Cycle – from assessments to planning, as well as implementation and monitoring. Already in the first two years of the 2018-2021 HRP, partners made significant strides in collecting, using and analysing gender and age-specific data, ensuring that the gender with age marker is incorporated into the methodology and design of nationwide surveys such as the WoA Assessment. This has yielded sex and age disaggregated data (SADD) for all population groups included in the 2020 HNO, as well as critical information relating to the presence of additional key vulnerabilities within the household, such as chronically ill members or pregnant and lactating women.

HNO 2020 also contained substantial new analysis of both disability and mental health issues in Afghanistan and efforts will be made to enhance data gathering on both topics to inform the response in 2020. Needs analysis and response planning in 2020 have been conducted in line with the 2019 IASC guidelines on inclusion of persons with disabilities[33] in humanitarian action. Handicap International also provided a peer review of this year's needs analysis to ensure it fully reflects the scale and impact of disability on the Afghanistan population. Enhanced use of standardised tools such as the Washington Group Questions (WGQs) on disability in assessments will continue in 2020. The pursuit of more durable shelter and WASH solutions in the HRP from 2020 will allow for more disability-sensitive design options to be implemented.

HNO 2020 sends a clear message around the high prevalence and severe consequences of mental health issues in Afghanistan after decades of war, poverty, debt, repeated displacement and now the added stressors brought on by the uncertainty of the pandemic. The COVID-19 pandemic is a threat not just to people's physical well-being but also their mental health. Concerns about health, beloved older relatives, financial stability and feelings of helplessness are all very common emotions among all age groups. Physical distancing, self-isolation, quarantine, and working from home may trigger reactions of isolation, loneliness, and loss of social contacts for a large number of people. Extreme stressors may induce, worsen or exacerbate pre-existing mental health conditions. The application of a more mental health-aware approach to programming, assessments and analysis will remain imperative in 2020 and 2021. With one in two people suffering from psychological distress,[34] aid agencies cannot hope to make substantial progress on building resilience and promoting recovery without addressing these psychosocial issues.

In response, while scaling up its response to the COVID-19 pandemic, the Health Cluster aims to expand access to specialised services for groups with specific need in 2020, including mental health and psychosocial support (MHPSS), physical rehabilitation services and the provision of assistive devices. In 2020, the Health Cluster plans to continue its collaboration with Protection partners to ensure mental health and psychosocial support services are context-appropriate and effective. Child protection and education partners are also prioritising psychosocial first aid and case management for children.

OCHA and REACH Initiative have committed to enhancing the representation of women in the household-level quantitative surveys for the WoA Assessment in 2020. Currently the vast majority of the enumerators are men and cultural expectations mean that the male head of household is exclusively expected to answer questions on behalf of each family. While questions are asked about the needs of female household members as part of the survey, these are generally answered by men on women's behalf. Women are usually only able to answer household level surveys when they are the household head. Conscious of this bias, regular comparisons are drawn between the answers of male and female-headed households on various issues in the analysis. However, the views of females living in male-headed households still remain under-represented in the quantitative data. Moving forward, depending on movement restrictions due to COVID-19, plans are under development to hire or source sufficient female enumerators to allow for separate male and female household level interviews in enough locations to provide a representative sample in 2020. Women's views are already more thoroughly captured through the WoA Assessment focus group discussions, with at least one women-only discussion conducted in every province as part of last year's data collection.

Efforts to reach more women and girls by increasing the number of female frontline workers – such as in healthcare delivery or protection from sexual and gender-based violence (SGBV) – are also being actively pursued. Good practices from partners operating outside the HRP are currently being explored as potential models, although the limited mobility of women, particularly in rural areas, when not accompanied by a male mahram (a male relative with whom contact is permissible) means that creative solutions are required. The hiring of husband-and-wife teams is an example of such a solution. Gender imbalance in the humanitarian workforce is not only an issue at the point of aid delivery but also in coordination forums where it is critical that more women's voices (particularly those of national female staff) are heard in discussions around programme design and protection risks. Addressing this imbalance, while challenging in the current environment, remains a structural priority for 2020.

**Fit-for-purpose field capacity and coordination**

In July 2019, the HCT endorsed a new HCT Compact that set out the key commitments of HCT members towards the Humanitarian Coordinator and one another in order to reinforce collective accountability to people in need of humanitarian assistance and protection. The HCT Compact was drafted and adopted as a follow-up to the recommendations from the 2019 Peer-2-Peer mission. It details

the interrelated procedural and operational commitments to cross-cutting priorities and mandatory areas of responsibility. These include AAP, the centrality of protection, humanitarian access, GBV, gender, linking relief and development and special consideration to people with specific needs. The HCT Compact also includes procedural commitments to ensure that coordination structures are fit-for-purpose in order to address these critical operational priorities.

In the second half of 2019, OCHA initiated a large-scale multi-stakeholder consultation exercise to better understand the coordination challenges at all levels of the response, but particularly in relation to field operations. This involved workshops at the Kabul and field levels, with the outcome being a Mutual Accountability Framework. The HCT endorsed the Framework in December 2019 and covers the following key issues:

- Coordination Architecture
- Accountability to Affected Populations
- Integrated Response
- Information Management
- Humanitarian Access and Civil-Military Coordination
- Triple Nexus

**Improved monitoring to support stronger advocacy**

In 2019, the ICCT faced some challenges in terms of response monitoring data, especially with regard to carry-over funds. Substantial donor contributions for the drought response ($112 million) were received very late in 2018 and it was only possible to spend these funds in early 2019. This skewed performance results when compared to funds received in the calendar year and, in turn, undermined funding advocacy. As a result, response targets for 2019 had already been exceeded by the end of quarter three. The ICCT and donors are working to avoid a repeat of this situation in 2020, given that substantial late funding was again received at the end of 2019. In 2020, clusters have provided an agreed carry-over figure ($96.37 million) that is being noted in all monitoring documents to provide full transparency. Financial Tracking Service (FTS) reporting was problematic in 2019 with instances of both under-reporting and inaccurate reporting identified. There has also been a disproportionate amount of funding listed under 'Sector not specified', making it difficult to accurately analyse funding levels for different sectors.

In a bid to improve the quality of monitoring data and its use in advocacy, the ICCT held a dedicated workshop in quarter one of 2020. This workshop (held in February 2020) was technical in nature and focused on monitoring obligations and data submission procedures for response monitoring and the reporting of funding to FTS. Data collection on the use of cash in 2019 was problematic due to a gap in leadership of the Cash and Voucher Working Group (CVWG). New chairs are in place and with the support of a CashCap, the Working Group is now focused on addressing these gaps.

**Data accountability**

In response to concerns raised by partners about the absence of clear guidelines on data-sharing for the humanitarian community, OCHA initiated the development of a Data-Sharing Protocol. With support from the Centre for Humanitarian Data in the Hague, OCHA held an initial workshop in June 2019 to discuss issues partners face in terms of sharing sensitive beneficiary data with the Government and with other humanitarian organisations. Issues raised included obligations under existing laws and policies, classification of personal data, data use and ownership protocols, third-party data sharing, complaints and referral obligations. It was widely agreed that the best interests of people in need should be the guiding principle and that clarity around people's consent for sharing their data is critical. The next steps on this project are to develop a formal HCT Data-Sharing Protocol that provides operational guidance on these issues and protects the interest of beneficiaries. This initiative remains a priority for the response however this work is likely to be affected by more immediate COVID-19 needs and may be delayed until 2021.

**Preparedness planning**

Afghanistan is one of the most disaster-prone countries on Earth with an INFORM Risk Index of 8 – the fifth highest risk country out of 191 countries profiled. INFORM's special COVID-19 Index places Afghanistan in the Very High category (score 6.8). Aligned with the Government's response planning, an initial three-month COVID-19 Multi-Sector Humanitarian Country Plan was published by the ICCT in March to kick-start the response. The COVID-19 plan was one of a series of thematic contingency plans completed or under development for 2020 covering emergency topics (pandemic, disaster preparedness and conflict). These are developed as-needed at both the national and sub-national levels.

Given the ever-present risk of earthquakes in the country's most populated zone, the ICCT produced an initial earthquake contingency plan in 2019 with support from the OCHA Regional Office for Asia and the Pacific. The draft plan paints a disturbing picture of the likely impact of a major quake near an urban centre. An earthquake in or near a major city would threaten lives, prompt significant humanitarian need, cause widespread destruction of infrastructure, interrupt access to basic services, and create logistical challenges. The plan models the impact of a magnitude 7.6 earthquake hitting Kabul and 14 other provinces, predicting it would result in some 4,400 deaths with 7 million people affected and 2.9 million people pushed into humanitarian need. Any serious earthquake in Kabul likely would limit the humanitarian community's ability to continue existing programming, with resources diverted to the earthquake emergency at least in the short term. With the modelling element of the document now complete, the priority next steps are to engage in inter-cluster response preparedness planning. This may run into 2021 given the competing priorities that COVID-19 presents.

# 1.4 Cash Programming

**Cash and COVID-19**

Opportunities to generate income, mostly within the informal sector, have been dramatically reduced due to lock-downs aimed at curbing the spread of COVID-19, leaving many families with a cash crisis. The impact of COVID-19 on the economy of the neighbouring countries has also significantly reduced or interrupted remittances, cutting off an additional lifeline for many families and increasing the number of people who need humanitarian assistance. Given Afghanistan's resilient markets, cash and voucher assistance remains a viable way of meeting these increased needs.

Cash and voucher assistance is an essential modality for providing life-saving support to the most vulnerable people and empowering them with additional choice and flexibility. As cash and vouchers don't require heavy or sustained staff presence and are not subject to many of the same logistical barriers as in-kind assistance, the modality can more easily continue during peaks of displacement and disruption such as during a pandemic. Cash is also a preferred way of receiving assistance at times of crisis. While limitations remain in terms of technological and policy-level barriers, many clusters are endeavouring to scale-up the proportion of their response that is delivered via cash or vouchers, especially in the face of COVID-19. Given the new context, the CVWG will prioritise the following activities:

- Adjusting operational modalities to ensure the continuity of delivery with special considerations to mitigate COVID-19 transmission risks. Cash and voucher assistance will focus on overcoming programmatic, contextual, market, and institutional challenges and introducing harmonised mitigation measures.
- Increasing use of cash and vouchers in sector-specific approaches for COVID-19 and non-COVID-19 sectoral responses. Some clusters that are already advanced in using cash support, such as FSAC and the ES-NFI, will scale-up use of this modality. FSAC plans to increase cash and voucher assistance, increasing from the 15 per cent target for delivering through cash in 2019 to a 25 per cent target in 2020. To support this cash scale-up in FSAC, the Cash-Cap has moved from OCHA to WFP. The ES-NFI Cluster will expand its existing cash strategy by focusing on collecting evidence on the use by and the impact of cash on affected populations, enhancing targeting methodologies, and refining approaches for determining best-fit assistance modalities. Health and Nutrition partners are looking to embrace new cash programming by offering cash or voucher support for vital medications and auxiliary costs (e.g transport). The WASH Cluster is tentatively exploring a pilot voucher programme to help very vulnerable families in urban informal settlements purchase water and hygiene items. Targeted, cash-based protection assistance will be expanded to respond to identified protection risks and to mitigate against extreme negative coping strategies. Cash and vouchers will also be used by education partners in their COVID-19 response with the aim of removing economic barriers that stop vulnerable children in accessing school, preventing drop-outs due to poverty, and increasing attendance.
- Increasing cross-sectoral use of Multi-Purpose Cash (MPC) to cover basic needs and reduce negative coping strategies. Use of MPC will be scaled-up in combination with other types of programming and appropriate services, such as case management and outreach, to maximise sectoral results and reduce negative coping strategies. This approach will be of particular importance in the protection and education responses.
- Linking humanitarian and development actors to harmonise implementation approaches for emergency social protection. Emphasis will be on complementary approaches by development and humanitarian agencies to streamline delivery systems and strengthen the transitional link between humanitarian cash and voucher assistance and development-oriented social protection.
- Capacity-building of the CVWG partners to ensure sufficient institutional and technical capacity of partners to safely implement cash and voucher projects.
- Coordinating and sharing knowledge among the partners around information management and financial service providers, to increase the potential for digital payments and promote financial inclusion.

**Preferences of affected people**

Even after years of conflict and now COVID-19, markets in Afghanistan remain mostly functional, physically accessible (with the exception of disability access) and are generally able to meet demand. The WoA Assessment confirms displaced people's confidence in the stability of markets and their desire to receive assistance via cash if possible. Seventy-five per cent of displaced people with self-reported needs indicated they would prefer those needs to be met in cash.[35] A similar proportion of host community households (77 per cent) reported that they prefer to receive cash assistance over in-kind support.[36] However, access to markets for displaced households headed by women remains challenging due to their relative lack of mobility. In the WOA Assessment, a higher proportion of female-headed, displaced households reported not having had access to a marketplace or

grocery store in or close to their village where they could buy food and non-food items in the week prior to data collection, compared to male-headed displaced households.

**Scale of cash use**

Cash and market-based responses have been implemented in Afghanistan since 2009 with the value of this approach widely acknowledged by the HCT, in terms of cost-efficiency and effectiveness, and the improved dignity, flexibility and choice it offers affected people. In 2019, cash programming in Afghanistan accounted for just over 20 per cent of the total expenditure under the HRP. But given that markets are resilient, and more than three-quarters of IDPs and host communities report a preference for cash, potential for wider use will be realised under the COVID-19 response.

Cash in envelopes and Hawala networks remain the primary cash transfer mechanisms in Afghanistan. Hawala systems, common throughout the Islamic countries, are well established in Afghanistan and have a strong footprint across the country. Use of such networks, as with cash-in-hand modalities more generally, brings some risks including cash diversion, fraud, security vulnerabilities for those carrying cash to distribution sites, and the risk of detailed beneficiary data falling into the wrong hands. In Afghanistan, these risks are mitigated by distributing cash in secure locations, splitting cash into several smaller distributions (over many distribution points or several days), distributing to vulnerable people first, separating cash-related duties within an organisation to dilute control, partners not sharing detailed beneficiary information with financial service providers, as well as including data protection clauses in contracts. There are also new risks from COVID-19 in terms of physical distributions, which partners are working to overcome by staggering distributions to ensure social distancing, staff wearing PPE, and the use of electronic transfers wherever possible. Limits on the maximum amount of cash withdrawals from banks also present a regulatory challenge to the scale-up of cash programming and partners plan to advocate with the Central Bank around exemptions to these rules to make large-scale humanitarian cash distributions easier.

While mobile money services are being used in Afghanistan, the environment remains challenging for expansion due to limitations in the banking sector, low usage of bank accounts, poor mobile phone coverage in hard-to-reach areas, and women's uneven access to banking-enabled mobile phones. Registered SIM cards are required to make full use of many mobile banking services and sign-up often requires the user to have a Tazkera or ID card. Few women have this ID, which creates an obstacle to independent use of mobile money. Displaced people also often have lost this ID during flight. Efforts are underway to work with financial institutions to overcome barriers and expand services.

**Coordination and building capacity**

In the second half of 2019, a NORCAP CashCap Adviser was recruited and a new NGO co-chair of the CVWG arrived in country. The arrival of these personnel responded to concerns raised in the Peer-2-Peer mission report and by the humanitarian community on the limited capacity of the CVWG and cash programming capacity. More broadly, they significantly boost dedicated cash leadership alongside WFP, which now has dedicated capacity as the Working Group's co-lead. New TORs for the CVWG have been implemented, while the group now reports to the ICCT and has a broader range of attendees.

To date, the main priorities of the CVWG co-chairs and CashCap have been to assess current cash capacity in the country, address capacity gaps at both national and sub-national levels, and establish a mechanism to accurately monitor cash assistance. COVID-19 has also seen the need to provide additional support to clusters in the revision of response approaches and greater incorporation of cash and voucher assistance in their programming. Regional trainings took place in the east, north and centre of the country during the last quarter of 2019 and strong engagement has begun with clusters, including some that have not previously tended toward cash as a modality of assistance, such as Health. Further trainings and consultations were carried out in the first quarter of 2020. Although the COVID-19 outbreak has pushed many of these trainings to online platforms, participation has been high. Strong collaboration also has occurred between the Working Group and development partners to ensure complementary approaches to cash are used as part of the COVID-19 response. The CVWG has also forged a new and vital working relationship with the Afghanistan Humanitarian Fund by identifying partner staff to undergo capacity-building so as to participate in AHF proposal technical assessments.

While it is anticipated there will be improvement in the proportion of the response delivered by cash modalities in 2020, conclusions from the capacity assessments and the trainings undertaken thus far indicate that ongoing capacity-building is required. While there is strong support for more ambitious targets, improving skills is essential to ensure that cash and voucher assistance is implemented safely. Depending on comfort levels with cash programming, clusters were given the option of setting their own cluster-specific 2020 cash targets, and most have confirmed plans to increase their cash programmes (see sector pages).

The International Rescue Committee is also piloting Safer Cash programming in Afghanistan and has seen strong interest from a number of partners that are considering participating in 2020, though training for the toolkit's introduction may need to be moved to online platforms given COVID-19 restrictions. This cash approach focuses on mainstreaming protection in cash programming activities and ensuring that all beneficiaries have safe access to cash and markets.

Afghanistan is also a pilot country for the Global Common Cash System (CCS – a joint initiative by UNHCR, WFP, UNICEF and OCHA to work more closely on efforts to build cash expertise and use) with a work plan drawn up for activities that benefit the broader humanitarian community in-country. The CCS work plan was developed in 2019 for a period of two years. It is anticipated that the work plan of the CCS agencies will shift during the COVID-19 response in 2020 to focus leadership and advocacy on issues identified by the CVWG as critical to facilitating the scale-up of cash and vouchers. The CCS will also work with the Emergency Response Mechanism (ERM-ECHO) and the CVWG to build on existing processes, improve common tools and harmonise activities across agencies, including working with similar NGO cash coordination initiatives.

1.5

# Operational Capacity and Access

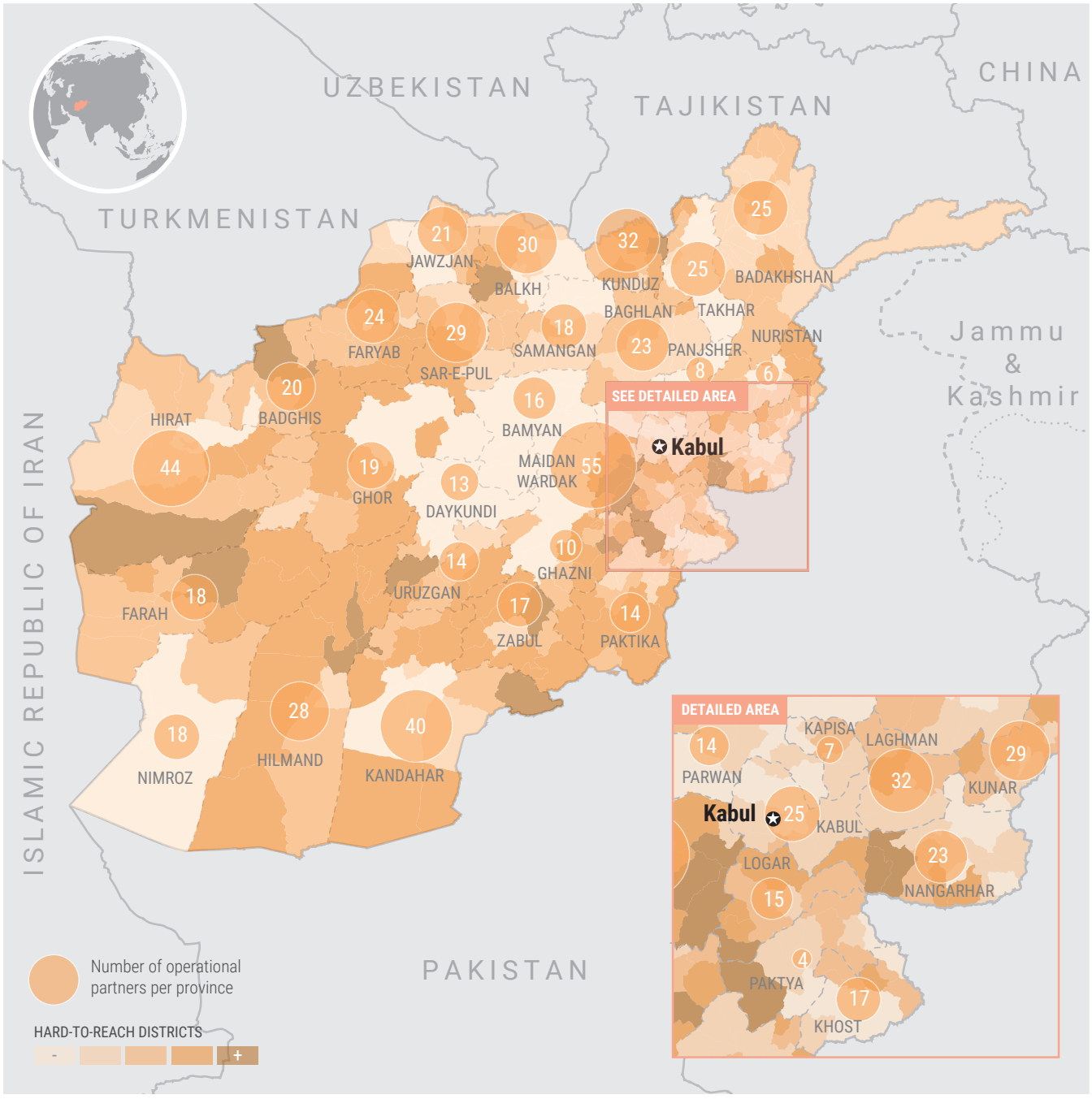
**OPERATIONAL PARTNERS**
161

**TREND (# OF PARTNERS)** (2015 - 2020)

**% OF PEOPLE LIVING IN HARD-TO-REACH AREAS**
23%

**AID-WORKER DEATHS & INJURIES** (JAN - APR 2020)
23

**COVID-19-RELATED ACCESS INCIDENTS** (JAN - MAY 2020)
78




*The designations employed and the presentation of material in the report do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.*

**Operating environment**

Afghanistan remains one of the most dangerous countries in the world for aid workers. Despite a deal signed between the United States and Taliban in February 2020, a week-long reduction in violence in February and a temporary Eid ceasefire, both the Afghan National Security Forces (ANSF) and the Taliban have resumed active-conflict postures. Uncertainty around the future of the US-Taliban agreement, intra-Afghanistan peace talks and the intentions of other NSAGs, primarily ISK, point to a highly dynamic security situation. While the long-term outlook is nearly impossible to predict, escalation in conflict, at least in the short term, is considered a likely scenario.

COVID-19 has further complicated this tense operating environment for aid agencies. In late March, the Government announced a number of lockdown measures in all major cities aimed at preventing the spread of the virus. While there was an agreement in principle to facilitate humanitarian movement during the lockdown, uniform implementation has proven difficult. National authorities have delegated the determination of lockdown measures to provincial authorities, resulting in uneven approaches and necessitating additional ad hoc efforts to overcome challenges. Cross-border movement of goods from neighbouring countries also has affected operations in Afghanistan and threatened the pipeline of critical supplies, particularly items warehoused in Pakistan. While borders with Pakistan have reopened for commercial traffic, aid agencies continue to emphasise the critical importance of maintaining a reliable flow of traffic for humanitarian cargo and are advocating for special consideration to expedite humanitarian food and relief items through border crossings.

Aid workers have also adopted physical distancing and other measures to safeguard staff and people receiving assistance. Steps are being taken at distributions to ensure large gatherings are avoided as much as possible and hygiene procedures are implemented. In some cases, double deliveries are being organised to overcome potential movement-related disruptions and reduce the number of times people need to visit distribution sites. Limited PPE in the country for frontline staff due to global shortages presents another challenge to those providing and receiving assistance. Concern remains over the potential infection of humanitarian staff in the course of their life-saving work.

The cancellation of international flights starting from mid-March has resulted in a significant reduction of the international humanitarian footprint in the country, with many organisations relocating non-essential staff members to work remotely due to the lack of medical evacuation options. The cancellation of international flights also led to disruptions to freight delivery, which caused delays and cancellations in importing medicines and other humanitarian supplies. The establishment of an UNHAS-operated international air bridge between Kabul and Doha in April has largely addressed this concern and will allow for the rotation of international humanitarian staff in and out of Afghanistan. National staff continue to work and humanitarian organisations report that their field presence largely is being maintained and that organisations are committed to staying and delivering for people in need. Figures indicate that the humanitarian community has the capacity to scale-up and deliver assistance in increased volumes in response to the COVID-19 pandemic, provided additional funds are released. The ban on commercial domestic air travel announced by the Government in early May has led to further reliance on UNHAS services to transport humanitarian staff and supplies throughout the country. While some commercial flights have resumed on an ad hoc basis, the sudden closure of the majority of commercial services underscores the importance of consistent resourcing of UNHAS capacity.

**Access trends**

The most significant challenges to the implementation of humanitarian activities in Afghanistan continue to be ongoing fighting, attempts at interference in programme design, and levy requests by parties to the conflict. While there always have been some limitations on movement due to conflict, these constraints reached new heights with government-imposed lockdown measures following the COVID-19 outbreak.

As a result of the lockdowns, aid workers have often been prevented from passing through newly established checkpoints or have been stuck in long queues, resulting in many organisations instructing staff to work from home and cancelling non-critical field missions. The lockdown measures have also led to the partial closure of a number of high-traffic highways, as well as the Khost-Gardez route.

Ongoing fighting between ANSF and NSAG forces continues to impede humanitarian movement, with temporary road closures that delay project implementation or field missions. IED detonations also continue to be a serious concern; while aid workers are not directly targeted in the majority of these attacks, they remain in danger of collateral or accidental impact.

Through until the end of April, the Humanitarian Access Group (HAG) recorded 11 aid workers had been killed, 12 injured and 20 kidnapped since the start of 2020, with most incidents occurring in the southern (7) and north eastern (8) regions. Incident rates are relatively on par with incidents recorded at the same time last year, with the exception of the number of aid workers injured.[37] Of the incidents resulting in the killing of aid workers, five were targeted killings and the other three incidents were primarily related to personal disputes. The remaining five aid workers were killed during IED detonations, crossfire or airstrikes. Most injuries to aid workers occurred during criminally-motivated incidents. All 8 incidents leading to the abduction of 20 aid workers occurred when aid workers were mistaken for government officials; all were released after their identity was confirmed.

Following the announced deal between the US and the Taliban in late February, international military forces (IMF) began withdrawing troops

and handing over more responsibilities to the Afghan security forces, including the conduct of airstrikes. This transfer of responsibilities raises concerns in the aid community about potential increases in mis-targeting and collateral damage.

Aid agencies continue to face challenges with parties to the conflict attempting to interfere with humanitarian activities, including programme parameters, staff recruitment and beneficiary selection, all contravening the provisions of the interagency Joint Operating Principles (JOPs) that were agreed to by the HCT in late 2019. The time required to negotiate around interference has often resulted in temporary suspension of project activities or the closure of facilities, with the difficult working environment also leading to a high-staff rotation. Organisations working in the health sector are particularly impacted, with NSAG health representatives often pushing for an upgrade in services in their areas. This pressure has escalated during the COVID-19 pandemic with NSAGs demanding that health services in contested areas be provided at commensurate levels with government-controlled areas, despite the security constraints and irrespective of needs. Organisations continue to experience levy requests despite assurances from the Taliban leadership that levies on humanitarian goods and services are not part of an official Taliban policy. While the Taliban are the most common source of levy-related incidents, aid agencies have also reported cases where government officials have issued levy requests. Pressure on national aid organisations is particularly high, with many finding it difficult to negotiate exemptions individually. There remains a need for the HAG and OCHA to increase direct engagement with Taliban to find a permanent solution to these problems. The HAG continues its high-level advocacy with the Taliban with the objective of reducing levy-related incidents.

While humanitarian operations in the highly dynamic security environment remain extremely challenging, aid agencies have found ways to maintain security awareness and mitigate against threats stemming from conflict and shifting national policies. Organisations such as the HAG and INSO, as well as community representatives, continue to provide information on changing security, access trends and ongoing fighting in order to support sustained humanitarian programming across the country.

### Humanitarian Access Group

The HAG remains the primary forum in Afghanistan through which operational coordination to analyse and discuss humanitarian access issues takes place. In 2020, direct and indirect humanitarian negotiations with parties to the conflict continued with both government and Taliban representatives emphasising each party's willingness to allow cross-line operations to alleviate human suffering. The HAG continues to support a humanitarian environment that fosters a more open dialogue and supports organisations on their engagements with parties to the conflict to enable improved humanitarian outcomes.

In December 2019, the Humanitarian Country Team endorsed the JOPs. In the beginning of 2020, a HAG working group developed a series of training modules to roll out the JOPs to the humanitarian community, donors and parties to the conflict. While the outbreak of COVID-19 has postponed the start of the trainings, partners increasingly refer to the JOPs when engaging with conflict actors, signalling greater familiarity with and acceptance of the JOPs. To maintain the momentum, the HAG is working on piloting online trainings.

To strengthen the inclusion of national NGOs, the HAG established a monthly national NGO HAG in November 2019. This has been successful with national partners engaging in access discussions and enabling greater feedback into the larger HAG. Going forward, the HAG will further prioritise representation of national NGOs in thematic HAG working groups, to ensure their inputs are equally integrated. The HAG will continue strengthening the access capacity of the regions by increasing support to the regional HAGs and improving two-way communication, with one key objective being the identification of suitable NGO co-chairs for the regional HAGs.

### Operational Presence by Sector

| SECTOR | NO. OF PARTNERS |
|---|---|
| Protection | 116 |
| FSAC | 83 |
| WASH | 51 |
| ES-NFI | 52 |
| Health | 39 |
| Nutrition | 32 |
| EiE | 17 |

### Operational Presence by Type

| TYPE | NO. PARTNERS |
|---|---|
| NGO | 81 |
| INGO | 68 |
| UN | 12 |

** Some of the organisations from the table above are working in the sector but not directly participating in the cluster.*

reliefweb

For the latest operational updates, visit:
**reliefweb.com/country/afg**

The HAG continues to collect and analyse information on access trends to support evidence-based advocacy with the donor community, humanitarian coordination entities and parties to the conflict. The HAG strengthened the access analysis in the

monthly humanitarian snapshot following a review of the Access Monitoring and Reporting Framework (AMRF) and renewed outreach to partners to share their access impediments. The HAG will continue working on reaching a broader audience with its publications to support advocacy efforts while maintaining full confidentiality of partners.

The drawdown of US forces has increased the importance of strengthened Civil-Military Coordination. The HAG will continue building its relationship with ANSF counterparts to negotiate key issues such as the no-strike list and accountability mechanisms for civilian casualties.

With the outbreak of COVID-19, the HAG has shifted focus to enabling humanitarian partners to stay and deliver during this new crisis. In April 2020, the HAG developed a COVID-19 Access Strategy, highlighting new access risks stemming from the pandemic and its response. The 'Stay and Deliver' document identifies what aid agencies require in the current situation in order to continue their programming in a safe and secure manner and indicates gaps that need to be addressed. The HAG took an active role in advocating for the establishment of the UNHAS air bridge as well as a Logistics Working Group, two key requirements identified in the 'Stay and Deliver' document. OCHA and the HAG, together with key partners such as ACBAR and INSO, continue to engage with the authorities to facilitate humanitarian movement during lockdowns. Existing Civil-Military Coordination continues with weekly meetings with IMF and ANSF partners to discuss how best to support COVID-19 efforts.

**Operational capacity**

In the first quarter of 2020, 161* partners managed or implemented projects across Afghanistan, which is a slight increase from the 157 recorded in the last quarter of 2019. National NGOs continue to make up the largest proportion of humanitarian responders in Afghanistan (81), followed by international NGOs (68), and UN organisations (12). While many international NGOs and UN agencies have temporarily scaled-down the presence of international staff in the country, the majority of aid agencies stand ready to continue to deliver services at current or potentially increased levels. The most recent 3W exercise (Who does What Where) in May revealed that there had been no reduction in partner presence and only a slight reduction in district reach in the first quarter of 2020 (380 districts) compared to the last quarter of 2019 (395 districts).

Most partners continue to operate in the eastern (67) and southern (62) regions, while central highland (18) and the south east (26) have the smallest partner footprint. Compared to 2019, partner presence in most regions remained largely stable, with the western region seeing the highest increase in partners from 47 to 51.

There continues to be a well-established and expanding humanitarian presence in the six provinces identified in the HNO as having the highest severity of needs – Farah (18 organisations), Ghor (19 organisations), Badghis (20 organisations), Faryab (24 organisations), Hilmand (28 organisations) and Uruzgan (25 organisations). In the first quarter of 2020, there was a further increase in the number of partners operating in all six provinces. Although partner presence is most dense in the provincial capitals, there is also an enhanced spread across districts within each of these high-needs provinces ensuring stronger localised coverage. Out of all six of these provinces with the most severe needs, only two districts, Khak-e Safed in Farah Province and Taywarah in Ghor Province are now without any humanitarian presence.

Greater investments in risk management, the development of access and NSAG engagement strategies, the exploration of remote management techniques, as well as contingency planning, will all continue to be prioritised in 2020. Given current levels of insecurity, the humanitarian response continues to rely heavily on national NGOs, which comprise roughly 50 per cent of all active organisations under the coordinated humanitarian response. Systematic capacity-building, including trainings and mentoring schemes, will need to be adequately resourced and regularly undertaken. Continued innovative approaches that encourage partners' willingness not only to 'stay and deliver' but also to 'enter and stay,' will be required given that operational capacity and the reach of partners is closely linked to sustained and unfettered humanitarian access, adequate and predictable resourcing from donors, and retention of necessary staff in areas where the needs are the greatest.

While there is no overall census of female staff and volunteers working for humanitarian organisations in Afghanistan, women are, without doubt, grossly under-represented in the workforce. This remains a key constraint in terms of the response's operational capacity to assess, understand and respond to the needs and concerns of women and girls. Measures are ongoing to redress this imbalance and recruit more women into humanitarian action include the hiring of husband-and-wife, as well as brother-and-sister teams. OCHA has employed additional female field monitoring staff for the AHF, while UNHAS offers reduced airfares for female national staff travelling on its flights as a way of encouraging managers to involve more women in field work, particularly assessments. A number of NGOs also have hiring policies for national staff that are designed to make it easier for women, who often have not had the same educational opportunities as men, to enter the humanitarian workforce.

To monitor the impact of COVID-19 on local and international supply chains and address logistics challenges in a systematic and coordinated manner, the HCT established a Logistics Working Group in May 2020.

** Only 147 participate in regional level Humanitarian Response Teams (HRTs).*

Part 2

# Monitoring and Accountability

**JALALABAD, EASTERN AFGHANISTAN**
*October, 2019. IDPs receiving cash assistance in Jalalabad*

*Photo: OCHA/Fariba Housaini*

# 2.1 Monitoring

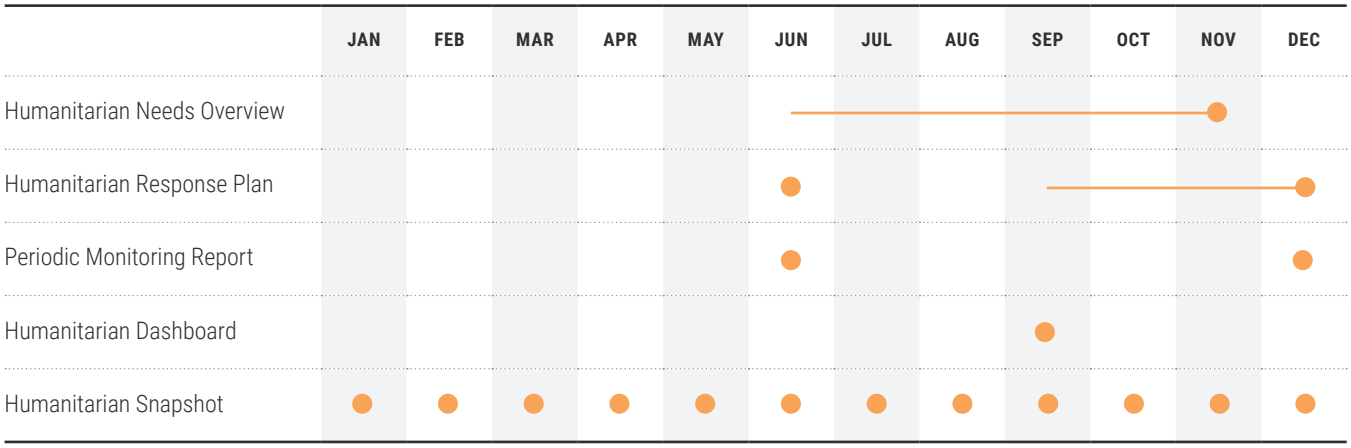
Given the uncertainties surrounding the current response environment and humanitarian needs, regular situation monitoring and response temperature checks will be critical to ensuring relevant, safe, timely and effective assistance in 2020 and 2021. The multi-year HRP has now been revised several times since its inception in response to changed conditions, particularly concerning the drought and the COVID-19. This current revision, which is a result of the far-reaching impact of the pandemic and shifts in the breadth and types of need, is an example of the document's responsiveness to changed operating conditions. However, it must be recognised that the reality of the current circumstances will make frontline data collection more challenging than ever in Afghanistan and in emergencies around the world. While continuing to emphasise strong monitoring and reporting, additional flexibility will be required as many organisations have adopted distancing requirements and remote working modalities, which may make it difficult to collect the same scope and quality of data. OCHA and the REACH Initiative are beginning to plan for the next annual WoA Assessment, which will involve adjustments to methodology and content as a result of COVID-19.

While there was an intention to issue HRP monitoring reports four times per year (dashboards in quarter one and quarter three, and analytical reports in quarter two and quarter four), dramatic changes have required a re-orientation of response plans and correlating reporting in 2020. While a quarter one report was not feasible, the mid-year report will detail activities from quarter one and quarter two, including those added for COVID-19 but not part of the original monitoring framework when the HRP was launched. Merging the reports into a more substantive mid-year report will provide time to consolidate information on COVID-19-related efforts and ensure that vital work is not missed. In the meantime, a regular operational situation report detailing cluster responses to COVID-19 needs will continue to be produced, with cumulative totals for assistance provided.

As in 2019, periodic reality checks of response progress and initial planning assumptions will be built into ongoing HRP monitoring. This will be accompanied by greater scrutiny and accountability of emergency preparedness, such as the stockpiling of supplies and monitoring of pipelines through quarterly pipeline snapshots at the national level, which will provide early warning of looming pipeline breaks. These regular pipeline snapshots were initiated in 2019. They have been warmly received by donors and partners and have improved preparedness in the response. Moving forward, these will reflect the revised planning needs outlined in the updated HRP.

Close attention will be paid to trends in the evolution of COVID-19 infections in Afghanistan and whether these trends align with common planning forecasts. Based on a hybrid of global modelling and consultations

**Humanitarian Programme Cycle Timeline**



with the Centre for Humanitarian Data, the ICCT has agreed to use a common planning figure of 300,000 people seriously ill and requiring hospitalisation and 80,000 deaths as a result of COVID-19. These figures are not predictive and simply provide a common base from which to plan. These assumptions may require adjustment depending on how the virus spreads throughout the country. This will rely heavily on official monitoring data published by the Ministry of Public Health.

The Protection Cluster is implementing new monitoring procedures to correct historical double-counting of beneficiaries in past HRP reporting. To avoid overlap and double counting of beneficiaries across sub-clusters, a new standard aggregation methodology is being used at the cluster level. Figures are aggregated across mutually exclusive categories (i.e. gender, age, and population type) using the maximum reached at the lowest administrative level where data is available (i.e. district) across sub-clusters. Employing this approach means that the calculated figure represents an underestimate of the actual number of people reached, however it drastically reduces the risk of double-counting. While this course correction will eliminate overlaps, it will mean that results from the first two years of the HRP will not be comparable to the second two years.

The ICCT will also continue to monitor the need for thematic emergency preparedness plans at the national level, as was done for the drought and the atypical 2019 floods and now COVID-19 in 2020. An initial earthquake-specific contingency plan has also been developed (although further work is required on this) and individual regions continue to develop and update local preparedness plans for conflict and disaster.

The HCT will continue to monitor its progress in implementing the prioritised recommendations from the 2019 Peer-2-Peer mission to Afghanistan, through HCT Compact.

2.2
# Collective Accountability

## Accountability to Affected Populations (AAP)

The HCT and humanitarian partners remain committed to ensuring that women, men and young people are engaged more meaningfully in humanitarian action, guiding the design of the response and providing feedback on its delivery amid pervasive threats to health, life, security, well-being and the resulting displacement. The COVID-19 pandemic adds to the dire situation facing many people in Afghanistan and increases the need for humanitarian operations to put people at the centre in all programming phases. The HCT is already scaling-up AAP activities as a matter of urgency, with an initial focus on RCCE, and wider accountability work to be done the rest of the year. A reinvigorated AAP Working Group (replacing the now defunct Community Engagement Working Group) will be a critical element of this approach.

### AAP strategy

A commitment to improving collective accountability has been included as a primary operational priority in the HCT Compact. AAP issues feature heavily in the complementary Mutual Accountability Framework developed between Kabul and the field. The AAP response in Afghanistan has been growing in 2020. An AAP specialist joined OCHA in April to reactivate the Communication and Community Engagement Working Group, which will become a broader Accountability to Affected Populations Working Group. Getting an AAP specialist through a standby partner was recommended in the 'Collective Approach to Community Engagement' (CACE) strategy, which was developed with support from OCHA's Regional Office for Asia and the Pacific in March 2019. The HCT will endeavour to ensure that this transitional standby support will be followed by a longer-term and more sustainable funding solution in-country.

In March 2020, the World Health Organization established a temporary RCCE Working Group specifically for the COVID-19 outbreak to support government-led RCCE efforts and "to ensure individuals are equipped with the necessary information about COVID-19, including on what it is; how it is transmitted; and how individuals and households can play a role in undertaking preventative measures…".[38] Messaging is being created in line with Ministry of Public Health guidance and disseminated in a culturally appropriate manner in several languages and tailored for varying levels of literacy. Working Group members include national and international NGOs, UN agencies, and an international consultant who is an expert in communication and community engagement. As described in its TOR, the RCCE Working Group will integrate into the AAP Working Group structure as a sub-group, once the response-wide entity is operational. The target date for that integration is mid-2020.

In the rest of 2020 and in 2021, the AAP Working Group will adopt a new TOR that will be informed by the CACE strategy and other key HCT policies. The Working Group will focus on strengthening response-wide accountability, including addressing accountability shortcomings identified in the 2019 Peer-2-Peer mission. It will strive to involve affected communities in decisions and processes that impact them. This will be achieved by establishing and expanding common communication and feedback channels that are accessible to all people in need, especially those who are most vulnerable or marginalised, including women, children and people with physical disabilities and mental health issues. Improving accountability on PSEA is a priority and will involve close collaboration with the newly reactivated PSEA Task Force. A core component of the AAP Working Group's new TOR will be to coordinate training on AAP for humanitarian partners. The need for AAP guidance and training, particularly at the sub-national level, was repeatedly raised as a concern during numerous field consultations in August 2019.

### Feedback mechanisms

The only response-wide accountability mechanism operating in Afghanistan is the Awaaz Afghanistan toll-free call centre. Awaaz has handled more than 120,000 calls from throughout the country since it started operations in May 2018. By dialling 410, callers can talk to one of Awaaz's call centre operators, 50 per cent of whom are women. Awaaz also is being utilised for outreach campaigns via SMS.

There is good evidence that some organisations and cluster partners have adjusted their field implementation arrangements due to feedback from affected people via Awaaz. Data from Awaaz also has been used to inform 2020 planning. In spite of the relatively high number of calls, the 2019 Whole of Afghanistan Assessment (WoA) results showed that 93 per cent of shock-affected people surveyed were still unaware of any feedback or complaint mechanism existing

in the country. Of the seven per cent who knew of one, only a quarter were aware of Awaaz, indicating that significant awareness-raising still needs to be done.

The COVID-19 outbreak has highlighted the ability of Awaaz to adapt quickly to different crises. It is serving as a key, two-way information platform for affected people with questions about COVID-19. In mid-February, the call centre collaborated with the WHO on risk communication and community engagement by recording awareness-raising messages that more than 13,300 callers from throughout the country had heard by early May. During this period, Awaaz's operators directly handled over 2,000 calls from all 34 provinces with questions regarding COVID-19. Caller questions and comments on the virus include:

- "I heard that rain can wash away the virus. Is that true?" (Female caller from Ghazni)
- "Since the COVID-19 spread, the food commodity prices have increased in our area." (Male caller from Nangarhar)
- "We heard it is better not to visit the hospital for testing of COVID-19, even when having symptoms, as the risk of getting infected with the virus there is very high." (Female caller from Balkh)
- "Are there any active cases of COVID-19 in my area?" (Male caller from Faryab)

Awaaz recently developed a specific dashboard for COVID-19 data, in addition to its regular summary, that is updated weekly and includes general information on the number and topic of calls. The COVID-19 dashboard and a downloadable anonymised dataset on all COVID-19-related cases are shared with partners for them to use and triangulate with their own data and analysis.

The COVID-19 pandemic poses many challenges for Awaaz, particularly in terms of continued staffing of the call centre. Two functionally identical teams now operate the call centre separate from each other on different shifts to reduce the risk of shutting down the entire call centre should one operator get sick. Other challenges include the continuous updating of information from partners on changes in services. This requires intensified collaboration with partners, greater publicity of the hotline, and frequent training of call centre operators on COVID-19 information and referral pathways, rumour tracking, myth-busting and the pandemic's psychosocial aspects.

Awaaz provides an essential and confidential service that is particularly important for reporting sexual exploitation and abuse, as well as issues around the diversion of humanitarian assistance. Still, it is only one component of a comprehensive AAP infrastructure. An average of about 20 per cent of all calls to Awaaz are from women. Women's lower access to phones helps explain that rate. The 2019 WoA showed that 42 per cent of female-headed households reported ownership of a registered SIM card compared to 56 per cent of male-headed households. That finding was affirmed in a recent communication preferences and information needs rapid assessment that the RCCE Working Group commissioned and designed, and that REACH conducted. In the assessment, 78 per cent of key informants said women in their community did not have the same level of access to phones as men. Ensuring that women and other vulnerable groups have access to a feedback mechanism will be another priority for the AAP Working Group.

Many individual agencies have their own well-developed systems of communication, community engagement and feedback for their programmes, to which Awaaz refers callers. Apart from Awaaz, the RCCE Working Group has undertaken a process of rumour tracking and correcting COVID-19 misinformation that is reported by affected community members through organisations working on the ground. Existing and new feedback mechanisms, as well as existing community representation structures, will be leveraged in 2020 and 2021 to build a common and cohesive AAP system in Afghanistan that ensures the continuation and expansion of response-wide feedback loops that return information to people in need. National organisations, which are the backbone of the Afghanistan response, will be critical drivers of this work at the field level.

The ICCT will regularly review results from Awaaz and individual agencies during the year through referrals, regular presentations and its published snapshots. These trends and results have informed this HRP revision. Regular HCT presentations also are scheduled.

**Response preferences of affected people**

Views on the response preferences and service access challenges facing people in need are assessed annually by the multi-sector WoA Assessment. The second annual WoA Assessment was conducted from July to September 2019 under the framework of the ICCT, co-facilitated by the REACH Initiative and in close collaboration with OCHA. A representative sample of more than 31,000 displaced and shock-affected households was assessed in accessible areas throughout all 34 provinces of Afghanistan, using random cluster sampling. A series of 68 focus group discussions were held, with a dedicated focus group discussion for women in every province.

Due to the volatility of the security and environmental situation in Afghanistan, multiple areas across the country remain hard-to-reach and, therefore, hard-to-assess in terms of response preferences. To ensure that humanitarian response planning for 2020 accounts for the needs of these populations, the REACH Initiative, in coordination with OCHA, the ICCT, and the HAG, conducted an assessment to profile multi- and inter-sectoral needs in prioritised hard-to-reach districts. This assessment was designed to complement and align with the

WoA Assessment, providing a more comprehensive dataset. Between July and September 2019, more than 3,100 Key Informant Interviews (KIIs) were conducted in 100 hard-to-reach districts spread across 23 provinces. REACH Initiative conducted a second round across 120 districts in January and February 2020. The assessment, which now will take place quarterly, will provide a much-needed evidence base to inform prioritisation and response in Afghanistan's most inaccessible areas.

Clear messages from the 2019 WoA Assessment data showed a strong preference among people for cash-based response modalities and more tailored response approaches to vulnerable groups including those with specific needs. The most frequently cited barrier to accessing humanitarian assistance was a lack of awareness about eligibility (53 per cent of all shock-affected households and 57 per cent of displaced households). Additional barriers revolve around physical issues such as the lack of access to and high cost of transport, social norms preventing women from travelling alone, security and explosive hazards. These preferences already are being incorporated into the response with many clusters newly embracing cash modalities, particularly to address high transport and medical costs.

Assessments indicate that a one-size-fits-all approach to communication should be avoided in Afghanistan. WoA data showed that multiple communication approaches are needed to maximise effective information exchange between responders and people in need. In the WoA Assessment, the majority of displaced households reported that their preferred communication modality with aid providers was via the phone/SMS (49 per cent for displaced households and 43 per cent for overall shock-affected) or a community leader (34 per cent for displaced households and 41 per cent for overall shock-affected households). These preferences appear to change over time, by gender and according to geography, suggesting the need for frequent reality checks on the best ways to reach specific groups of people in any given location at any given time. For example, in the south east, phone communication is strongly preferred (71 per cent of displaced people and 66 per cent for overall shock-affected people), followed by religious or community leaders (25 per cent and 20 per cent for overall shock-affected people). The figures are almost completely reversed in the north with 69 per cent of displaced people (55 per cent for overall shock-affected) preferring to receive information from religious and community leaders compared to 26 per cent of displaced people (26 per cent for overall shock-affected) preferring by phone. It is likely that the lower preference for phone communication was driven by mobile service shutdowns in the north during the assessment period, given that preferences for phone communications were much higher there the previous year. This speaks to the volatility of results and the need for responders to constantly cross-check communication choices. These nuanced results have been noted by the HCT and ICCT and will continue to guide this Response Plan in 2020.

Approximately 2,175 interviews across all districts in Afghanistan were conducted in the RCCE WG-REACH Initiative rapid assessment (April 2020)[39] to assess specific COVID-19 communication preferences and information needs. Initial results from the assessment show regional variations in awareness of COVID-19 symptoms, prevention best practices, and appropriate physical distancing behaviours. Limited awareness is particularly noted in the eastern provinces, potentially highlighting a need for targeted awareness raising in those areas.

# Protection from Sexual Exploitation and Abuse (PSEA)

Sexual Exploitation and Abuse (SEA) constitutes the most egregious breach of trust between humanitarian responders and those they serve. Measures must be in place at both the community level (AAP) and organisation level (PSEA) to prevent it, protect affected populations from it and contribute to the design of safer programming. There cannot be a complete collective approach to accountability unless it is linked with collective PSEA measures. Equally, there cannot be an effective system for preventing SEA without factoring-in the communication preferences and challenges of affected people and reaffirming a commitment to strong information-sharing among agencies, clusters and the AAP Working Group.

In line with the Peer-2-Peer recommendations, the HCT Compact and the AAP strategy (CACE), the PSEA Task Force for Afghanistan was re-established in mid-2019 with UNICEF, followed by IRC and UNHCR as co-chairs. The PSEA Task Force ensures that this critical issue is a central part of coordinated humanitarian action. Based on the approved country work plan, the PSEA Task Force meets regularly to update on progress. The work plan focuses on five thematic areas: SEA risk identification and risk management; prevention from SEA; complaint reporting and response; enforcement and compliance standards; and PSEA coordination and engagement. Each thematic area has a smaller working group to move the actions forward and ensure progress in 2020.

Progress to date includes drafting guiding principles for mainstreaming PSEA in all clusters; updating key referral pathways for victims of PSEA; developing inter-agency Standard Operating Procedures; sharing PSEA technical guidance for COVID-19; identifying PSEA focal points across agencies and developing training for those

focal points. Recognising that sexual and gender-based violence, including risks of sexual exploitation and abuse (SEA), increases in times of crisis, in April the PSEA Task Force released a technical note to support the COVID-19 response in Afghanistan. The note encourages five actions that can prevent SEA and help identify SEA cases, to rapidly assist victims and take corrective measures. The actions include: the integration of key PSEA activities in sector projects; roll-out of PSEA messages in organisational-level community awareness and in public information campaigns; inclusion of PSEA in all training and implementation guidelines for partners involved in the COVID-19 response; the establishment of a protection monitoring and reporting mechanism that includes contact numbers for inter-agency reporting of SEA; and for donors to require mandatory reporting of SEA for all implementing partners.

The Task Force also undertook a capacity mapping exercise in 2019 to identify the key PSEA gaps in the humanitarian community. From this mapping, it was clear that additional work is needed to raise awareness in local communities, clarify how people can report SEA and strengthen victim assistance. The Task Force also has drafted guidelines for mainstreaming PSEA across the clusters and will roll-out training in 2020. WFP has funded a PSEA coordinator who works to promote goals and principles for accountability and will collaborate with the reactivated AAP Working Group. The PSEA Task Force is providing regular updates to the HCT on progress via scheduled Mandatory Area of Responsibility presentations, ensuring relevant PSEA issues remain high on the national agenda.

Affected communities will be engaged in planning, service delivery and monitoring of the PSEA plan. Community-based complaint and feedback mechanisms will be supported that take into account the communication formats people say they prefer, and that are accessible for all literacy levels. Affected communities, particularly vulnerable people, must have clear and accessible ways to inform humanitarian responders about issues with the behaviour of service providers and to get updated on corrective actions that are taken in response.

Priority activities for the PSEA Task Force in 2020:

- Mainstream PSEA into all programming
- Train government counterparts, community leaders and aid agencies on PSEA and exploitation prevention and response
- Advocate for gender parity and diversity in decision-making to ensure the needs of all are considered in PSEA
- Build and strengthen sustainable community-based PSEA networks
- Engage with the AAP Working Group and the RCCE Working Group to increase accountability at the community level and adapt to needs of COVID-19
- Develop culturally appropriate PSEA communication materials

Part 3

# Sectoral Objectives and Response

**SURKH ROD, EASTERN AFGHANISTAN**

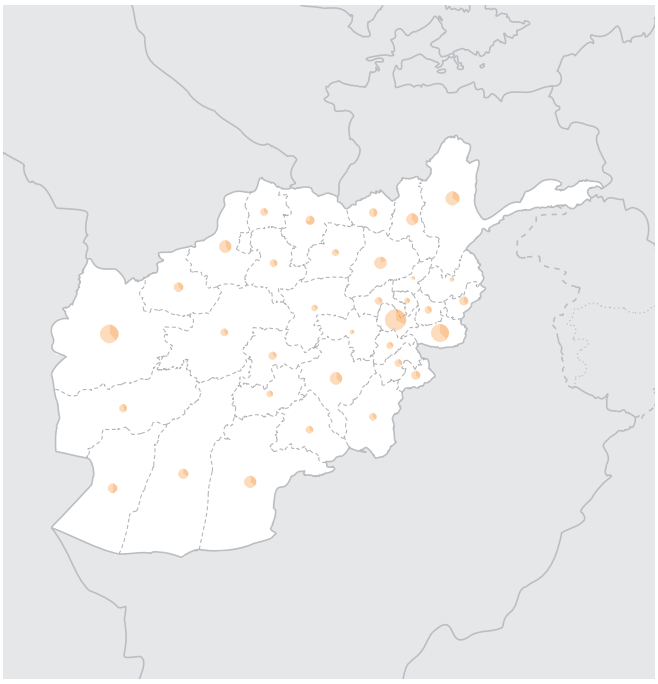
*November 2019. IDP Children in Surkh Rod area in the eastern province of Nangarhar. Photo: OCHA*

# Overview of Sectoral Response

| SECTOR | REQUIREMENTS (US$) | PEOPLE IN NEED | PLANNED REACH | PARTICIPATING ORGANISATIONS |
|---|---|---|---|---|
| Education in Emergencies | **$68.1M** | 2.6M | **0.9M** | 17 |
| Emergency Shelter and NFI | **$122.9M** | 5.3M | **1.4M** | 40 |
| Food Security and Agriculture | **$370.3M** | 13.2M | **9.8M** | 38 |
| Health | **$171.1M** | 10.1M | **7.0M** | 38 |
| Nutrition | **$114.6M** | 4.6M | **2.4M** | 37 |
| Protection | **$91.9M** | 11.5M | **2.3M** | 116 |
| Water, Sanitation and Hygiene | **$152.2M** | 7.2M | **3.8M** | 24 |
| Aviation | **$25.0M** | - | **-** | - |
| Coordination | **$14.9M** | - | **-** | - |
| **TOTAL** | **$1,131M** | **14M** | **11.1M** | |

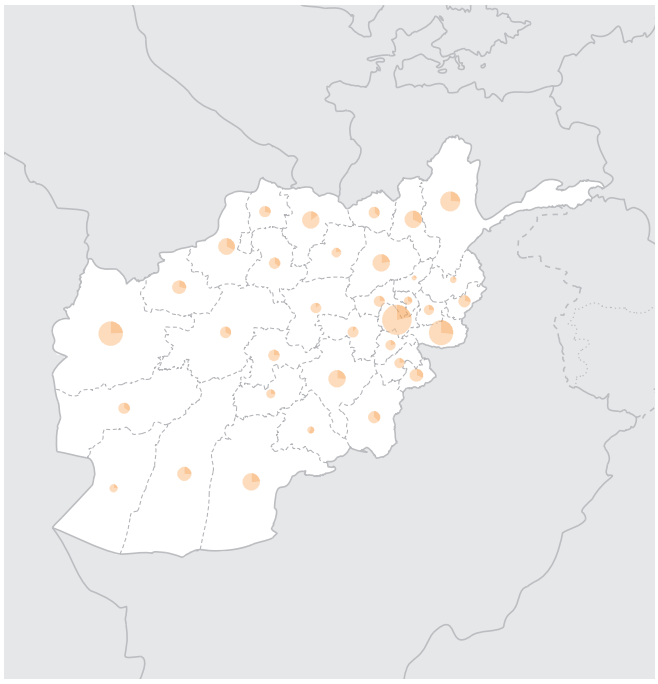
## 3.1 **Education in Emergencies**

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS (US$) |
|---|---|---|
| 2.6M | 0.9M | $68.1M |



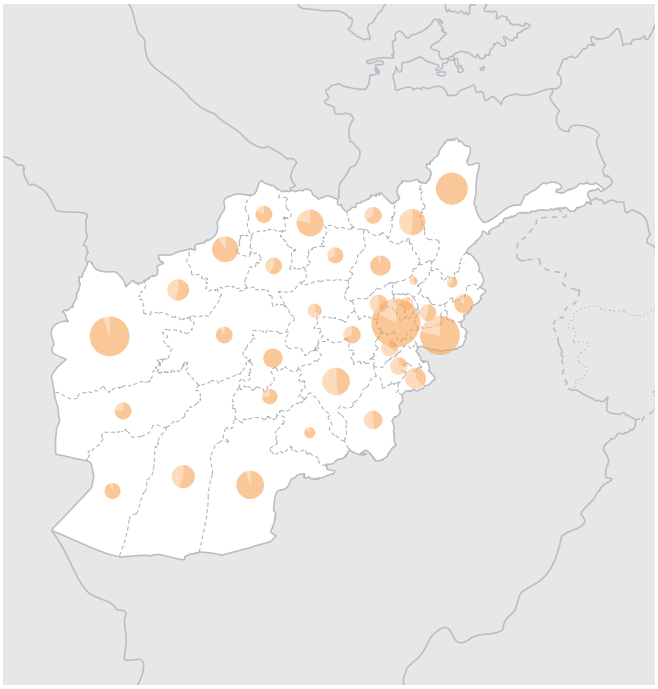
## 3.2 **Emergency Shelter and NFI**

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS (US$) |
|---|---|---|
| 5.3M | 1.4M | $122.9M |



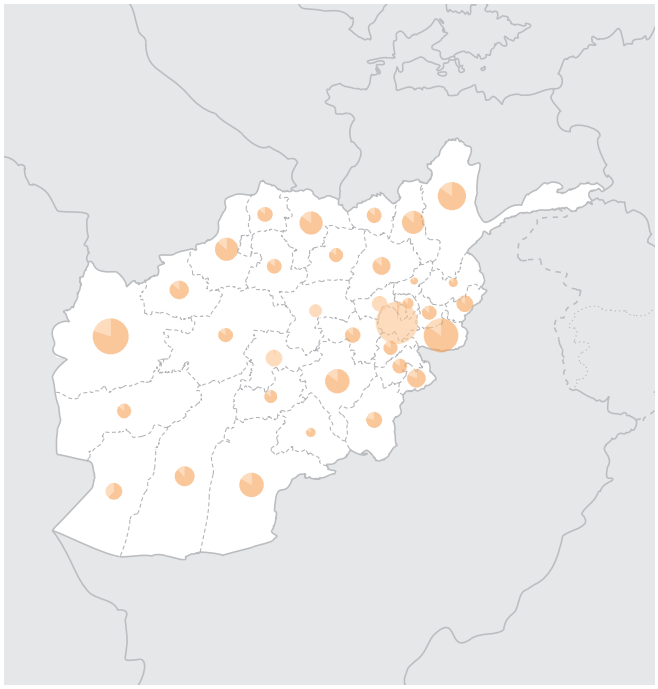
## 3.3 **Food Security and Agriculture**

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS (US$) |
|---|---|---|
| 13.2M | 9.8M | $370.3M |



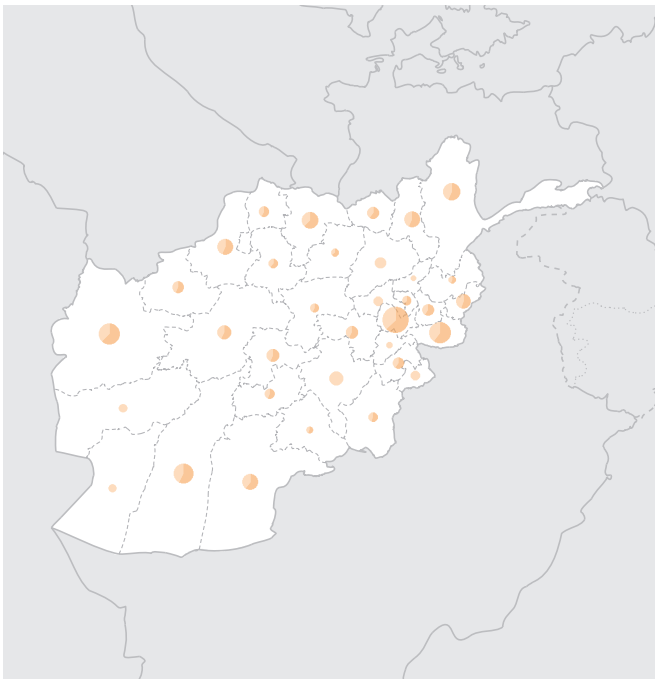
## 3.4 **Health**

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS (US$) |
|---|---|---|
| 10.1M | 7M | $171.1M |



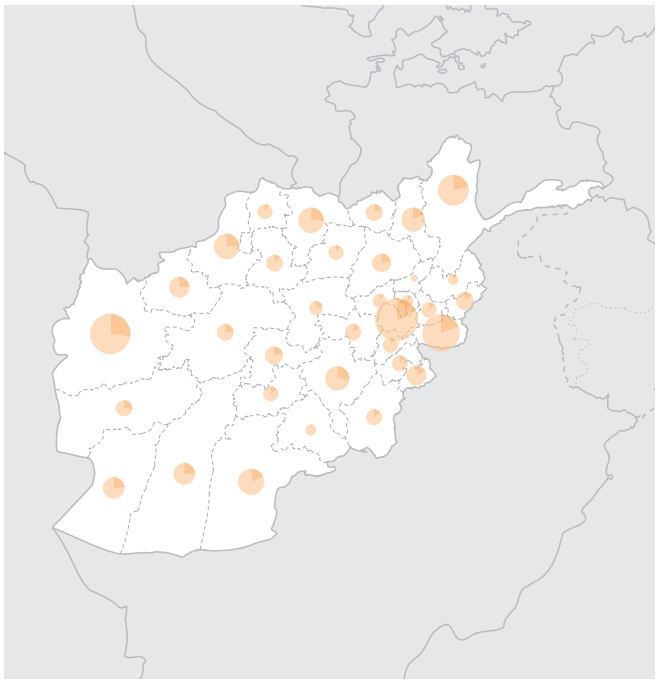
## 3.5 **Nutrition**

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS (US$) |
|---|---|---|
| 4.6M | 2.4M | $114.6M |



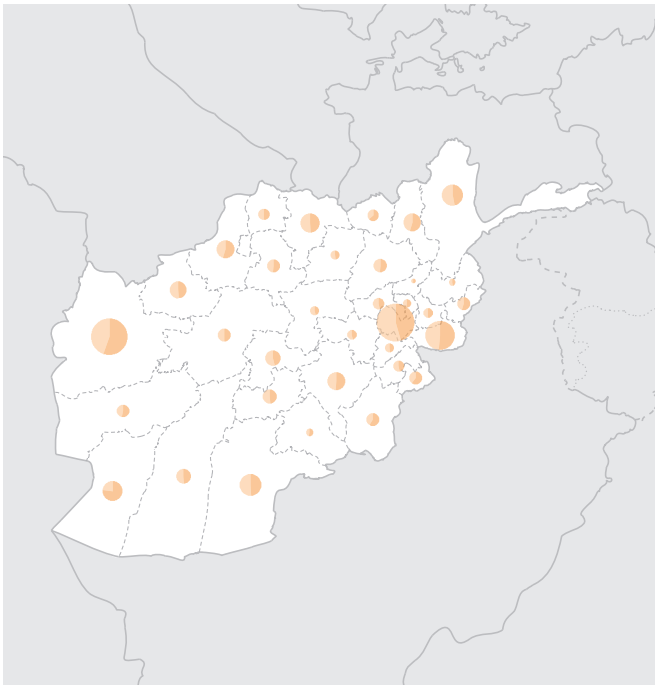
## 3.6 **Protection**

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS (US$) |
|---|---|---|
| 11.5M | 2.3M | $91.9M |



## 3.7 **Water, Sanitation and Hygiene**

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS (US$) |
|---|---|---|
| 7.2M | 3.8M | $152.2M |



3.1

# Education in Emergencies

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS (US$) | PARTNERS |
|---|---|---|---|
| 2.6M | 0.9M<br>COVID-19: 0.5M<br>NON-COVID-19: 0.4M | $68.1M<br>COVID-19: 20.8M<br>NON-COVID-19: 47.3M | 17 |

## NEEDS ANALYSIS

### New COVID-19 needs

The pandemic's burden on the already stressed education and child protection system is severe. To mitigate the spread of COVID-19, the Ministry of Education (MoE) announced the suspension of all education activities on 14 March 2020. Schools and community-based education initiatives are not realistically expected to reopen at least until September 2020. When reopening eventually takes place, it will be phased and different from province to province based on capacity for virus testing and treatment. At present, approximately 10 million children have had their normal schooling interrupted.[40] This is in addition to more than 3.7 million children who were out of school even before COVID-19.[41] After a rapid analysis of needs, the Education in Emergencies Working Group (EiEWG) has identified 2.6 million children (52 per cent of whom are boys and 48 per cent are girls) who are in need. Of these children, EiEWG partners plan to reach 0.9 million children with support.

It is feared that prolonged absence from school will result in loss of skills, especially in literacy and numeracy, and declining commitment to learning. The chances of children permanently dropping out are also higher. If children are unable to return to school, multi-dimensional poverty levels in Afghanistan could rise from 51.7 per cent to 60.9 per cent in the long term.[42] Moreover, restrictions on movement are disrupting children's routines and sense of stability, placing new stressors on parents and caregivers. This stress has the potential to increase vulnerability to violence, exploitation, and psychosocial distress, especially among IDP and returnee children who already face increased risks of physical and emotional abuse and GBV. As opportunities for income generation become increasingly limited and the situation stretches on, education will be de-prioritised even in communities where EiE programming restarts – due to unaffordable auxiliary and opportunity costs of unpaid and paid labour – thus contributing to dropout and child protection risks.

The current alternative learning modalities such as TV- and radio-based classes and e-learning are not accessible to many shock-affected and vulnerable children, as well as those in hard-to-reach and NSAG-controlled areas. Based on past trends, these groups are the most at-risk and families are frequently driven to employ negative coping mechanisms like child labour and early marriage instead of sending children to school. Other alternative learning pathways that do not rely on technology, such as small-group learning, require comprehensive protocols and strict hygiene measures to prevent transmission of the virus. This makes these largely impractical when some 33 per cent (nearly 6,000 schools that serve 2.6 million students) lack water and WASH facilities.[43] This will also require significant attention when schools are able to reopen.

## CLUSTER STRATEGY

### Multi-year strategy 2019-2021

The EiEWG will continue its strategic partnership with multi-year education funds, such as the Education Cannot Wait (ECW) fund, linking emergency-phase response to sustained access to education. ECW has committed to provide multi-year funding to the education in emergencies response in Afghanistan, ensuring approximately 120,000 children are able to access education beyond 2020.

### Cluster response objectives

In the face of the pandemic, the primary objective of the EiEWG will be to extend student, teacher and community outreach to ensure continued learning during lockdowns. During school closure, alternative learning pathways will be considered, including paper-based self-learning materials and audio-visual distance-learning modalities (TV and radio). Support to teachers' wellbeing and professional development will also be extended. To enable a protective environment for eventual school reopening, COVID-19 awareness campaigns will be conducted. Once schools re-open, the EiEWG will promote catch-up hours and the extension of the school year into the winter period. Safe school reopening is a multi-sector commitment. The EiEWG will ensure the implementation of integrated WASH responses to reopen schools safely with appropriate hygiene facilities; promote child protection (including addressing children's psychosocial needs); and extend winterisation support to reach regular schools and Community Bases Education (CBE) learning spaces in Afghanistan.

In line with SO2 of the HRP, the EiEWG will continue its advocacy around schools as protected spaces and mitigation measures to reduce the risks of violence against children attending classes. Once schools reopen, the EiEWG will resume promotion of CBEs (which are

**FAIZABAD, NORTH-EASTERN AFGHANISTAN**
*August 2017. This 7-year-old boy studies in grade 1 in a school in Faizabad, a north-eastern province in Afghanistan. He wants to become a pilot. Photo: UNICEF/UNI205872/Karimi*

better stepping stones to regular school and more formal education). Under SO3 of the HRP, the EiEWG will continue to improve access to and quality of the education provided to vulnerable school-aged children. Unlike previous years when EiE support focused only on Temporaty Learning Centres (TLC) and CBEs, the Working Group plans to reach regular schools under its new 'WASH in schools' package. Training of School Management Shuras on the importance of education, especially for girls, to increase awareness and skills in relation to gender, disability inclusion and negative socio-cultural practices (such as early or child marriage), will form part of the Working Group's contribution to community resilience building.

### Geographical prioritisation

The EiEWG considered several parameters in identifying priority geographic areas for the EiE response. These include areas hosting the highest number of out-of-school children, areas where significant gender disparities in education remain, and areas with high severity of education and protection needs based on the 2020 HNO severity analysis. Additionally, high-risk districts bordering Iran and Pakistan – in Hirat, Nimroz, Kandahar, Faryab and Nangarhar provinces – are also prioritised.

## RESPONSE PLAN

### Response plan

In quarter two, the EiEWG established a dedicated Student Learning Pathway Taskforce and Teacher Engagement Taskforce to support MOE to deliver alternative education modalities. Through the Student Learning Pathway Taskforce, partners will support the MoE to develop audio-visual distance learning materials which they hope will reach four million school-aged children. Partners have already supported the development of a rapid household survey to determine feasibility of and access to multi-media distance learning modalities. Through the Teacher Engagement Taskforce, the EiEWG will support the MoE to develop a remote teacher support framework, including guidance for teacher well-being (as teachers are also under stress during the pandemic) and professional development during the school-closure period. It is anticipated these will form the basis for stronger teacher engagement through the recovery phase of the EiEWG response. This is also expected to guide teachers in using new approaches to student assessment and learning. In the first phase of the EiE response in quarter three, the EiEWG partners, in close collaboration with the Health and Protection Clusters, will disseminate messages (through TV and radio) on health and well-being for children as well as parents

and caregivers, including on how to create a supportive learning environment at home. The EiEWG will also work with Protection partners to set up a child help line, mobile psychosocial teams and remote Psychological First Aid (PFA) for referred cases. The EiEWG will continue to engage teachers and School Management Shura (SMS) members during the school closure period to undertake community awareness campaigns to promote prevention messages in high-risk areas.

In the second phase of the EiEWG response in quarter four of 2020, partners will focus on preparing government hub schools and CBE learning spaces with adequate WASH facilities and winterisation supplies for the resumption of classes. Through a jointly developed prioritisation plan, the EiEWG and the WASH Cluster will extend clean water for drinking and handwashing (through provision of water storage containers and water chlorination facilities). While not all schools lacking access to WASH services will be reached, schools in hard-to-reach districts and those in communities affected by extreme income loss will be prioritised. In addition to water, a 2,000-litre storage tank will be provided to each CBE learning centre and two tanks will be provided to hub schools. The EiEWG will also distribute hygiene kits adapted to COVID-19. EiEWG partners will provide specialised winterisation support and heating of classrooms to ensure students can complete the academic year during the harsher winter conditions.

**Cluster capacity and operating environment**

The pandemic brings novel challenges to sustainable delivery of humanitarian services. Although EiEWG partners have a strong presence in nearly all 34 provinces (including in hard-to-reach areas), the suspension of international travel, measured lockdowns and movement restrictions have necessitated stronger coordination with national and local actors. The EiEWG will adopt a more inclusive coordination structure (at the national and sub-national levels) to elevate local voices to decision-makers.

**Cost**

The cost per person to provide education services has decreased from $110.50 to $75.40. This is due to cost savings made on activities that have been paused in quarter three of 2020. Cost savings in quarter three are balanced against expanded reach in quarter four to include: vulnerable children affected by declining household income (both in regular schools and through community-based education programmes); winterisation assistance for schools, which are expected to run through the harsh winter conditions; WASH in schools assistance; and resumption of regular education activities (TLCs and CBEs). The cost for education materials in the market has not changed, however prices for hygiene and winterisation materials have increased.

## WAYS OF WORKING

**Integrated programming/multi-sectoral responses and improving inter-sector linkages**

The EiEWG will work closely with WASH, ES-NFI, Child Protection and Health Clusters in 2020. After schools reopen, education will be the entry point for delivering an inter-sectoral response within learning spaces. The EiEWG has revised the minimum standard package of education response for 2020, which includes Child Protection, WASH, and winterisation activities. The EiEWG and the ES-NFI Cluster will jointly develop the 2020-2021 Joint Winterisation Strategy – with the EiEWG leading on school winterisation and ES-NFI on household winterisation components. The EiEWG will also cover all the infrastructure and hygiene components of its 'WASH in schools' assistance while the WASH Cluster will focus on provision of the water itself and provide technical oversight and maintenance of WASH facilities. Throughout its response, the EiEWG will ensure collaboration with communities, parents and school staff to ensure application of MoPH's COVID-19 protocols.

## People in need and planned reach (2020)

| | BY POPULATION GROUP | | | | | | |
|---|---|---|---|---|---|---|---|
| | PEOPLE DISPLACED IN 2020 | RETURNEES IN 2020 | PEOPLE AFFECTED BY SHOCKS | ACUTELY VUL. PEOPLE WITH HUM. NEEDS | REFUGEES LIVING IN AFG. | TOTAL | REQUIREMENTS US$ TOTAL |
| People in need | 0.22M | 0.12M | 0.04M | 2.23M | 0.002M | **2.6M** | **68.1M** |
| Planned reach | 0.14M | 0.07M | 0.03M | 0.69M | 0.002M | **0.9M** | |

Evidence from Ebola outbreaks and other emergencies shows that national and local capacities are fundamental to successful crisis responses and recovery from them. The EiEWG will, therefore, ensure national and local actors have been fully involved in the design and implementation of the response. EiEWG partners are encouraged to establish structured partnerships with local actors and co-implement with them, where possible, for sustainability of operations.

### Links to development programming

While EiE programming has historically served as a stopgap measure to mitigate disruption of education during crises, linkages to development support and formal schooling are required so that shock-affected children maintain sustained access to education. The COVID-19 pandemic only highlights the shortcomings of an emergency-only response. In its revised planning, the EiEWG will conduct a mapping exercise to identify the humanitarian-supported CBE programmes in the country in an effort to create links with development programming and create opportunities for longer-term learning pathways. This includes identifying children enrolled in CBE who might be transitioned to formal/hub schools. However, children in CBE programmes and those who are out-of-school are usually unable to make this transition due to poor absorption capacity from hub schools and insufficient transition planning. The EiEWG aims to coordinate with development actors to address this issue. These coordination efforts include using the COVID-19 lens to start system-wide reforms, the roll-out and scale-up of a new curriculum, and capacity-building of CBE and formal public-school teachers to deliver quality, inclusive instruction and classroom management.

### Cash programming

To deal with the economic challenges of the pandemic, vulnerable households are likely to adopt negative coping mechanisms, such as taking children out of school, pushing children to engage in child labour, and forcing children into marriage. The EiEWG is considering cash and voucher modalities, where feasible, to address financial barriers to education. The Cluster is exploring the extension of an unrestricted and unconditional multi-purpose cash[44] grant to cover basic needs and mitigate the impact of COVID-19 on vulnerable children's education.

## DATA

### Methodology

In its revised analysis, the EiEWG identified that school closures and the socio-economic impact of the pandemic have left more children in need of EiE assistance. The EiEWG estimates it can support 70 per cent of girls and 60 per cent of boys from within its initial planned reach among IDP, returnee and shock-affected children. This estimation is based on an assumption that not all children who were planned to be reached with EiE support at the start of the school year will start classes when schools eventually reopen. Approximately seven per cent of children who are acutely vulnerable, are at risk of dropping out, and have exercised negative coping mechanisms, also have been included. Additionally, the EiEWG has included schools and CBEs with no access to clean water and hygiene options.

### Monitoring

To improve monitoring of response, the EiEWG will develop tools (using mobile phones) to enable partners to collect and share data. The EiEWG will conduct capacity-building workshops for all new sub-national focal points, Provincial Education Directors (PEDs), and national and international NGOs once schools reopen. To ensure community feedback guides the response, the EiEWG will work with partners to develop a standardised feedback and complaint mechanism.

### Gaps and limitations

To improve data quality issues (data inconsistencies, duplication and lack of disaggregation), the EiEWG has conducted a series of trainings in 2020 to improve reporting. While significant improvement has so far been seen, much work remains to be done, including to overcome COVID-19 challenges to data collection and monitoring of needs and response. Further trainings aimed at sub-national EiEWG partners and coordination bodies are planned in quarter four of 2020.

## Contacts


| TILAL MOHAMED SALIH | ROMAL ABDULLAH |
|---|---|
| EiEWG Co-Lead | EiEWG Co-Lead |
| UNICEF | Save the Children |
| tmsalih@unicef.org | romal.abdullah@savethechildren.org |

3.2

# Emergency Shelter and NFI

| PEOPLE IN NEED | PLANNED REACH | | REQUIREMENTS (US$) | | PARTNERS |
|---|---|---|---|---|---|
| 5.3M | 1.4M | COVID-19: 0.7M<br>NON-COVID-19: 0.7M | $122.9M | COVID-19: 67.5M<br>NON-COVID-19: 55.4M | 40 |

## NEEDS ANALYSIS

### New COVID-19 needs

Conflict, natural disaster and poverty continue to drive shelter and NFI needs across different population groups. With the COVID-19 pandemic accentuating vulnerabilities, it is estimated that 5.3 million people require assistance to access shelter and household items and cope with the next winter season. Of those in need, at least 2.8 million are considered as having needs that are directly related to COVID-19 due to vulnerabilities associated with their type of shelter, security of tenure, and their inability to access sufficient priority household items, health and WASH facilities. Those who stand out as suffering the most are older people, people with co-morbidities, people with mental and physical disabilities, women, children and young people, IDPs, returnees, refugees and asylum seekers, and people who have lost their sources of income and fall outside social protection systems. These vulnerabilities are exacerbated when people live in densely populated areas with limited access to basic services, and when other shocks and stresses occur due to natural disasters (floods) or conflict.

While home isolation is recommended as the best approach for people who may have been exposed to COVID-19 but do not yet show symptoms, the ability of individuals and families to isolate themselves will depend on the type of house and/or shelter they live in. Often having fled with nothing more than personal possessions, hundreds of thousands of people displaced by conflict do not have access to adequate shelter to preserve their well-being/survival and support self-isolation. Around two-thirds of displaced households (65 per cent) reside in collective centres, open space, makeshift shelter, tents, and poor transitional shelters that do not protect them.[45] The pandemic has also decreased the purchasing power of vulnerable people with many workers in the informal sector no longer able to undertake their daily activities. Many have started reporting that they cannot afford food and other basic household items due to price inflation and the lack of income resulting from their inability to work because of movement restrictions. With 70 per cent of Afghanistan being mountainous, many people live in high-altitude areas that are susceptible to harsh weather conditions. This is particularly challenging as a staggering 63 per cent of IDPs has less than 1 blanket per person in their household. Heating of shelters already was a major challenge for people living in poverty during winter, and their capacity to cope is expected to be further eroded by COVID-19 by the time winter starts at the end of 2020.

At least 53 per cent of people in informal settlements reported that their shelter had been damaged in the last 6 months.[46] The shelter conditions and absence of centralised services for these and other vulnerable groups leaves large numbers of people (including IDPs, returnees and host communities) at heightened risk of widespread transmission of COVID-19. Returnees often reside in informal settlements with limited access to basic services and insecure land tenure. In Kabul alone, 28 per cent of returnees and IDPs are renters.[47] The pandemic also comes against the backdrop of the flood season as well as displacement due to conflict that is further complicating the response and depleting in-country supplies. Between January and May 2020, more than 39,000 people have been affected by floods, landslides, and other natural disasters. More than 75,000 individuals fled their homes due to conflict.

### Multi-year strategy 2019-2021

In 2018-2019, the ES-NFI response focused primarily on emergency shelter assistance and basic household items within an initial period of up to three months. Recognising that such support has been vital to saving lives but has not created opportunities for recovery, the ES-NFI Cluster adopted a more holistic approach at the start of 2020, with life-saving assistance being provided at the onset of the emergency alongside carefully targeted support for improved shelter conditions, in line with the HCT's course adjustment for humanitarian planning. Transitional shelter solutions will not only contribute to security, safety, health, and well-being and offer additional protection against COVID-19, but will also promote recovery among displaced and non-displaced affected people. While the unit cost of a transitional shelter is higher than a tent's costs, it will contribute in part or whole to a more durable shelter solution for an affected household, which could offer the beginnings of a permanent home and produce longer-term cost savings through reduced need for winterisation support.

In the face of the pandemic, the Cluster will continue its strategy, outlined at the year's start, with a response that is adapted to address the additional needs caused by the pandemic. The Cluster will sustain its response (emergency and transitional shelter as well as non-food items and winterisation support) to pre-existing humanitarian needs while simultaneously prioritising people with COVID-19-related vulnerabilities. To address the effects of COVID-19, the Cluster will expand the volume and reach of its emergency and transitional shelter programmes, rental subsidies and winterisation support.

**BADGHIS, WESTERN AFGHANISTAN**
*March 2020. IDPs living in tents and makeshift shelters at a site in Hirat. Photo: OCHA*

The Cluster will continue to advocate for the maintenance of a strong pipeline system. This has been crucial to rapidly mobilising a response during sudden-onset crises by avoiding lengthy procurement and transport lead times. It also is expected to be critical in overcoming COVID-19-related movement restrictions and border closures. The Cluster will leverage established logistics and supply-chain arrangements and pre-position ES-NFI supplies at strategic warehouses across Afghanistan.

### Cluster response objectives

In line with SO1 of the HRP, the ES-NFI Cluster plans to ensure people who have been directly impacted by COVID-19 or other new emergencies have access to adequate shelter and NFI assistance, thus ensuring their protection while mitigating their exposure to the virus. Under SO3, the Cluster will support the improvement of existing shelter conditions, particularly for vulnerable families who have been living in makeshift or poor shelter conditions for a protracted period. It is envisioned that vulnerable people will construct transitional shelter, carry-out shelter upgrades, or conduct repairs through short- to medium-term support or rental subsidies.

### Geographical prioritisation

Geographic prioritisation follows the 2020 HNO analysis. There are needs in every province of the country with Kabul, Nangarhar, Hirat, Badakhshan, Ghazni, Faryab, Baghlan, Kandahar, and Takhar having the most severe ES-NFI needs. The Cluster will prioritise shelter and NFI activities for newly displaced people with the highest needs who are residing in IDP sites, for people living in high-risk areas with higher connectivity to cross-border movement from COVID-19 hotspots in Iran and Pakistan, and in areas where the highest self-reported shelter needs remain.

## RESPONSE PLAN

### Response plan

In its revised planning, the ES-NFI Cluster will continue all its core lifesaving activities – emergency and transitional shelter, distribution of non-food items, and winterisation support to address needs resulting from conflict and natural disasters (new and protracted). Population density is a key factor for COVID-19 transmission. Shelter assistance can help reduce this risk by increasing available shelter and housing options for those who are vulnerable. Where people reside in a congested setting, the Cluster will expand its transitional shelter support by providing housing extensions to create partitioned and upgraded living conditions. Transitional shelter options are a good stepping stone for people's journey towards self-reliance. Such shelter and housing extension support is also expected to facilitate home isolation options for people affected by COVID-19. As a mitigation measure against COVID-19 transmission, the Cluster plans to increase the volume of NFIs (household items) to each family in order to discourage sharing of utensils within households. The Cluster will also provide tents and pre-fabricated housing units to serve as isolation places in IDP sites, storage spaces for pre-positioned stocks, additional space for health and nutrition support, and spaces for the

provision of psychosocial support and information dissemination. To address the effects of COVID-19, the Cluster will expand its rental support to help people (particularly those in informal settlements) cover rent, utilities, and other housing-related needs. This should prevent possible evictions.

The Cluster will also expand its winterisation assistance to assist more vulnerable people (including those whose needs have been exacerbated due to COVID-19-related income loss) with heating and fuel support to help them cope during the winter. Together with other clusters, the ES-NFI Cluster will develop the 2020-2021 Joint Winterisation Strategy. During delivery of all assistance, ES-NFI partners will mainstream risk communication and community engagement to reduce fear and misinformation. Existing community mechanisms, as well as distribution activities, will be leveraged to disseminate sensitisation messages. Information, Education and Communication (IEC) materials will be disseminated during shelter and NFI distributions. The Cluster will also prioritise protection of frontline staff through provision of non-medical PPE (for example, reusable masks, alcohol-based hand sanitizer and gloves) and installation of handwashing stations at NFI distribution centres.

### Cluster capacity and operating environment

In 2020, it is anticipated that the number of partners managing or implementing the ES-NFI response across Afghanistan will remain similar. However, new approaches are required to encourage partners to stay and deliver. So far, COVID-19 has affected the way rapid assessments (including group discussions), trainings and post-distribution monitoring exercises are undertaken. Logistics challenges related to border closures are threatening the response. The capacity of humanitarian agencies to import relief items, among other factors, will depend on border opening and the stability of local and international suppliers. Delays in delivery of core relief items to affected regions may further be experienced if domestic movement restrictions and border closures are extended. Conflict and natural disasters such as such as floods, add to the pressure in terms of supplies.

### Cost

In its revised planning, the cost-per-person for the ES-NFI response has increased from $77.70 to $87.70. This is due to the introduction of costlier housing extension kits as a new component of the shelter package. There is also an increase in the number of people planned to be reached with rental support and a scaled-up winterisation assistance to include those unable to pay rent and those who have lost their livelihoods due to COVID-19 and the related movement restrictions. While these increases are considerable compared to the original HRP, the cumulative number of additional people reached with transitional shelter and winterisation assistance remains marginal compared to the needs. A cost increase in the standard NFI package (based on updated market assessments) and an increase in the volume of items per household to discourage sharing add to the increased ES-NFI costs.

## WAYS OF WORKING

### Integrated programming/multi-sectoral responses & improving inter-sector linkages

The Cluster will seek to respond through area-based approaches that are inclusive of all population groups. Complementarity and integration with other clusters is critical. ES-NFI will work closely with the Protection Cluster to support people at risk of eviction and in need of rental support. The Cluster will work with Health and other clusters to utilise prefabricated housing units to support the extension of existing spaces for health and other services. Together with the EiEWG, Food, Protection and WASH clusters, the ES-NFI Cluster will develop the 2020-2021 Joint Winterisation Strategy (expected at the end of June 2020) reflecting inter-sectoral priorities. The Cluster will focus on household winterisation needs while the EiEWG will focus on a minimum package for school winterisation. Where opportunities exist, the Cluster will aim to ensure that short-, medium-, and long-term programming are coherently aligned to effectively reduce needs and build resilience.

### Links to development programming

The Cluster will continue to advocate and coordinate with the Government and development actors, including UN Habitat, for sustainable shelter solutions for IDPs, returnees and those affected by conflict or natural disasters. This includes supporting pathways

## People in need and planned reach (2020)

| | BY POPULATION GROUP | | | | | | |
|---|---|---|---|---|---|---|---|
| | PEOPLE DISPLACED IN 2020 | RETURNEES IN 2020 | PEOPLE AFFECTED BY SHOCKS | ACUTELY VUL. PEOPLE WITH HUM. NEEDS | REFUGEES LIVING IN AFG. | TOTAL | REQUIREMENTS US$ TOTAL |
| People in need | 0.32M | 0.26M | 0.09M | 4.63M | 0.04M | **5.3M** | **122.9M** |
| Planned reach | 0.22M | 0.17M | 0.08M | 0.90M | 0.03M | **1.4M** | |

for communities to access resilience-building projects such as the Citizens' Charter project. The Cluster will continue to support relevant government ministries through enhancing national response capacity for shelter and settlement planning. The Cluster will also continue to advocate with its development partners to step in earlier after an emergency to provide medium- and long-term support to people affected by natural disasters, encouraging early recovery and self-reliance.

### Cash programming

The ES-NFI response will be delivered through a combination of in-kind as well as cash and voucher-based modalities. All assistance will be provided in line with the Cluster's minimum standards. In 2019, cash assistance constituted 25 per cent of the overall ES-NFI response. In 2020, the Cluster will promote the increased use of cash-based responses, as appropriate, and aims to increase the cash share to 30 per cent in 2020 and up to 35 per cent in 2021, making this Cluster the highest proportional user of cash support.

## DATA

### Methodology

For each population group, the Cluster defined a list of indicators and thresholds that highlight ES-NFI needs across the country based on the type of shelter, the extent of damage to the shelter, the type of tenancy agreement a person has, access to priority NFIs, access to heating/fuel and blankets for winter, sources of income (formal or informal) and overall level of vulnerability. From these indicators, the Cluster identified the most up-to-date sources of data available for each of the population groups. From each data source, the Cluster identified either direct or proxy indicators that can be used to link to specific thresholds on need. From the identified indicators, the Cluster defined a composite index that interlinks the severity of needs across the different indicators. The Cluster then multiplied the scores derived at the province level against the total projected planning figures to produce its regular programming numbers.

For the COVID-19 response numbers, in coordination with partners, the Cluster identified a list of vulnerabilities that aggravate the risk of transmitting COVID-19, including age, co-morbidities, lack of income, households at risk of eviction, populations residing in IDP sites with the highest needs, districts in high-risk provinces of return, and access to health and WASH facilities. The Cluster then applied the COVID-19-specific scores against the regular programming numbers to provide a sub-set for COVID-19.

### Monitoring

The Cluster will continue to rely on the WoA Assessment and partner assessments to guide its response. ES-NFI will collect response data through the ReportHub database to measure progress against cluster objectives and will publish these results monthly to highlight gaps in the response. Additionally, ES-NFI will also undertake regular field missions to hotspot areas to verify and understand key drivers of ES-NFI needs. Throughout 2020, the Cluster will continue to work with Awaaz to ensure communities' concerns are heard and responded to in a timely manner. The Cluster will also undertake rental-market assessments, an evaluation of the 2019 winterisation response, and a countrywide study on the local shelter architecture. Monitoring of funding, as well as stocks and pipelines for key commodities, will continue through FTS and ReportHub. Post-distribution monitoring will be used to assess the impact of the ES-NFI response and inform planning of future assistance.

### Gaps and limitations

Movement restrictions, staff health concerns, and challenges in undertaking rapid assessments have challenged regular programme implementation. In the face of these challenges, the Cluster is employing new approaches to implementation and is putting in place robust prevention measures for frontline staff – through the provision of appropriate non-medical PPE and hygiene materials. The pandemic comes against the backdrop of the flood season, as well as escalating conflict and resulting displacement. Partners' already stretched resource and response capacity is being placed under further strain by the humanitarian consequences of the pandemic – with partners sometimes having to redirect committed resources. The Cluster continues to advocate for early mobilisation of funds and pre-positioning of stocks. In a similar scale to the past, security-related constraints continue to challenge partners' capacity to access affected people in some parts of the country. Strong advocacy continues to ensure that humanitarian partners can identify and address needs driven by COVID-19 and other crises.

## Contacts


| IRENE MUTEVU | MOHAMMAD GUL AHMADI |
|---|---|
| ES-NFI Cluster Coordinator | ES-NFI Co-Lead |
| UNHCR | IOM |
| MUTEVU@unhcr.org | GAHMADI@iom.int |

3.3

# Food Security and Agriculture

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS (US$) | PARTNERS |
|---|---|---|---|
| 13.2M | 9.8M COVID-19: 3.1M NON-COVID-19: 6.7M | $370.3M COVID-19: 60.7M NON-COVID-19: 309.6M | 38 |

## NEEDS ANALYSIS

### New COVID-19 needs

The COVID-19 pandemic is magnifying a grim food security situation in Afghanistan. The latest Integrated Food Security Phase Classification (IPC) analysis shows that some 12.4 million people (33 per cent of the population) will be in "crisis" and "emergency" levels of food insecurity between June and November 2020. While there was a slight improvement from the previous projection, in which 14.3 million people (38 per cent of the population) were categorised as being severely food insecure until March 2020, the number of people in "emergency" levels of food insecurity has worryingly increased from 3.4 million to close to 4 million people. By June the lean season will be coming to an end. It is a time when vulnerable households usually have depleted their seasonal food stocks and are relying on debt to cover their short-term food needs. While the harvest that began in late-May is anticipated to bring some improvement in rural areas, the pandemic's most acute impact is expected to persist in urban centres where there is reduced economic activity and price rises. Unskilled day labourers, low-income employees, small traders and those relying on remittances from family members working abroad are the most vulnerable to economic shocks of the pandemic. It is estimated that some 44 per cent of the population – more than 16 million people – rely on livelihoods that will be disrupted by COVID-19.[48]

Rising food prices are challenging families' access to food across the country. Prices of staple foods – wheat, wheat flour, rice, oil and pulses – have remained at elevated levels since a steep rise in mid-March 2020.[49] Some of the surge in prices may be associated with delays in imports from Pakistan (which had closed its border for all movement before opening key crossing points in the second week of April for limited movement) and interruptions to food supply lines. In other cases, these appear to be opportunistic and not justified by actual shortages. While the cross-border movement situation has improved, sustained opening for commercial and humanitarian goods is critical to ensure accessibility of food and other basic items necessary for survival, and eventual stabilisation of prices. The pandemic has also affected agricultural, poultry and livestock supply chains. Market monitoring data[50] already shows that the purchasing power of casual labourers has deteriorated by 14 per cent from 17 March to 21 May. This is partly associated with inability to work due to lockdown measures.

In rural areas, farmers and agricultural seasonal workers are still reeling from preceding shocks (including the 2018/19 drought and 2019 floods) and are at risk of having their livelihoods drop sharply should there be further disruptions to their cultivation, harvest, and access to markets and agricultural inputs. Ongoing risks of plant diseases (such as wheat rust), locusts, floods and poverty have compounded smallholder farmer's vulnerabilities. A likely intensification of COVID-19 in the country and introduction of further movement restrictions and border closures will have adverse effects in rural areas – disrupting supply chains of agricultural and poultry, and livestock inputs as well as products at critical times in the season and creating diminished returns for these products due to restricted access to local and regional agriculture-produce markets. If it materialises, this will cause a strain on cash flows and coping capacities of vulnerable farmers and herders. The impact of the pandemic will hit those with reduced coping capacity the hardest, especially the landless, marginal and smallholder farmers and herders, including the nomadic Kuchi. Vulnerable smallholder farmers and herders struggling to meet their basic needs may ignore prevention measures as they seek to sell their products in markets.

Any further deterioration in the current COVID-19 or conflict situation could significantly affect food insecurity, including access to agriculture inputs for the coming autumn planting season. As such, FSAC will undertake a detailed IPC analysis in mid-2020 to confirm whether adjustments to current projections are required for the remainder of the year. Continuous monitoring of food prices is also critical.

## CLUSTER STRATEGY

### Multi-year strategy 2019-2021

In line with its renewed strategy at the start of 2020, the FSAC maintained its focus on a deeper vulnerability analysis and plans to support vulnerable people to cope with the effects of new and protracted shocks. Unlike past years, the Cluster has included urban food insecurity in its analysis and response planning. In addition to scaling up ongoing food distributions, FSAC will prioritise support towards local food production and strengthening local value chains along with communal asset creation through cash and food-for-work. This is a cost-effective means to rapidly increase and sustain food availability, while protecting agriculture-based livelihoods and

**SURKH ROD, EASTERN AFGHANISTAN**
*Photo: OCHA/Charlotte Cans*

safeguarding coping capacities. Investing in local food systems provides people with the means not only to survive, but also to absorb shocks and endure this crisis. In the face of the pandemic, the FSAC's response strategy is to build a COVID-19 lens within existing critical humanitarian food and livelihood assistance. Considering the impacts of the pandemic, the FSAC's response strategy will be centred around a set of early action pillars that are aimed at protecting agricultural livelihoods and rapid response food assistance by:

- ensuring the uninterrupted functioning of all agriculture activities and related markets;
- ensuring that relevant stakeholders in food value and supply chains as well as agri-food systems, in particular, providers of staple crops, adopt COVID-safe practices so as not to contribute to the transmission of the virus;
- supporting seasonal migration of nomadic groups to summer and, later, to winter pastures in a COVID-safe manner;
- providing nutritious food assistance, including fortified wheat flour (with iron supplements);
- undertaking regular and in-depth market monitoring of food and agricultural input prices to inform response planning.

This focus on uninterrupted and safe agriculture value chains and food supply chains will be orientated towards mitigating the impacts of COVID-19 while avoiding interruptions to regular agricultural activities. It will also help the Cluster anticipate supply shocks and monitor household-level coping actions to guide early warning and early action. Such monitoring will also inform targeted advocacy around opening food and agriculture transport corridors while safeguarding the health of farmers across the value chain in line with national public health guidelines.

**Cluster response objectives**

In its revised planning in 2020, the FSAC's primary objective is to deepen the linkages between existing humanitarian food and livelihood assistance in areas highly affected by COVID-19. Considering the key pillars that form the basis of food and livelihoods planning, the Cluster's objectives outlined at the beginning of the year remain the same. Under SO1 of the HRP, the Cluster aims to ensure continued and regular access to food for acutely food insecure people across the country. In 2020, this will now include specific food assistance for additional people who are vulnerable as a result of COVID-19. In line with SO1 and SO3, the Cluster also plans to ensure access to livelihoods protection assistance for shock-affected vulnerable people at risk of hunger and malnutrition. Under SO3 of the HRP, the FSAC will strengthen resilience capacity through emergency preparedness, timely assessments and response, and enhanced capacity of partners to deliver effective assistance.

**Geographical prioritisation**

The FSAC's geographic priorities will continue to be areas with high concentration of vulnerable people experiencing acute food insecurity (IPC 3 and 4). Priority areas where emergency levels of food insecurity (IPC 4) have been recorded include urban centres in Kandahar and Hirat, and Daykundi and Badakshan provinces. The FSAC will also prioritise areas where livelihoods have significantly destabilised as reflected through the increase of people in IPC 4 over the projection period. Current analysis shows that urban areas and key agricultural market hubs are highly affected by the impact of COVID-19. Efforts will continue to support areas with high returnee and refugee populations, including refugees in Khost and Paktika.

## RESPONSE PLAN

**Response plan**

FSAC partners continue to assist food-insecure and vulnerable families across Afghanistan. In its revised planning, the Cluster will maintain all its emergency food and livelihoods assistance while expanding its reach to additional vulnerable households whose needs have been aggravated in the pandemic. The response will focus on urban and rural areas and strive to reach, with different amounts of assistance, the majority of those identified as being at 'crisis' and 'emergency' levels of food insecurity (IPC 3 and 4) throughout the year. Continuation of planned food assistance is critical to ensuring the population can survive the challenging months ahead.

To mitigate challenges posed by the pandemic, FSAC partners have adopted operational and logistical flexibility. This includes smaller distributions, limiting the number of people present at distribution sites to allow for physical distancing, and installing hand-washing stations in distribution sites. Families already selected for assistance have been provided with double rations of food or once-off cash, to limit the number of people at distribution sites and help families stay home during lockdowns without going hungry. FSAC partners aim to reach 8.3 million people with food assistance throughout 2020. As all schools are closed and regular school-feeding programmes are on hold, FSAC partners are providing alternative take-home packages (with a continued focus on approximately 61,000 female students), which parents collect from schools once a month. FSAC partners will continue their emergency and seasonal livelihood support and will expand to reach new people whose needs have been aggravated by the pandemic. Emphasis will be on ensuring that vulnerable marginal/smallholder households do not miss the autumn wheat-planting season as well as the livestock protection needs of vulnerable Kuchi households being safeguarded in a time-critical manner.

In addition to the 2.3 million people that will be reached through livelihood activities, FSAC partners will provide complementary support to 60,000 people through the distribution of PPE and will conduct campaigns in the most congested markets across the country to promote adoption of COVID-19-safe practices including handwashing, sanitisers, disinfectants, PPE, and physical distancing. Partners will also undertake capacity-building of authorities, food-market managers, farmers and other stakeholders on the adoption of COVID-19-safe practices as per WHO guidelines, to mitigate the risk of transmission and keep the domestic food supply chains functional.

In line with government relief efforts, FSAC partners will provide one-off cash assistance to urban households suffering from the economic impact of lockdowns – approximately $78 to cover immediate food needs. This amount was determined as comparable to the Government's response but is lower than the value of a standard food basket, (estimated at $90). Seasonally food-insecure households will continue to be served with ongoing food assistance, which has been increased from three to four months to promote improved food security. To facilitate recovery, the FSAC will create a systematic integration between scaled-up, agriculture-based livelihood assistance with complementary cash transfer programmes. Communal asset creation/rehabilitation activities will also be increased. Unconditional

### People in need and planned reach (2020)

| | BY POPULATION GROUP | | | | | | |
|---|---|---|---|---|---|---|---|
| | PEOPLE DISPLACED IN 2020 | RETURNEES IN 2020 | PEOPLE AFFECTED BY SHOCKS | ACUTELY VUL. PEOPLE WITH HUM. NEEDS | REFUGEES LIVING IN AFG. | TOTAL | REQUIREMENTS US$ TOTAL |
| People in need | 0.40M | 0.15M | 0.12M | 12.45M | 0.07M | **13.2M** | **370.3M** |
| Planned reach | 0.40M | 0.15M | 0.12M | 9.05M | 0.07M | **9.8M** | |

cash transfers and backyard poultry and/or nutrient-sensitive kitchen-gardening inputs for women-headed households and other vulnerable groups will be an important way to mitigate this economic shock. This will also allow the poorest households to maintain a level of access to fresh and nutritious food.

In its response, FSAC will prioritise subsistence and small-scale farmers, urban poor in vulnerable employment, agricultural labourers (landless farmers), labourers along the rural-urban food value chain, IDPs, returnees and vulnerable nomadic and semi-nomadic pastoralists who face movement limitations. Among these groups, FSAC partners will prioritise women-headed households and households headed by a person with disability. Partners will be encouraged to strengthen feedback mechanisms and increase engagement with Awaaz Afghanistan.

### Cluster capacity and operating environment

Aside from temporary interruptions to movement of food and agriculture supplies and some delivery delays associated with 'measured lockdowns' across different provinces, the capacity of FSAC's implementing and cooperating partners remains largely unaffected by COVID-19. Humanitarian movement during these measured lockdowns is being addressed on a case-by-case basis. While the limited movement between Afghanistan and Pakistan has temporarily created longer transport lead times, this has not significantly affected the FSAC's capacity to respond. The impact of such border closures is dependent on the length of time these interruptions last and protectionist actions taken by neighbouring countries. FSAC partners have already demonstrated the capacity to deliver an increased volume of assistance by rapidly mobilising double-ration distributions.

### Cost

The cost per person to deliver food assistance has increased from $18 to $19 per person in this revision of the HRP. This marginal increase in cost of food delivery is due to the inclusion of PPE for delivery staff and distributing awareness materials. However, for the caseload of COVID-19-affected people, the cost per person will be $10 per person. This is because this newly added caseload will receive only a partial basket of assistance to complement their existing food stocks and bring this assistance in line with planned government relief assistance. So far, additional costs related to transportation and food prices in local markets have not yet affected humanitarian requirements. The global food market is also not yet facing challenges with food availability. The costs for livelihood assistance package costs vary from $12 per person to $35 per person depending on the assistance package and activity. There are plans to re-evaluate the food basket and livelihood assistance package prices by mid-2020 as the impacts from the intermittent border openings and changes in domestic production become clearer.

## WAYS OF WORKING

### Integrated programming/multi-sectoral responses & improving inter-sector linkages

The FSAC will coordinate with the Health and Protection clusters to deliver pre-established COVID-19 messages and guide its awareness-raising efforts. In addition, the COVID-19 situation may increase the risks for the most vulnerable experiencing abuse, neglect and violence. Food support to these groups will be explored where appropriate. Livelihood programmes by partners have already included supporting the production of COVID-19-related protective masks to stimulate economic activity and meet health needs. The FSAC also is committed to jointly addressing the issues of malnutrition and access to clean water. FSAC will, therefore, work with the Nutrition Cluster to develop more targeted nutrition indicators during the annual Seasonal Food Security Assessment (SFSA) and jointly assess where food insecurity and nutritional gaps overlap. Joined-up programmes will be promoted in these areas to deliver maximum food and nutritional outcomes for affected people. Similarly, areas with lower access to basic services (as identified by the WoA Assessment) will also be prioritised for joint needs assessments with the WASH Cluster.

### Links to development programming

FSAC partners are engaging proactively with the World Bank in its relief efforts to address the needs of chronically poor households across the country under its social safety net type response. Complementary assessments are being planned and the FSAC is contributing to the design of World Bank's COVID-19 REACH project. Joined-up targeting will be considered for maximum impact. The IPC analysis has provided the baseline for development partners' analysis of people in need of social assistance against the backdrop of COVID-19. The FSAC will continue to engage UNDP in the annual SFSA and support the development of social protection assessments. Later in the year, the Cluster is planning to undertake a workshop for food and livelihoods actors in the humanitarian and development streams aimed at improving recovery work. The FSAC further plans to work with the HLP sub-cluster to determine land-tenure challenges and guide agriculture-based activities.

### Cash programming

In its revised planning, the FSAC plans to further expand its reach through cash assistance, primarily to those in urban areas. FSAC considers cash assistance as a key approach to address immediate basic needs and support livelihoods recovery where markets are functioning and affected people can access them. Rural livelihoods assistance will also feature an increased focus on cash assistance where appropriate. Prior to COVID-19, the Cluster had already planned to increase its cash footprint from 15 per cent in 2019 to 20 per cent in 2020. Depending on market assessments and financial service

provider agreements, it is anticipated that up to 25 per cent of the FSAC response could be delivered through cash by the end of the year.

## DATA

### Methodology

The primary data source for FSAC's revised planning is the updated IPC analysis conducted in April and May 2020. In addition, FSAC partners utilised qualitative assessments sourced from key informants, including agriculture offices, the private sector, implementing partners, producers, CDCs and Shura representatives. FSAC partners are undertaking rapid assessments to analyse the impact of COVID-19 on markets, consumers, farmers and nomadic people. These complementary assessments (results are expected in June 2020) will allow a more nuanced understanding of the pandemic's impact on food value and supply chains.

### Monitoring

Ongoing monitoring of market and agricultural value chains will be crucial to mobilising an early response to the COVID-19's impact. This includes a mix of remote (phone-based) monitoring and reliance on key informants to reduce potential exposure and spread of the virus. It is anticipated that conditions will allow for the annual SFSA to take place in August 2020, which will inform the next iteration of IPC analysis in late 2020. To have a harmonised data pool, the FSAC will continue to support complementary assessments such as the WoA Assessment and the Joint Market Monitoring Initiative.

### Gaps and limitations

Early in the COVID-19 crisis, some field-monitoring activities for some partners were paused but a phased restart of this crucial activity began in May 2020 while adhering to physical distancing and PPE requirements.

## Contacts


| JEAN-NOEL MELOTTE | BARAT SAKHIZADA |
|---|---|
| FSAC Coordinator | FSAC National Officer |
| FAO | FAO |
| jeannoel.melotte@fao.org | Barat.Sakhizada@fao.org |

# 3.4 Health

| PEOPLE IN NEED | PLANNED REACH | | REQUIREMENTS (US$) | | PARTNERS |
|---|---|---|---|---|---|
| 10.1M | 7M | COVID-19: 5.1M<br>NON-COVID-19: 1.9M | $171.1M | COVID-19: 107.6M<br>NON-COVID-19: 63.5M | 38 |

## NEEDS ANALYSIS

### New COVID-19 needs

The COVID-19 pandemic is exacting an enormous toll on individuals, families, communities and societies around the world. Daily lives have been profoundly changed, economic productivity has fallen at a record pace, and many of the traditional social, economic, and public-health safety nets that many people rely on in times of hardship, have been put under an unprecedented strain. It took just a few months for a localised outbreak of COVID-19 to evolve into a global pandemic with three defining characteristics: speed and scale, with the disease spreading quickly around the world and overwhelming even the most resilient health systems; severity, as 20 per cent of people have severe or critical cases, with a crude clinical case fatality rate of more than 3 per cent (increasing in older age groups and in those with certain underlying conditions); and societal and economic disruption, with deep shocks to health and social care systems and measures taken to control transmission creating adverse socio-economic consequences.

The new virus has presented an unprecedented challenge to Afghanistan's under-developed health care system, which is thinly spread across the country due to ongoing conflict and insecurity, and to under-investment in infrastructure. About 30 per cent of the country's people has limited access to basic health services within a two-hour travel radius of their home. The fragile health system is further overburdened by mass casualty incidents and recurrent outbreaks of communicable diseases, especially among IDPs – a situation that COVID-19 only worsens. Auxiliary costs associated with attaining health care mean that many of the most vulnerable households are unable to afford access to critical health services – this could be crucial in the fight against COVID-19. Women and girls face additional challenges in accessing health services. The combination of restrictions on men providing medical treatment to women and a shortage of women health professionals (particularly in rural areas) compromises women's access to sustained and quality health care. Across the country, only 15 per cent of nurses and two per cent of medical doctors are women – far below the 75 per cent global average of female health personnel. In the face of COVID-19, this means that women and girls are less likely to seek health care, even though the role of caring for the sick and elderly within the home disproportionately falls upon them, potentially exposing them to the virus. A significant portion of Afghanistan's citizens have a disability. More than four decades of war have left millions with amputated limbs, visual or hearing disabilities, depression, anxiety and post-traumatic stress. This pandemic exacerbates the problems faced by people with disabilities. For those with disabilities who live in rural areas far from medical clinics, the absence of transportation, lack of paved roads, and long distances to clinics can create insurmountable barriers to obtaining health care.

All groups of people in Afghanistan's Humanitarian Response Plan – IDPs, returnees, shock-affected non-displaced people, acutely vulnerable people (reeling from the cumulative impact of past shocks) and refugees – are at risk of disproportionately suffering from the outbreak's health and socio-economic impact. Presently, most of the COVID-19 deaths recorded are among those with underlying conditions such as diabetes and cardio-vascular disease. Even before the pandemic, the incidence of a range of serious diseases was especially high among people displaced by conflict – notably measles, AWD in children under five and tuberculosis. Polio and Crimean Congo Haemorrhagic Fever outbreaks also persist across Afghanistan's provinces. These co-morbidities make these groups of people highly susceptible to complicated infections if they contract the virus. It also makes the continued provision of non-COVID-19 health care critical. Even in a 'normal' year, 13 per cent of all deaths among children under five in Afghanistan are associated with diarrhoeal diseases.[51] The combination of other underlying factors, including low vaccination coverage (required for stronger immune systems) and long-term poor nutrition, add to the COVID-19 vulnerabilities.

Disruption of critical existing health services is also adding needs. Due to the requirement for social distancing, two major polio vaccination programmes have been suspended in Afghanistan. This is of special concern to the humanitarian community as Afghanistan is one of two countries in the world that has not yet eradicated wild polio. If this interruption to services is sustained, it is estimated that 9.9 million children will miss critical polio vaccinations, putting them at risk of lifelong impairments and hampering global efforts to stamp out the disease for good. Polio health workers and volunteers have been redeployed to COVID-19 surveillance and case identification work. The pandemic is expected to further strain preventative health-care services. Even prior to COVID-19, antenatal care was accessible only to a limited portion of the population – up to 32 per cent of IDPs


**HIRAT, WESTERN AFGHANISTAN**
*March 2020. Screening returnees from Iran at the border in Islmail Qala. Photo: OCHA/Linda Tom*

report unavailability of antenatal care where they live.[52] Access to these services is expected to be further reduced by the outbreak and people's unwillingness to go to health facilities because of travel costs and fears of catching the disease. Between January and April 2020, attendance rates for antenatal care in Comprehensive Health Centres and at the district level have decreased by 31 per cent compared to the same period in 2019. At the same time, community-based health providers such as mobile health teams have been overwhelmed and seen an increase in demand by up to 83 per cent in 2020.

## CLUSTER STRATEGY

### Multi-year strategy

The overarching multi-year humanitarian strategy for the Health Cluster remains intact but with the added dimension of COVID-19 requiring a massive scale-up of services and adjustments to some delivery modalities, under the overall leadership of the Government. The strategy uses a medium-term planning lens for health actions and seeks to enhance engagement with spheres of influence outside the scope of humanitarian action, to find lasting solutions for the people in need. While recognising the need for nexus-conscious programme design, the Health Cluster strategy remains primarily a humanitarian one that is underpinned by adherence to and promotion of IHL, as well as the humanitarian principles of humanity, impartiality, neutrality and independence. In 2020 and 2021, the Health Cluster aims to: provide access to quality, affordable and essential life-saving health services, including in response to COVID-19; ensure that vulnerable communities and health facilities are better prepared to respond to emergencies, particularly during conflict and the current pandemic; and promote access for vulnerable people in Afghanistan to health services due to strengthened health coordination, information and health advocacy.

Successful implementation of adapted COVID-19 preparedness and response strategies will depend on strong national and sub-national coordination, as well as on community engagement. Under the leadership of the Government, the Health Cluster intends to engage relevant Line Ministries to provide coordinated management of COVID-19 preparedness and response. The Health Cluster has included significant additional activities in response to COVID-19, including more extensive surveillance activities, risk communication and community engagement, infection prevention control activities, and acute respiratory diseases case management as related to COVID-19.

### Cluster response objectives

In the 2020 HRP revision, the overall goal of the Health Cluster is to control the pandemic by slowing down transmission and reducing mortality associated with COVID-19, while simultaneously maintaining other critical life-saving health assistance so that lives are not lost to other illnesses. COVID-19-specific objectives are summarised below:

- Control sporadic and clustered cases and prevent community transmission by rapidly finding and isolating all cases, providing people appropriate care, and tracing, quarantining and supporting all contacts.
- Suppress community transmission through context-appropriate infection prevention and control measures.
- Reduce morbidity and mortality by providing appropriate clinical care for those affected by COVID-19, and by ensuring the continuity of essential health and social services.

As outlined in the original 2020 HRP, in line with SO1, the objective of the Health Cluster is to respond to immediate health needs in Afghanistan by ensuring access to critical and lifesaving health assistance through health service delivery. In line with SO2, the Health Cluster will continue to advocate against attacks on health facilities that cause massive interruptions to service provision every day and will explore mitigation measures that make health centres safer places to work and to receive treatment. In line with SO3, the Cluster had planned to strengthen the preparedness and resilience of the health system, and the preparedness of vulnerable communities more broadly, giving them a better chance of recovery. In this revision, the Cluster will now prioritise COVID-19-focused system-strengthening activities, instead of using the broader lens originally planned.

**Geographical prioritisation**

The Health Cluster, through its risk communication and community engagement, and surveillance, plans to reach all corners of the country. There is an increase in focus on hard-to-reach areas and areas controlled by NSAGs, where access to health care has been limited and where the COVID-19 response provides new potential openings.

## RESPONSE PLAN

**Response plan**

With regard to the pandemic, the focus of health response is on preparedness, containment and mitigation – strengthening detection and surveillance capacity at points-of-entry into Afghanistan (such as airports and border-crossing sites), and training medical staff on case management and risk communication and community engagement. Surveillance, testing, the establishment of isolation wards and intensive care units (ICUs) also are critical to supporting the national health system to cope with COVID-19. This work will reach a new population group – those who will become seriously ill and require hospitalisation due to the pandemic. A common planning figure of 300,000 people has been agreed to by the ICCT for this group based on a hybrid of multiple global models and consultations with the Centre for Humanitarian Data. To expand its reach, particularly in hard-to-reach and NSAG controlled areas, the Cluster aims to deploy more, well-equipped mobile health teams and pre-position medicines and supplies. This will not only extend COVID-19-related health care, but also mitigate disruptions to other ongoing health services. There has already been a notable decline in the seeking of obstetric and antenatal care – partly due to a self-imposed reluctance to go to health facilities for fear of transmission of the virus. Health partners will focus on providing such services through community-level health facilities (as opposed to hospitals) to increase reach, requiring provision of specialised training and equipment to these locations. This will allow people to receive care closer to home. Disease surveillance campaigns will continue. Mobile health teams will be augmented to include an additional vaccination component. The Health Cluster will work together with the Protection Cluster and provide mental health and psychosocial support (MHPSS) through health services to meet increased need. The Cluster will link its COVID-19 activities with the polio eradication programme, where

## People in need and planned reach (2020)

| | BY POPULATION GROUP | | | | | | |
|---|---|---|---|---|---|---|---|
| | PEOPLE DISPLACED IN 2020 | RETURNEES IN 2020 | PEOPLE AFFECTED BY SHOCKS | ACUTELY VUL. PEOPLE WITH HUM. NEEDS | REFUGEES LIVING IN AFG. | TOTAL | REQUIREMENTS US$ TOTAL |
| People in need | 0.33M | 0.30M | 0.09M | 9.34M | 0.06M | **10.1M** | **171.1M** |
| Planned reach | 0.27M | 0.22M | 0.09M | 6.42M | 0.02M | **7M** | |

operating, and draw on its staff as additional resources where it is not. The Cluster will also adapt its recovery and system-strengthening work with a COVID-19 lens. The pandemic has exposed the underlying weaknesses in the health system and the need for extensive capacity-building at the emergency end of the spectrum. In its revised response, the health response will, therefore, give specific focus to better equipping health facilities and capacity-building of health personnel, prioritising a COVID-19-type system strengthening. The Health Cluster will work with the WASH Cluster to improve availability of water and sanitation facilities and hygiene options in top priority health facilities.

Health Cluster partners will continue to implement all other non-COVID-19 essential health services with a focus on a community approach. There will be increased emphasis on providing essential services via mobile health teams. There will also be an increase in focus on mental health and psychosocial support, disability and other vulnerable groups.

**Cluster capacity and operating environment**

The Health Cluster comprises national and international partners that have diverse operational capacities and specialisations. Partners are committed to adhering to international humanitarian principles, non-politicisation of humanitarian aid, and accountability in humanitarian action, including 'do no harm' and PSEA.

A recent capacity review of Health Cluster partners showed that 85 per cent of international partners and 100 per cent of national partners are operating to full scale. The addition of redirected capacity from BPHS implementing partners – traditionally, the development side of the health response – adds to the Cluster's emergency health delivery capacity. Some 36 operational partners are currently driving the health response. Of these, 18 are national NGOs; four are UN agencies, funds and programmes; and 14 are international NGOs or other implementers, including the International Red Cross and Red Crescent Movement. The actors have operational presence in 302 districts across all provinces.[53] A 34,000-strong polio surveillance team has been re-purposed towards surveillance and case management, as well as contact tracing and risk communication activities in the COVID-19 response.

Since the onset of the pandemic, substantial funding has been received for the pandemic response. The Cluster has demonstrated its ability to absorb this significant injection of funds within current capacity. As of the end of May, the Health Cluster had supported the Government in the establishment of ten testing laboratories. The Cluster has also trained more than 34,000 polio surveillance volunteers to undertake COVID-19 surveillance, early detection and contact tracing and these teams have already been mobilised. The Cluster has trained approximately 3,000 health workers on infection prevention and control and continues to deploy more COVID-19 mobile screening teams.

National NGOs, which make up a large part of health response, have scaled-up significantly. National NGOs are key partners of the COVID-19 and broader health response. Most have been engaged in the distribution of medical supplies, risk communication activities, emergency health treatment, psychosocial support, and trauma care in some of the most hard-to-reach areas of the country. Many national NGOs have long-standing experience in providing services and have the widest presence across the country, with established links with communities and public institutions. Many of them are reviewing their operational capacity and work modalities, based on their thematic specialisation and geographic presence, to expand their coverage and capacity in adapting to this urgent humanitarian work.

**Cost**

The average cost per person of the health response has slightly decreased from $34.40 at the start of the year to $32.50 in this revision of the HRP, largely because of the inclusion of substantial high-reach, low-cost risk communication activities. Some expensive non-COVID-related system-strengthening work has also been de-prioritised due to the situation. These factors have offset rises in other costs. Some health response costs have surged as a result of COVID-19 specifically. These include more expensive hospital care and infection prevention control measures. There are increased costs of providing isolation wards and equipping health facilities with necessary testing materials, equipment, PPE and other medicines and supplies, including a significant global logistics effort to get supplies to where they are needed. Shift to more mobile health teams to expand the outreach has also added to the overall financial requirements.

## WAYS OF WORKING

**Integrated programming/multi-sectoral responses and improving inter-sector linkages**

The Health Cluster will collaborate with other sectors at different levels and on different scales. The Health Cluster will collaborate with the Protection Cluster to ensure effective implementation of activities such as MHPSS and community engagement. In addition, an integrated response to GBV will be coordinated with the Protection Cluster, as GBV encompasses protection, psychosocial and medical elements; here, the Health Cluster will focus more on the medical aspects at the facility level. The Health Cluster will build nutrition actors' capacity to screen and refer severely malnourished children with medical complications. In addition, Health and Nutrition will jointly follow the Health Service Delivery in Emergencies Framework developed by the Ministry of Public Health and continue to use joint Mobile Health and Nutrition Teams wherever possible. In collaboration with the WASH Cluster, the Health Cluster will ensure a WASH component in the assessment and rehabilitation of health facilities.

Joint information education and communication activities related to hygiene behaviour will further be coordinated between the two clusters. The Health Cluster and WHO are leading on response-wide efforts to coordinate COVID-19 risk communication and community engagement.

### Links to development programming

In line with its original planning, the Health Cluster will aim to ensure that humanitarian and development programming is coherently aligned to provide more durable and sustainable assistance to vulnerable groups, more effectively reducing needs and vulnerability and building resilience. Since the onset of the pandemic, health response capacity has been scaled-up – particularly through engagement with BPHS implementing partners and other development partners such as UNDP, which are pivoting towards a more emergency-focused response. This has further expanded the Cluster's capacity to respond to acute health needs driven by COVID-19.

### Cash programming

In the past, cash was not a component of the health response. However, with COVID-19 wreaking havoc on the socio-economic conditions that the people of Afghanistan face, the Cluster is planning cash programming for the first time to support the purchase of medicine and to address auxiliary costs associated with seeking health services, such a travel.

## DATA

### Methodology

Using a mix of multiple global models that provide a forward outlook of COVID-19 infections and deaths, the ICCT is using a common planning scenario of 300,000 people with serious infections and 80,000 COVID-19 deaths across Afghanistan in 2020. This should not be considered predictive, but rather a common basis for planning. Continued modelling work is underway by a range of institutions to better estimate the impact of the virus in developing countries such as Afghanistan.

### Monitoring

The Health Cluster continues to do assessments throughout the year. Regional Health Clusters will continue to do monthly monitoring of humanitarian projects in the field. To monitor the COVID-19 situation, the Cluster will primarily rely on surveillance data, collected at a national scale. To ensure all COVID-19 information is systematically collected, the Cluster has updated ReportHub with COVID-19-related indicators. The Health Cluster will continue to collect key performance indicators systematically that will be disseminated to inform planning and response on a regular basis.

### Gaps and limitations

Routine vaccination programmes, polio programmes, antenatal care, mental health and psychosocial support have been interrupted. If prolonged, this could lead to re-emergence of communicable diseases, non-communicable diseases and worsening maternal mortality rates. In relation to COVID-19, global supply shortages (including laboratory reagents and RNA extraction kits) are affecting testing capacities. Global logistics constraints are limiting supplies of essential equipment such as PPE, ventilators and oxygen concentrators.

## Contacts

**DAVID LAI**

Health Cluster Coordinator

WHO

laidavid@who.int

# 3.5 Nutrition

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS (US$) | PARTNERS |
|---|---|---|---|
| 4.6M | 2.4M COVID-19: 1M NON-COVID-19: 1.4M | $114.6M COVID-19: 42.1M NON-COVID-19: 75.2M | 37 |

## NEEDS ANALYSIS

### New COVID-19 needs

There is a high prevalence of under-nutrition in Afghanistan. Forced displacement, low access to basic services and natural disaster-related shocks, combined with acute food insecurity, cause high rates of acute malnutrition. Poor feeding practices of infants and young children are also strongly linked with under-nutrition. Almost all children in Afghanistan are breastfed but only 54.4 per cent of children under six months are exclusively breastfed.[54] Analysis of data from 50 SMART surveys conducted from 2015 to 2019 indicates that a staggering 15.3 per cent of infants under six months in Afghanistan are affected by wasting (a state of nutritional deficiency that creates severe health consequences, including mortality, and undermines child growth and development). Of these children, some 6.2 per cent are severely wasted.[55] In a deteriorating trend from the beginning of the year, findings of the most recent nutrition surveys show that 26 out of 34 provinces are now above the emergency threshold for acute malnutrition. The nutrition outlook for the remainder of the year remains bleak. Worsening economic conditions and food insecurity, coupled with interruptions to health services, are likely to contribute to climbing rates of acute malnutrition. Nutrition treatment is already being compromised due to movement restrictions and community fears of COVID-19. As of April 2020, the Public Health Nutrition Directorate/Ministry of Public Health's nutrition database showed a 38 per cent decrease in admissions for treatment of severe acute malnutrition in health centres – 'inpatient' treatment – and a 10 per cent decrease in 'outpatient' treatment. This is primarily due to precautionary measures taken by people to avoid health centres for fear of contracting the virus. Undernutrition is a risk factor for complications and death in people with COVID-19, as it weakens people's immune system.[56] While a clear correlation between malnutrition and COVID-19-related mortality has not yet been made, malnourished individuals are more likely to have severe COVID-19 symptoms.[57] This situation is made worse by weak health care in the country.

In the revised HRP, the Nutrition Cluster has identified 4.6 million children and women who will need emergency nutrition assistance to avoid preventable health complications, as well as prevent morbidity and mortality. This is a 38 per cent increase in needs since the start of the year. Throughout 2020, approximately 783,583 children under five are now projected to have SAM and 2.1 million children are projected to have MAM. Additionally, 650,438 acutely undernourished pregnant and lactating women (PLW) are now in need. A further 435,445 children under five, 232,877 PLW and 414,534 mothers and caretakers are also estimated to be nutritionally 'at-risk.' Of these people in need, the COVID-19 pandemic is expected to have pushed an extra 106,214 children under-five into SAM, approximately 284,688 children under-five into MAM, and about a 87,298 undernourished PLW to require life-saving treatment and nutritional support.

## CLUSTER STRATEGY

### Multi-year strategy 2019-2021

The Nutrition Cluster will continue to prioritise life-saving treatment as well as preventative nutrition services in priority locations. Past years' responses have shown that when sufficient funding is provided, the Cluster is able to reach a large number of people, in some cases exceeding projections. Over recent years, the Cluster has gradually been expanding the number of nutrition treatment sites around the country – now 1,411, up from 1,308 in 2018. These treatment sites have been critical to the provision of sustainable access to nutrition services across the country. The existing Nutrition Cluster strategy for 2020 encompasses activities that aim to address acute needs, while at the same time supporting system-strengthening. In this revision, the Cluster has adjusted its strategy to factor in COVID-19 by expanding its outreach in preventative services, employing predictive analysis to mobilise early treatment responses, and adopting mobile response delivery modalities to mitigate disruptions to people's access to services. It has also embraced cash for the first time to reduce the financial burden of accessing assistance by subsidising travel costs.

To prevent a deterioration of nutritional status aggravated by COVID-19, the Cluster will reach an expanded group of children at risk of malnutrition through its blanket supplementary feeding (BSF) programme. Prior to the pandemic, the Cluster targeted children between six and 23 months. To mitigate the pandemic's adverse effects on the nutritional status of children and subsequently their wellbeing, the Cluster will expand the age group of children targeted under its BSF programme – up to 5 years old. To estimate the likely impact of the pandemic on SAM and MAM prevalence, the Cluster

**BAMYAN, CENTRAL AFGHANISTAN**
*August 2019. A girl getting screened for malnutrition at a Medair-supported project in Bamyan. Photo: OCHA/Fariba Housaini*

applied global standards for estimation of increased acute malnutrition in a crisisand adapted it to the Afghanistan context. In terms of its facility-based nutrition-treatment assistance, the Cluster will upgrade existing facilities to meet COVID-19 standards. As a result, Nutrition partners will reach more children and women who will fall into a state of acute malnutrition. The Cluster will also expand its reach for those receiving infant and young child feeding (IYCF) assistance to include children 'at-risk' of malnutrition. In its preventative response, the Nutrition Cluster will give increased attention to informal settlements. To mitigate disruptions to ongoing assistance, the Cluster will revisit its delivery modalities with an increased focus on mobile teams to ensure nutrition services reach those who are unable to access health centres – either due to COVID-related movement restrictions or fear of approaching health facilities. Provision of counselling services on optimal maternal and childcare practices to mothers of children at risk of acute malnutrition will utilise mobile and media technologies.

### Cluster response objectives

Guided by needs outlined in the HNO and the overall Strategic Objectives of the HRP, the Nutrition Cluster's primary objective is to support the survival of children and PLW.

Under SO1 of the HRP, the Cluster aims to improve equitable access to timely and quality lifesaving curative and preventative nutrition services for vulnerable people. It will focus on priority areas with emergency level acute malnutrition and COVID-19 at-risk provinces through systematic identification, referral and treatment of acutely malnourished people, blanket supplementary feeding and micronutrient supplementation for vulnerable children and PLWs.

Under SO3 of the HRP, the Cluster plans to strengthen systems, capacity, partnerships and coordination to increase the resilience of vulnerable people to shocks and threats including COVID-19, which affect their nutritional status. Doing so will also boost people's ability to fight off and recover faster from infections and illnesses. The Cluster also plans to mitigate deterioration in acute malnutrition through prevention-oriented services such as counselling to mothers on optimal care practices.

### Geographical prioritisation

At the start of 2020, the Cluster had identified 25 priority provinces for nutrition response. The Nutrition Cluster has since re-reviewed this analysis through a COVID-19 lens. The Cluster considered several parameters – Global Acute Malnutrition (GAM) thresholds, severity of food insecurity (IPC 3 and 4), internal displacement, immunisation coverage, prevalence of diarrheal diseases, sub-standard informal settlements, prevalence of other aggravating factors, and COVID-19 risks – to inform its revised analysis. Based on these parameters, the Cluster has now identified 26 priority provinces.[58] Compared to the start of 2020, 24 of the 26 priority provinces remain the same. Farah

province was de-prioritised as assessments show an improvement in food security. Rural Kabul and Kandahar have, however, been added given the prevalence of acute food insecurity (as per the revised IPC analysis) and of COVID-19 cases.

## RESPONSE PLAN

### Response plan

The Nutrition Cluster will continue to provide lifesaving nutritional treatment services in priority locations under eight sectoral areas of need.[59] As mentioned above, in the face of the pandemic, the Cluster will expand both its nutrition prevention and treatment services, as well as rely on mobile response delivery modalities to widen people's access to nutrition services and mitigate disruptions to ongoing assistance. To improve the quality and efficiency of services for children with SAM with medical complications, the Cluster will strengthen the capacity of therapeutic feeding units (TFU) for 'inpatient' treatment and care in COVID-19 hotspots. In these centres, health workers will receive training on inpatient management of SAM among other specialised trainings such as infection prevention and control, and hygiene protocols. The Cluster will undertake functional upgrading of existing facilities to meet COVID-19 standards. This includes increased space between beds (1.5 metres) and inclusion of a WASH and an environmental health package of assistance to reduce transmission risks. In order to scale-up IYCF services and counselling on optimal maternal and childcare practices, the Nutrition Cluster will use various communication modalities – radios, cell phone messages and community announcements. IYCF initiatives promote a well-balanced, diversified and nutritious diet and contribute to maintaining a stronger immune system – a requisite to fight infectious illnesses and recover faster.[60] The Nutrition Cluster will also support partners to explore the possibility of nutrition-sensitive cash assistance and will introduce new cash rebates to cover travel costs of those getting inpatient care. The Cluster will expand its BSF programme to provinces at the highest risk from COVID-19. The expansion of the BSF programme to children under five supports nutritional resilience. Nutrition partners will target the most vulnerable households. Targeting will be jointly conducted with WFP VAM teams and other stakeholders. Additionally, SMART surveys and nutritional assessments that were planned in priority locations and require close contact between individuals, will be temporarily postponed in line with global guidelines.[61]

### Cluster capacity and operating environment

The Nutrition Cluster undertook a capacity-mapping exercise in early March 2020 and the Cluster's ability to deliver remains robust. Analysis of past years shows that the Cluster was able to reach more people than initially planned in 2016, 2018 and 2019. Conflict continues to be the main driver of access challenges for nutrition partners and the Cluster continues to work with the Humanitarian Access Group to address these challenges. In the face of the COVID-19 pandemic, the Nutrition Cluster has modified its service delivery to minimise physical contact. The current treatment modality for SAM and MAM provided at Comprehensive and Basic Health Centres often requires hours of travel from remote villages to the town centres, long hours waiting, and overcrowding. This is not recommended in the current COVID-19 context. In order to reduce the mass physical contact and minimise the risk of COVID-19 transmission, while simultaneously continuing the provision of lifesaving nutrition treatment services, the Cluster adapted wider practical mitigation measures, specific to Afghanistan. Drawing from global guidance notes, the Nutrition Cluster, in consultation with its partners and the Government, has modified its guidance on Integrated Management of Acute Malnutrition (IMAM) and IYCF. This guidance note recommends limiting follow-up visits of SAM children to fortnightly (changed from weekly), using appropriate protective materials for nutrition personnel (e.g. gloves, masks), and reducing MAM visits from fortnightly to monthly, accompanied by a scale-up in IYCF messaging. The Nutrition Cluster will simultaneously enhance services at the community level through mobile teams by deploying more teams and

## People in need and planned reach (2020)

| | BY POPULATION GROUP | | | | | | |
|---|---|---|---|---|---|---|---|
| | PEOPLE DISPLACED IN 2020 | RETURNEES IN 2020 | PEOPLE AFFECTED BY SHOCKS | ACUTELY VUL. PEOPLE WITH HUM. NEEDS | REFUGEES LIVING IN AFG. | TOTAL | REQUIREMENTS US$ TOTAL |
| People in need | 0.20M | 0.10M | 0.04M | 4.27M | 0.02M | **4.6M** | **114.6M** |
| Planned reach | 0.10M | 0.05M | 0.02M | 2.25M | 0.01M | **2.4M** | |

increasing the frequency of visits. The Cluster has expanded its reach through preventative nutrition services, particularly towards those in 'borderline' and 'at-risk' under-nutrition to mitigate a rapid deterioration in their nutrition situation.

Reflecting on supply side challenges, the Cluster foresees that intermittent border closures and movement restrictions are likely to cause further delays in the shipment and transportation of nutrition commodities in the coming months. Nutrition partners continue to advocate for the uninterrupted movement of critical humanitarian supplies to mitigate stock shortages and pipeline breaks.

### Cost

The Nutrition Cluster seeks $114.6 million to reach 2.4 million people, up from 1.25 million at the start of the year. The cost per person to deliver nutrition services has increased to $59.70, compared to $53.80 at the start of the year. This is due to the increased unit cost for 'inpatient' treatment for SAM. To reduce transmission of COVID-19, the Cluster has included functional upgrading of 'inpatient' wards (with provision of respiratory, hygiene and protective equipment, and increased space between beds). The Cluster has also included cash/voucher-based support to cover the transportation expenses of mothers seeking SAM treatment for their children. There is also an increased cost for outpatient SAM care to include protective equipment for frontline staff and the higher running costs of mobile health and nutrition teams, as the Cluster shifts to a more community-based mobile outreach modality. This is aimed at avoiding overcrowding in facilities and ensuring the ability to reach those fearing or unable to seek treatment due to COVID-19. The inclusion of more children under the BSF programme has also contributed to the added costs. The Cluster will expand its BSF programme to COVID-19 at-risk provinces to provide a malnutrition 'safety net' type preventative response.

## WAYS OF WORKING

### Integrated programming/multi-sectoral responses & improving inter-sector linkages

Nutrition Cluster partners will continue to engage with other nutrition-sensitive sectors (WASH, Health, Food Security and Agriculture, and Education) to maximise prevention of and recovery from malnutrition. Emergency nutrition services are delivered either through existing health facilities or emergency mobile teams. Nutrition partners will continue to strengthen the linkages between health and mobile nutrition teams and pursue integrated Mobile Health and Nutrition Teams (MHNTs) wherever possible. Where funding allows, the Nutrition Cluster will provide hygiene kits to acutely malnourished children and their caregivers and ensure minimum WASH facilities are functional at nutrition service centres. To ensure a comprehensive and joint response package that addresses food and nutrition security for vulnerable people, the Nutrition Cluster will work with the FSAC to undertake collaborative assessments, share nutrition data for the biannual IPC analysis, and collect supplementary nutrition data in the yearly Seasonal Food Security Assessment. The Nutrition Cluster, together with WASH and the FSAC, will continue to identify priority areas of need so that vulnerable people's access to clean water, well-functioning food and agricultural markets, and a balanced nutritious diet go hand-in-hand.

### Links to development programming

Malnutrition is a multi-causal problem that requires integrated and holistic programming for effective results. Therefore, the package of emergency nutrition services is designed to take advantage of and is complementary to ongoing, longer-term health and nutrition service delivery mechanisms. BPHS and EPHS partners are responsible for providing primary and secondary health-care services including nutrition services before, during and after an emergency. The Nutrition Cluster collaborates with BPHS and EPHS partners to build their capacity to respond during emergencies by providing essential nutrition-supply training to health workers and monitoring support of emergency nutrition programmes.

Analysis of past years' responses shows that more than half of all children with acute malnutrition induced by chronic deprivation and under-development who live in areas below emergency thresholds (which are not prioritised for nutrition response) have been left out of assistance altogether. The Cluster promotes that these needs must also be met through development investments, including preventative nutrition-sensitive services such as IYCF and social safety net type assistance.

### Cash programming

As a new approach, the Nutrition Cluster supports the adoption of cash modalities, wherever applicable. In the context of COVID-19, cash incentives to compensate mothers for the transportation costs of reaching inpatient SAM treatment sites with their children have been included in the Cluster's planning.

## DATA

### Methodology

In its revised needs analysis, the Cluster relied on the latest SMART surveys, nutrition anthropometric data from SMART surveys conducted between 2018 and 2020, the 2019 SFSA, and data from the Health Management Information System (HMIS). The Cluster also drew on other data sets regarding prevalence of diarrhoea, immunisation coverage, acutely food insecure populations (IPC 2020), displacement and COVID-19 prevalence.

The Cluster applied standard global methodology to project SAM and

MAM cases throughout the year. To estimate the likely impact of the pandemic on SAM and MAM prevalence, the Cluster applied global standards for estimation of increased acute malnutrition in a crisis situation and adapted it to the Afghanistan context. It is expected that SAM rates in IPC 4 areas will increase by 20 per cent and by 15 per cent in IPC 3 areas. The Nutrition PiN is a summation of projected SAM and MAM cases, undernourished PLW, and children and women at risk of malnutrition due to COVID-19.

### Monitoring

Nutrition Cluster partners conform to a national nutrition cluster monitoring framework. The performance of the treatment programmes is assessed using standard performance outcome indicators including cure, default and death rates in accordance with SPHERE standards. In 2020, the Nutrition Cluster will strengthen the existing system of online reporting by incorporating components that include supply monitoring and reporting on Accountability to Affected People. Furthermore, the Nutrition Cluster will conduct project coordination meetings with all stakeholders to monitor progress of implementation, identify problems, and take corrective measures to ensure efficiency. The Nutrition Cluster will also conduct biweekly virtual meetings with members of its Strategic Advisory Group, partners and the Government to monitor the implementation of nutrition responses in priority provinces with a focus on COVID-19 risk and contextual challenges. The Cluster will also receive monthly response updates from its partners and monitor stocks of nutrition commodities at the district level. Sub-national clusters and nutrition field monitors will conduct regular engagement to support partners in field-monitoring visits.

### Gaps and limitations

In the face of COVID-19 and physical distancing requirements, the Cluster will have to reduce mass screenings, SMART surveys and coverage assessments. Instead, the Cluster will continue to capitalise on existing data and information systems (survey databases and HMIS data) to evaluate changes in peoples' nutritional status and to prioritise response.

## Contacts


| AYE AYE KHAINE | BEKA TESHOME |
|---|---|
| Nutrition Cluster Coordinator | Nutrition Cluster Co-Lead |
| UNICEF | ACF |
| akhaine@unicef.org | nuthod@af-actionagainsthunger.org |

# 3.6 Protection

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS (US$) | PARTNERS |
|---|---|---|---|
| 11.5M | 2.3M COVID-19: 0.8M NON-COVID-19: 1.5M | $91.9M COVID-19: 2.1M NON-COVID-19: 89.8M | 116 |

## NEEDS ANALYSIS

### New COVID-19 needs

The humanitarian crisis in Afghanistan is, at its core, a protection crisis and COVID-19 is bringing the acute underlying protection vulnerabilities to the fore. While all population groups have critical protection needs, people with specific vulnerabilities – those with disability, single women heading households, children and women more generally, among others – have higher exposure to violence, sexual exploitation and abuse, separation from families. They risk being excluded from accessing critical services, especially during lockdowns. Women and girls bear a disproportionate brunt of the crisis and their lives are put at heightened risk. Since the beginning of the COVID-19 pandemic, global evidence suggests that a 30 per cent median increase in violence against women and girls was noticed across 15 countries.[62] In Afghanistan, GBV partners note a deterioration of the GBV environment based on several rapid assessments, including one that showed 97 per cent of interviewed women had noted an increase in GBV since the start of the pandemic crisis. Although there is a lack of representative data on GBV trends in Afghanistan, a longitudinal comparison of REACH Initiative's WoA Assessment and other protection assessment findings reaffirmed a substantial increase of people in need of GBV assistance. Reports from humanitarian partners further highlight a likely surge in negative coping mechanisms with recurrent reports of child marriage coming up through informal channels. Furthermore, where movement is restricted, people are confined, poverty and unemployment are increasing, and protection and health systems are weak, vulnerable populations are at greater risk of experiencing violence in their homes. At the same time, lifesaving care and support for gender-based violence survivors are likely to be further compromised.[63] Fear of infection and, eventually, rising public demand for medical care, may potentially make accessing GBV support services (where they are integrated and are permitted to operate) in a health-care setting difficult.

With lockdown measures in place, children are at greater risk of experiencing neglect, violence and exploitation, and face challenges related to their mental health.[64] The effects of the pandemic may be especially severe for children and families who were vulnerable prior to the COVID-19 crisis – displaced children, children in conflict hotspots, children in detention, children associated with armed forces, returnees, children living in the streets, working children, unaccompanied and separated children, children living in situations of violence, and child survivors of SGBV, including child marriage. Insecure land tenure and general housing, land and property (HLP) rights issues have also been exacerbated by socio-economic pressures associated with COVID-19, creating situations for reduced capacity to meet living costs (such as utilities and rent payments), rising household debt, and increasingly insecure tenure for the most vulnerable. Returnees' insecurity of tenure is accentuated by COVID-19-related stigmatisation. The increased number of returnees from Iran and Pakistan, and lack of familiarity of the locations they are living in, leave them at higher risk for death and injury from explosive remnants of war (ERW).

## CLUSTER STRATEGY

### Multi-year strategy 2019-2021

The COVID-19 pandemic affects some of the Protection Cluster's traditional service delivery modalities, which had relied on delivery in common spaces that are accessible to a large group of people. Consequently, the Protection Cluster and its sub-clusters have adapted their delivery modalities to continue the provision of essential services, adhering to global guidelines on physical distancing, avoiding the use of confined spaces for case management, and adapting services in light of the closures of some government facilities. In addition to shifting its delivery modalities, the Protection Cluster has designed its response strategy through an evidence-based planning process, coupled with rapid mobilisation of preventative and responsive sets of protection activities. This approach in 2020 is expected to be applied to 2021 as well.

COVID-19 response priorities will encompass the delivery of services to children through psychosocial support (using alternate/mobile outreach modalities), case management, referrals and alternative care arrangements to ensure that all children receive quality support during the pandemic. The Cluster will focus on sensitisation of returnees to explosive ordnance risk. Focused information on HLP rights and assistance for returnees, particularly those at risk of forced eviction as a result of stigma, will also be areas of emphasis. GBV survivors' access to quality multi-sectoral assistance will be supported through monitoring of GBV prevalence, case management, the provision of safe spaces, legal, health and psychosocial support, as well as the provision of dignity kits to women and girls. Joint protection

**SURKH ROD, EASTERN AFGHANISTAN**

*November 2019: This girl and her mother were displaced by conflict from Khogyani to the Surkh Rod area in the eastern province of Nangarhar. Her father was killed in the conflict and she does not go to school as she supports her family. They are being assisted with relief items by IRC, through a project supported by the AHF. Photo: OCHA/Charlotte Cans*

monitoring to inform countrywide protection analysis will be critical to ensure that individual protection assistance and specific protection services including referrals and psycho-social support, are provided to the most vulnerable households. It will also be key to ensure that those who are the most in need as a result of lost income are prevented from resorting to negative coping strategies under the immense socio-economic pressure of COVID-19, disproportionately affecting the lives of women and girls.

### Cluster response objectives

In its revised planning, the Protection Cluster aims to prevent and address critical protection problems that are exacerbated by the COVID-19 crisis. This includes identification of people in need and provision of direct assistance to vulnerable people and those with specific needs, as well as resilience-building and strengthening of coping mechanisms. Harmonised country-wide protection monitoring will provide a robust information base on the protection situation in Afghanistan. The provision of psychosocial support will be critical for the well-being and resilience-building of vulnerable people negatively impacted by COVID-19. More specifically, the sub-clusters of the Protection Cluster have the following objectives:

- Gender-Based Violence (GBV): The GBV Area of Responsibility (AoR) aims to promote the dignity and protection of women, girls, boys and men, by improving access to lifesaving GBV services, including through outreach among returnees, IDPs and host communities.
- Mine Action: Mine Action aims to protect the lives of civilians from threats posed by explosive hazards, in particular Vehicle Operated Improved Explosive Devices (VOIEDs) and ERW, through the provision of land clearance, risk education and Explosive Ordinance Disposal (EOD) activities. The Mine Action AoR also plans to ensure that mine and ERW victims' rights are advocated for and their needs are embedded in response activities. Mine Action will specifically focus on providing explosive ordnance risk education – combined with COVID-19 awareness messages – to the returnees from Iran and Pakistan due to COVID-19 to ensure their safe return in Afghanistan.
- Child Protection in Emergencies (CPiE): CPiE AoR will prevent and respond to increased child protection risks including child labour, child marriage, sexual and physical violence and abduction, by providing multi-sectoral, specialised child-protection services. These include strengthening the case management approach through provision of family tracing and reunification, alternative care and integrated psychosocial support. Children and their families affected by humanitarian

crises, including COVID-19, will have access to life-saving services and will be supported to improve their well-being with a focus on mental health and psychosocial support (MHPSS).

- Housing Land and Property (HLP): The 2020-2021 HLP response objectives include protection from eviction, durable HLP solutions for informal settlements and improved access to land and housing for IDPs and returnees. These activities will be tailored to respond to the socio-economic HLP pressures associated with COVID-19, and the eviction risk associated with COVID-19 stigmatisation.

**Geographical prioritisation**

The Protection Cluster's scope of response was focused on six main provinces before the COVID-19 crisis: Nangarhar, Hirat, Badakhshan, Kabul, Hilmand and Kandahar. Four of these provinces (Hirat, Kabul, Badakhshan and Nangarhar) remain priorities in the Cluster's revised planning as they have a high concentration of COVID-19 cases and of cross-border returnees. Additional provinces – Baghlan, Faryab and Ghazni – are now prioritised in the Cluster's response. The focus on Faryab is mainly attributed to CPiE, whose partners will provide holistic Child Protection programming, including psychosocial support and case management, with family tracing and reintegration support to returnee children. The GBV AoR will put a renewed focus on Baghlan and Ghazni, along with Hirat, Nimroz, Kabul, Nangarhar, Balkh and Kandahar, with response focused on a survivor-centred approach, multi-sectoral GBV responses including increased access to safe facilities and community-based psychosocial support outreach, caregivers' capacity-building, community engagement and awareness on key GBV issues focusing on social and behavioral aspects of COVID-19.

## RESPONSE PLAN

**Response plan**

Against the backdrop of the COVID-19 pandemic, the Protection Cluster, under its general protection umbrella, plans to:

- Scale-up case management and individual protection assistance (IPA) including psychosocial support and referrals.
- Enhance the identification of Persons with Specific Needs (PSNs) through expanded protection monitoring and existing community networks. Specific attention will be given to the most vulnerable – people with a disability, elderly, and women and children who head households.
- Provide new Cash-for-Protection assistance – a one-time cash grant to the most vulnerable households with underlying protection needs (being followed-up on through case management support or receiving other protection assistance) to prevent their exposure to further risks and them resorting to negative coping strategies.
- Scale-up of awareness-raising activities to include information on COVID-19 prevention and control, and dispelling misinformation in coordination with the COVID-19 Risk Communication and Community Engagement (RCCE) Working Group, notably to prevent further stigmatisation of communities already suffering from discrimination in Afghanistan.

While general protection partners will continue to deliver through community-based protection systems and build their capacity, some of these activities have been scaled-down as a result of physical-distancing requirements, lockdowns and closure of relevant government offices.

## People in need and planned reach (2020)

| | BY POPULATION GROUP | | | | | | |
|---|---|---|---|---|---|---|---|
| | PEOPLE DISPLACED IN 2020 | RETURNEES IN 2020 | PEOPLE AFFECTED BY SHOCKS | ACUTELY VUL. PEOPLE WITH HUM. NEEDS | REFUGEES LIVING IN AFG. | TOTAL | REQUIREMENTS US$ TOTAL |
| People in need | 0.50M | 0.57M | 0.12M | 10.25M | 0.07M | **11.5M** | **91.9M** |
| Planned reach | 0.16M | 0.20M | 0.03M | 1.91M | 0.02M | **2.3M** | |

## Sub-Sector
## Gender-Based Violence

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS |
|---|---|---|
| 7.2M | 1.2K | $32M |

The GBV AoR's revised plan considers vulnerabilities posed by COVID-19, especially intimate partner violence, reduced access to services, and employment of negative coping mechanisms. GBV responders will operate through community-based outreach (door-to-door delivery modalities through mobile teams) and the use of safe spaces in adherence with global guidelines on physical distancing. Implementing partners will provide cash assistance to those needing referrals to services, improve the GBV response capacities of caregivers, and increase psychosocial support through static and mobile approaches – for example, using health facilities and outreach teams. As global and locally collected evidence suggests the negative impact of COVID-19 will drastically increase women's and girls' existing vulnerabilities, it is anticipated there will be a higher demand on services to address urgent protection needs. Specifically, GBV implementing partners plan to provide the following response activities:

- Multi-sectoral response (psychosocial, safety, health and legal) including PEP kits and enhanced psychosocial outreach through mobile teams.
- ssistance through Family Protection Centers (FPCs) and Women Friendly Health Spaces (WFHSs) following physical distancing requirements. WFHSs provide entry points for community-based services and referrals, whereas FPCs are more suited as a one-stop-centre for specialised GBV services.
- Improved and strengthened referrals and case management, including through cash support. The scattered population and the scarcity of services render the provision of support challenging, especially in terms of resources to access and utilise services for women, girls and other vulnerable groups. Through cash, related treatment and transportation costs will be covered.
- Placement of psychosocial counsellors in health facilities and outreach teams for improved door-to-door services.
- Building caregivers' capacity on psychosocial support and psychological first aid, clinical management of rape, identification and referrals of GBV cases, counselling and reporting.
- Engaging community members (including community elders, religious leaders and community gatekeepers) in community dialogues and awareness-raising on key GBV issues focusing on the social and behavioral aspects of COVID-19.
- Provision of dignity kits.
- Economic and Social Empowerment (EA$E) activities to reduce the risk of intimate partner violence.

## Sub-Sector
## Mine Action

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS |
|---|---|---|
| 2.7M | 783K | $7M |

Mine Action partners will continue to deliver two key life-saving activities under their humanitarian programmes – clearance and risk education. Clearance work includes the provision of explosive ordnance disposal and survey activities. While these activities are impacted by COVID-19, particularly the movement restrictions, their implementation will continue in strict adherence to COVID-19 preventative measures, following adjustments to existing operational procedures. When it comes to clearance, only areas that meet humanitarian criteria – those that scored 'very high' or 'high' on the national mine action authority's impact scale – will be considered in this revised planning. Specifically, in response to the pandemic, Mine Action partners will provide the following:

- Increased Explosive Ordnance Risk Education (EORE) activities in response to more returnees from Iran and Pakistan, particularly at border points.
- Incorporation of key messages on COVID-19 into risk education materials, thereby allowing teams to raise awareness on the dangers of COVID-19 and on suggested preventative measures while delivering behavioral change-focused messages on the threats caused by explosive devices.

## Sub-Sector
## Child Protection

| CHILDREN IN NEED | PLANNED REACH | REQUIREMENTS |
|---|---|---|
| 1.6M | 806K | $17.3M |

In its revised planning, the CPiE AoR aims to scale-up case management of children at significant risk of, or currently experiencing, child protection issues and extend services to children in detention/juvenile facilities. Registration and assessments of the situation facing children of concern will be conducted face-to-face and by use of mobile phones and followed by care plans and referrals to access services, including psychosocial support, family tracing and reunification, alternative care, health, nutrition and other services as required. This scale-up includes case management for child GBV survivors, including children at risk of forced marriage. Standard Operating Procedures of CPiE services are being reviewed to integrate a COVID-19 lens and protective steps.

Group activities in Child Friendly Spaces (CFSs) have been paused. Those no longer receiving psychosocial support at CFSs are now being

reached through different communication modes (phones, radio, TV and electronic platforms) and through house-to-house visits. CPiE partners also aim to relocate safe-space indoor psychosocial activities to COVID-19-appropriate outdoor premises. Through CPiE's door-to-door extension of assistance, recreational materials will be provided alongside guidance for parents and caregivers on positive parenting, maintaining children's psychosocial well-being, and techniques for positive coping and stress management. Once the situation changes, there are plans to gradually reopen safe spaces in consultation with the Government and community members.

Risk communication and community engagement will also be scaled-up to support children, families and communities in making informed decisions to protect themselves and their families. This will be done through house-to-house visits, community leaders, and use of mass media and other platforms. COVID-19-specific awareness-raising will be developed to ensure child-friendly and child-participatory methodologies are being used. Capacity-building and support will be provided to first-line case workers and community volunteers to promote their safety and wellbeing, and to mitigate transmission of the virus.

In line with planning at the start of 2020, provision of victim assistance to children in conflict, as well as advocacy and response to child recruitment will continue. Services to children in Juvenile Rehabilitation Centers (JRC) are included in case management activities. A scale-up of this complex set of responses would not be feasible in the current operational context and so existing 'planned reach' have been maintained.

## Sub-Sector
## Housing, Land and Property

| PEOPLE IN NEED | PLANNED REACH | REQUIREMENTS |
|---|---|---|
| 4.8M | 180K | $2.3M |

Despite increases in need, the planned reach of HLP activities has gone down from 280,955 to 235,344 (with approximately 180,000 unique individuals targeted across the provinces) in 2020 as some activities have been scaled-down due to operational challenges from COVID-19. In addition, some activities have been put on hold to resume when the situation improves. This downscaling recognises that COVID-19 is a public health emergency, and activities that directly address the spread of the disease should be prioritised. Legal assistance and capacity-building of duty bearers have been scaled-down to represent changes in the operating environment, such as restrictions on social interaction and the closure of courts and government buildings. Currently, awareness-raising activities that require large-scale community interaction have been suspended by HLP partners, including enumeration of vulnerability assessments for HLP awareness raising and information sharing, and trainings for HLP duty bearers. These activities will resume in line with government advice on physical distancing and are anticipated to begin again sometime in quarter four. Specific COVID-19 adjustments include:

- Existing HLP activities, including information sharing, counselling on HLP rights and legal assistance, will be tailored to respond to HLP threats exacerbated by COVID-19, such as those associated with economic and market pressures.
- Tailored HLP response based on existing activities (information sharing, counselling and legal assistance) will be provided to increased numbers of returnees in Hirat, Kabul and Kandahar due to the likelihood of stigmatization.
- Existing datasets will be used to support inter-cluster responses to tackle COVID-19 in at-risk urban informal areas.

**Cluster capacity and operating environment**

All 15 general protection partners, in addition to more than 20 partners conducting MHPSS activities, have maintained operational presence throughout Afghanistan, some with lower capacity on the ground. Essential programme staff are moving on a rotational basis with most international staff working remotely from outside of Afghanistan. Since several organisations have scaled-up their activities to respond to the COVID-19 crisis, the workload has substantially increased for frontline workers to meet the increased targets, but the Cluster is confident these are manageable. In order to curb the spread of COVID-19 and observe physical distancing protocols, partners have adopted remote psychosocial support approaches and will undertake awareness-raising activities in open spaces with fewer participants. For protection staff interacting with people, provision of PPE is factored-in. An overview of the capacity of the four AoRs is summarised below.

- GBV: GBV partners are increasing their service outreach and footprint across Afghanistan for the COVID-19 response.
- Mine Action: While Mine Action partners have been affected by movement restrictions to curb the spread of COVID-19, they are working with the Government's Directorate of Mine Action Coordination to adjust operational procedures and incorporate preventative measures to continue delivery of lifesaving mine action activities. This includes the implementation of activities (for example, risk education in certain areas of the country) through alternative modalities that include mandatory use of PPE, physical distancing and changes to work routines such as moving to outdoor spaces.
- CPiE: More than 70 Child Protection partners are present in 34 provinces, including hard-to-reach areas. The CP AoR is structured with five field-based CPiE working groups and three technical sub-groups – Case Management, Children on the Move, and Children in Conflict. While the community quarantine is in effect, the CP AoR will primarily rely on online modalities for coordination, risk communication, community

engagement and capacity-building. SOPs are currently being reviewed to integrate needs and activities related to COVID-19.

- HLP: HLP partners are operating in 18 provinces across Afghanistan. The changed operating environment has resulted in the downscaling of some HLP activities. Where possible, however, HLP activities will remain ongoing if they do not pose a risk of increased COVID-19 transmission. A key HLP activity – information-sharing and awareness-raising on HLP – will continue using different modalities to reach a broad number of people.

**Cost**

The unit cost for general protection services is $22.80. Both the reach of general protection activities and their costs have increased. This is partly due to inclusion of all MHPSS support under general protection assistance, inclusion of cash-for-protection assistance and expanded individual protection assistance. The average cost for individual protection assistance remains the same and ranges between $27-$500 depending on the specific protection need to be addressed.

- GBV: The unit cost for the GBV services is $27.80. The increase in the number of people being reached with assistance, the expanded number and type of activities, the shift to mobile delivery modalities (with costly running expenses) have all added to increased financial requirements. In particular, the revised package of services encompasses response tailored to address psychological well-being, reduce the use of negative coping mechanisms, and promote economic empowerment to increase resilience (addressing long-term livelihood issues, including control over resources to maintain purchasing power). The increase in unit cost is also attributable to the inclusion of cash for referrals and the facility upgrade and mobile running costs associated with requirements to adopt facility-based and community-based service delivery to the pandemic.
- Mine Action: While the unit cost for all Mine Action activities, as compared to the start of the year, remains the same, the increased volume of returnees requiring more risk education has slightly increased Mine Action's overall financial requirements.
- CPiE: The sector has uncovered a historical funding miscalculation that resulted in a gross under-estimation of the real funding requirement in the existing HRP (by a factor of seven). The increased costing figures are largely the result of a costing correction. In addition, to enable meaningful response, including to child protection needs aggravated by COVID-19, the CPiE AoR aims to provide an expanded range of services to the existing number of people to whom it had planned to deliver assistance. This has also added to the cost. Case management services will include more complex cases through support to child GBV survivors and family-tracing and reunification activities. The development of community networks, as well as the volume of assistance and follow-up per child now being more comprehensive, adds to the overall costs. The unit cost for two major CPiE activities include provision of psychosocial support and awareness-raising of protection concerns and COVID19. This is because most of activities of PSS provision and awareness-raising will now be conducted online, through social and electronic media.
- HLP: The unit cost for capacity-building for duty-bearers has marginally increased due to longer transportation and increased PPE costs (unit costs have risen from $33 at the start of the year to $40 in this revision).

## WAYS OF WORKING

**Integrated programming/multi-sectoral responses and improving inter-sector linkages**

In 2020, the Protection Cluster renewed its engagement in various other sectoral groups to strengthen its multi-sectoral response and ensure effective coordination in the field, avoiding duplication of activities and geographical scopes of response. This engagement has translated into the inclusion of the MHPSS Working Group jointly under the Protection and Health Clusters. MPHSS strategies have also been absorbed into protection activities as a matter of priority. The Cluster has put guidelines in place to ensure that PSEA is factored into all project proposals from protection partners. The Protection Cluster is also part of the Gender in Humanitarian Action (GiHA) COVID-19 Working Group and the COVID-19 Risk Communications and Community Engagement (RCCE) Working Group to make sure that all guidance and messaging disseminated throughout communities in Afghanistan is prepared through a protection lens, and that all actions are protection-oriented. Besides engagement in sectoral groups, HLP partners are also using their existing datasets to support inter-cluster responses to tackle the flow-on impact of COVID-19 in urban informal settlements. This has included providing data about food insecure families to the FSAC Cluster and renters to the ES-NFI Cluster.

**Links to development programming**

The Protection Cluster has engaged in discussions with the World Bank to fine-tune its Cash-for-Protection strategy to align with existing relief efforts and identify complementarities. While this is a short-term activity, it will open further discussions with the World Bank and other development actors to support medium- and longer-term development aims and durable solutions, the latter of which is at the centre of the Protection Cluster strategy.

### Cash programming

A renewed emphasis will be put on the provision of emergency cash for vulnerable households at risk of slipping into negative coping mechanisms so that they can meet their basic needs in areas where their livelihoods have been destroyed by the pandemic. In addition to the existing cash component of the individual protection assistance, additional one-off cash assistance will be provided to extremely vulnerable households that are facing acute, protection-specific risks. This cash approach is designed to prevent people from engaging in actions that put the lives of women and children at risk, for instance, through forced child marriage or forced hazardous work. Households already set to benefit from this cash assistance have been identified through existing programmes, while others will be identified through the joint and harmonised Protection Monitoring put in place by the Protection Cluster.

## DATA

### Methodology

The analysis of protection needs was done through the same methodology as last year and applied by the Cluster and its sub-clusters. New data sources included the updated hard-to-reach analysis by the REACH Initiative, DTM's population flow mapping of areas with highest connectivity to COVID-19 hotspots in Iran and Pakistan, as well as preliminary results from various protection monitoring visits carried out by partners. The largest increase in protection needs is under GBV, where the number of people in need has doubled (from 3.6 million at the start of the year to 7.2 million in this HRP revision). The overall number of people in need of protection assistance has gone up from 7 million to 11.5 million. This number was calculated by taking the maximum of people in need across sub-clusters, by province, population group, and age/gender in order to remove double-counting of people receiving multiple kinds of assistance under different AoRs. While some of the Cluster's needs indicators could be updated with new quantitative data, a qualitative approach was used to review other indicators in the absence of new countrywide needs assessments for all population groups.

Planned reach was determined through an analysis of partner capacity and presence, and the severity of protection needs per province. As with the PiN, the number of people planned to be reached is based on the maximum number of people to be assisted across sub-clusters, by province, population group, age and gender.

### Monitoring

The Cluster will maintain existing monthly and quarterly monitoring frameworks – primarily through the 4Ws in ReportHub and the Information Management System for Mine Action (IMSMA) for Mine Action specifically. New indicators – adapted to the COVID-19 context – will be added. The Cluster will keep a weekly operational overview of the protection response at the national and sub-national levels. At the beginning of the COVID-19 crisis, the Protection Cluster introduced a joint Protection Monitoring tool with a COVID-19 component, for use at household-level and community-level assessments. This harmonised tool will enable the Cluster to receive comparable data, in order to produce regular countrywide analysis of the protection situation in Afghanistan and detect trends in protection risks. The Cluster will continue to work closely with Awaaz and other individual agency AAP mechanisms to ensure beneficiary feedback and participation systems are in place, are working effectively and are inclusive of age, gender and disability considerations.

### Gaps and limitations

Data and response gaps and limitations overall have remained the same since the end of last year. Women, boys and girls, as well as people living with disabilities remain largely underrepresented in national surveys. It remains difficult to engage women in meaningful discussions around their protection needs. Hard-to-reach areas also remain difficult to assess due to physical and conflict-related access constraints. GBV prevalence data continues to be a significant gap. Additionally, the lack of an updated WoA Assessment for this HRP revision limited the possibility to use country-wide data applicable to all sub-clusters of the Protection Cluster.

## Contacts


| ELISE VERRON | SAMIRA BAVAND |
|---|---|
| Cluster Coordinator | Cluster Co-lead |
| UNHCR | NRC |
| verron@unhcr.org | samira.bavand@nrc.no |

3.7

# Water, Sanitation and Hygiene

**PEOPLE IN NEED**
**7.2M**

**PLANNED REACH**
**3.8M**
COVID-19: **1.8M**
NON-COVID-19: **2M**

**REQUIREMENTS** (US$)
**$152.2M**
COVID-19: **67.4M**
NON-COVID-19: **84.8M**

**PARTNERS**
**24**

## NEEDS ANALYSIS

### New COVID-19 needs

COVID-19 has exposed the underlying WASH needs in Afghanistan. The 2019 WoA Assessment had shown that some 57 per cent of displaced households have insufficient or barely enough water. The same assessment showed that more than 65 per cent of returnees (the majority of whom came from Iran) live in settlements that do not have access to any WASH services, whilst others stay in host communities where services are already overstretched. Needs continue to be more pronounced in areas that are hard-to-reach. Women and people with disabilities have even lower access to WASH facilities. Disrupted livelihoods and reduced income, coupled with chronic underlying poverty, further challenge families' capacity to purchase essential hygiene supplies. As many as 68 per cent of displaced households report not having access to or being unable to afford basic hygiene items.[65] Poor WASH conditions contribute to disease outbreaks, especially diarrhoea, and present high risks for the spread of COVID-19, against which handwashing is a critical weapon. In a 'normal' year, 13 per cent of all deaths among children under five in Afghanistan are associated with diarrhoeal diseases. Furthermore, the immune response of children affected by acute watery diarrhoea is highly compromised, increasing their risk of mortality when exposed to other diseases – such as COVID-19. Since the outbreak of COVID-19, the Cluster has conducted several assessments and a rapid analysis of WASH needs in the country. The number of people in need of WASH assistance through the end of the year is now 7.2 million people, up from 4.9 million in the original 2020 HRP. Additionally, as a result of COVID-19, the needs of this group are now more complex, requiring a more comprehensive WASH response focusing on hygiene promotion and safe water supply activities, often at higher volumes. As a result of this deeper response approach to escalating needs, the WASH Cluster's requirements have increased from $70.9 million to $152.2 million.

## CLUSTER STRATEGY

### Multi-year strategy 2019-2021

The WASH Cluster aims to ensure the provision of safe water and access to sanitation and hygiene to people with critical needs. Against the backdrop of the pandemic, the Cluster has adopted a "kite strategy" that approaches WASH response planning from four angles: scaling-up to address WASH-related acute vulnerabilities; adapting WASH support to mitigate against COVID-19 transmission and stigmatisation (integrating disinfection and risk communication); enhancing flexibility and rapid mobilisation of the response to emerging COVID-19 hotspots or heightened risk factors; and providing sustainable handwashing access by linking humanitarian and development handwashing promotion activities.

### People in need and planned reach (2020)

| | BY POPULATION GROUP | | | | | | |
|---|---|---|---|---|---|---|---|
| | PEOPLE DISPLACED IN 2020 | RETURNEES IN 2020 | PEOPLE AFFECTED BY SHOCKS | ACUTELY VUL. PEOPLE WITH HUM. NEEDS | REFUGEES LIVING IN AFG. | TOTAL | REQUIREMENTS US$ TOTAL |
| People in need | 0.45M | 0.51M | 0.10M | 6.13M | 0.06M | **7.2M** | **152.2M** |
| Planned reach | 0.41M | 0.45M | 0.08M | 2.76M | 0.06M | **3.8M** | |

**HIRAT, WESTERN AFGHANISTAN**
*March 2020. Hand-washing facilities at a transit centre for returnees from Iran.*
*Photo: OCHA*

To ensure flexibility and quick implementation during the pandemic, the WASH Cluster is planning an expansion of rapid-response mechanisms to include mobile WASH teams closely linked with Health, Nutrition, Education and/or Protection components, that are quickly deployable to install at least functional handwashing devices and safe water to meet COVID-19 WASH needs at the community and institutional levels. The multi-year plan for the WASH Cluster will continue to focus on building partnerships between humanitarian and development actors to work towards the overall goal of sustainably meeting the basic WASH needs of the most vulnerable people affected by conflict and natural disasters who are living in temporary shelters and in the most inaccessible, insecure, rural and remote parts of the country. The pandemic presents an opportunity to reboot handwashing promotion as a strategic bridge between humanitarian and developments programmes (sometimes within the same organisation) for a more comprehensive and resilient package of WASH services.

In 2018 and 2019, the multi-year strategy of the WASH Cluster provided good continuity to planning of the humanitarian response with no observed interruptions in implementation. Due to the inter-connectedness of activities across the past two years of the multi-year HRP, it was possible to rapidly programme substantial late funding from donors at the end of 2018 into early 2019 and again in late 2019 into 2020. However, the fact remains that early mobilisation of funds is required to carry out a life-saving response, particularly during the COVID-19 outbreak. The Cluster also acknowledges that the pandemic is likely to see additional funds released for COVID-19-related WASH activities, but it is of concern that this may be at the expense of funding for existing but no less vital regular programming.

### Cluster response objectives

In line with the priorities of the Global Humanitarian Response Plan (GHRP), the WASH Cluster's primary objective is to ensure that vulnerable people have access to improved WASH services that are tailored to COVID-19. This work is supported by the WASH Cluster's COVID-19 Task Force, which provided country-specific guidance and standard operating procedures to partners. In line with this advice, the Cluster has updated its multi-year HRP response objectives.

In line with SO1, the Cluster aims to ensure:

- Affected people have access to the COVID-19-tailored water, sanitation and hygiene services, facilities and supplies they need.
- WASH services are delivered to people living in hard-to-reach areas and overcrowded settlements.

In line with SO3, the Cluster will ensure:

- Vulnerable people have access to safe drinking water and systems supporting handwashing, led by development networks.
- A sustainable WASH package is extended to people living in hard-to-reach areas and overcrowded settlements.

**Geographical prioritisation**

The Cluster will continue to prioritise responses where WASH needs are the highest according to the results of the WoA Assessment, the HTR Assessment and Cluster-specific surveys – notably in Badghis, Hirat, Faryab, Zabul, Badakhshan, Nimroz, Kunduz and Jawzjan provinces. Some of these provinces are also priority areas for the COVID-19 response. To mitigate spread of the virus, the WASH Cluster will prioritise the most vulnerable areas with limited access to WASH services at community and institutional levels (hosting people under IPC phase 3 and 4) and in overcrowded places. The Cluster will prioritise hygiene promotion in main border entry points. The Cluster will also introduce activities in areas of return from Iran and Pakistan and 'at-risk' urban informal settlements. Urban informal settlements are new areas for the Cluster's response. Even prior to the economic strains of the pandemic, some 53 per cent of IDP households living in informal settlements reported not having access to soap. The need for a response in these locations and in prisons is also greater because of the risks posed by poor hygiene in spreading COVID-19.

## RESPONSE PLAN

**Response plan**

In its revised planning for COVID-19, the Cluster has increased the volume of regular water provision. The Cluster will increase water quantity, water storage capacity and frequency of filling water points, and extend longer opening hours of water points to mitigate crowding. WASH partners will set up a queuing system with physical distancing requirements and put in place a dedicated operator to reduce handling of each water point. New items, such as buckets with taps and lids for handwashing, will be included in the standard WASH response package. Hygiene kits will be augmented to include bathing and laundry soaps, jerry cans, washing jugs, chlorine sprayers, sanitary pads and a COVID-19 fact sheet.

The Cluster will expand its promotion of water-efficient and appropriate handwashing at community and institutional levels and extend house-to-house visits, with hygiene promoters adhering to minimum physical-distancing requirements. WASH partners will promote environmental cleaning and waste management – disinfecting common water points and materials during distributions and ensuring that personnel involved in waste management have appropriate protective equipment. Extensive risk communication work will continue through religious and community leaders, as well as through WASH committees and WASH-response personnel. The Cluster will increase its provision of WASH infrastructure in priority health centres, isolation wards and other facilities. The Cluster will look at more 'at-risk' population groups (such as prisoners) in its response.

The WASH Cluster plans to reach all population groups of the HRP that have acute WASH needs. In collaboration with IOM's DTM and the ERM, the Cluster will continue monitoring movement of IDPs and returnees. The Cluster will continue assessing and upgrading existing infrastructure or install new durable WASH facilities – particularly in informal settlements – to overcome the additional pressure exerted on the limited infrastructure by increased returns and the elevated risks posed by COVID-19.

To ensure rapid mobilisation of the response and mitigate challenges from movement restrictions, the Cluster will pre-position WASH supplies in key regional and provincial hubs. Voucher-based support will be considered to assist the high numbers of households that, in the 2019 WoA Assessment, reported an inability to afford hygiene items. Cash will be considered where movement restrictions have the highest impact on the in-kind response (see more below).

**Cluster capacity and operating environment**

Despite the logistics challenges, the WASH partner footprint at district level remains mostly unchanged and is able to scale-up by relying on development capacity that has pivoted towards the COVID-19 response. While lockdown and movement restrictions have reduced the mobility of staff working from office spaces, operational capacity has been retained through the adoption of alternate working modalities. So far in the country, no interruption of WASH services on the ground due to COVID-19 has been reported. Partners have adopted new mobile-based assessment approaches in view of physical-distancing requirements. Aside from security-related access challenges, COVID-19 has not created significant access challenges affecting WASH response. While cargo movement restrictions across borders have been linked with price hikes for key commodities in domestic markets, shortages of critical WASH supplies (hygiene kits) have not yet been witnessed. The WASH Cluster has re-customised the standard hygiene kit to address COVID-19 challenges, including prioritising locally procured items instead of imported ones.

The Cluster has already proven its capacity to scale up activities providing a more comprehensive range of services to more people at risk because of COVID-19. Between January and mid-May 2020, more

than one million vulnerable people received hygiene promotion as per the cluster standard. Almost 3.5 million bars of soap were distributed in 139 districts across the country. In April alone, through 28 partners, 400,000 affected people were reached with WASH activities (20 per cent of the 2 million people targeted in the original 2020 HRP).

### Cost

The cost per person to deliver WASH response has increased from $35.50 to $40. This is due to a rise in the cost of WASH materials from local markets, the expanded reach, and inclusion of more comprehensive, COVID-19-specific support within existing programmes. All WASH activities – regular and new – are tailored for COVID-19 to include basic prevention/mitigation supplies that add to programme costs for existing activities. These factors and the increase in volume of the regular package of assistance have led to an overall increase in WASH requirements.

## WAYS OF WORKING

### Integrated programming/multi-sectoral responses and improving inter-sector linkages

The WASH Cluster will continue close engagement with other sectors in terms of response planning as well as response delivery. The Cluster will increase WASH services provided in the physical infrastructure used by other clusters, especially handwashing facilities in health centres and isolation wards. In collaboration with the Health Cluster, 94 health care facilities have been prioritised across conflict-affected provinces in five regions to allow for improved hygiene. These health facilities also provided nutrition treatment, which the Cluster will support through the provision of hygiene materials to people. While WASH services in currently closed Community-Based Education and Temporary Learning Centres is de-prioritised in quarter three, the Cluster will – through mobile teams – ensure readiness for rapid disinfection and chlorination requirements in schools in the last quarter of the year when schools are expected to reopen. The Cluster will also work with the Education in Emergencies Working Group to ensure safe-water provision, prioritising the most at-risk schools. The Cluster will pay particular attention to protection considerations – PSEA, GBV and people with unique vulnerabilities – in its response.

### Cash programming

With support from the CVWG, the Cluster has taken positive steps to mobilise partners with institutional expertise on cash and voucher assistance in other programmatic areas to start incorporating similar approaches in their WASH programmes, where safe and feasible. In areas where movement restrictions could affect planned distributions, the Cluster will explore the use of e-vouchers and mobile money to ensure people receive hygiene materials. As a new activity, the Cluster will explore the feasibility of a voucher-based response in informal settlements to enable vulnerable households' access to water from private vendors. In tandem with the Nutrition Cluster, a voucher-based top-up will also be provided to mothers travelling to SAM treatment facilities so they can buy basic hygiene materials. Similarly, together with the EiEWG, the Cluster will consider vouchers for purchasing safe water to support handwashing in schools.

### Links to development programming

Where it can, the WASH Cluster is committed to delivering durable solutions rather than short-term unsustainable responses. It aims to extend water-system management and handwashing through a more comprehensive social approach in collaboration with development programmes. The Cluster will continue to provide new or rehabilitated WASH infrastructure, mostly in hard-to-reach areas. Capitalising on this window of opportunity to access areas that are difficult to reach, WASH partners will aim to put in place resilient infrastructure – which is cost effective in the long-term – to mitigate disruption of water supply and reduce the number of maintenance issues with water schemes. The Cluster will mobilise existing operational development networks – such as the Community-Led Total Sanitation (CLTS) framework, including handwashing promotion in Afghanistan – to support this effort. The Cluster is co-led by MRRD, ensuring longer-term government ownership of the response. The Cluster is boosting its early warning systems to support contingency planning, response preparedness and rapid mobilisation of response.

## DATA

### Methodology

In its revised analysis, the WASH Cluster considered data from DTM's population movement tracking, informal settlement data from IOM and the REACH Initiative, data showing areas with the highest SAM and MAM prevalence, the new HTR analysis from the REACH Initiative, COVID-19 outbreak mapping from MOPH, and other health data from WHO. New WASH assessments and reports on COVID-19 preparedness and response activities also formed the basis for the Cluster's revised analysis. To analyse WASH needs in informal settlements, the Cluster drew on data from the WoA Assessment, as well as informal settlement-specific assessments, such as a recent UN Habitat and WHH study in Kabul informal settlements.

### Monitoring

The Cluster has updated its online reporting hub to capture information on COVID-19. The Cluster has also set up a new 4W matrix to monitor the COVID-19 and existing WASH response. Together with the REACH Initiative and other partners, the WASH Cluster plans to participate in joint market assessment and analysis to understand changes in market prices for key hygiene items and water supplies. The Cluster will cross-monitor changes in needs by reviewing other assessments and indicators from other Clusters (primarily Health, Nutrition, Protection and Education) and is committed to expanding the sharing of information from WASH mobile teams.

The WASH needs indicators outlined in the HNO at the start of 2020 will remain the same with an emphasis on access to hygiene. These are: percentage of people who do not have access to or cannot afford soap for hygiene promotion activities; percentage of people who do not have access to improved and functional water sources; and percentage of households that do not have an improved and functional latrine.

### Gaps and limitations

While physical-distancing requirements will limit usual assessment procedures, WASH Cluster partners will employ mobile data-collection tools for future assessments, KAP surveys and post-distribution monitoring. The Cluster will also piggyback on the REACH Initiative's key informant interviews for the Hard-To-Reach assessment and informal settlements analysis.

## Contacts


| FRANCOIS BELLET | JOSEPH WAITHAKA | ABDUL MALIK TEMORY |
|---|---|---|
| WASH Cluster Coordinator | WASH Cluster Co-Lead | National Co-lead |
| UNICEF | DACAAR | MRRD |
| fbellet@unicef.org | joseph.waithaka@dacaar.org | malik.temory@mrrd.gov.af |

# 3.8 Coordination and Common Services

**REQUIREMENTS** (US$)

**$39.9M**

OCHA: **$10.8M**
IOM DTM: **$2.8M**

REACH INITIATIVE: **$1.2M**
IMMAP: **$0.2M**

UNHAS: **$25M**

### Coordination

In addition to its liaison role with the Government, OCHA leads coordination between international and national humanitarian actors through the HCT at the strategic level and the ICCT at the operational level both in Kabul and in the field. COVID-19 is demanding an enhanced OCHA Coordination response spanning both humanitarian and development initiatives. OCHA Afghanistan will continue to scale-up its efforts in response to COVID-19, as well as ensuring needs arising from conflict and natural disasters are not forgotten during the pandemic. OCHA leads on annual response planning through the ICCT and continues to support humanitarian partners with access and civil-military coordination. Ensuring timely delivery of humanitarian aid is even more crucial in the face of measures such as lockdowns, movement restrictions and unpredictable border closures, in addition to the usual constraints imposed by the parties to the conflict. In this context, OCHA's civil-military coordination and access support is critical. OCHA also manages the Afghanistan Humanitarian Fund. In 2019, the fund allocated $63.91 million, enabling 66 humanitarian response projects through an inclusive and coordinated process of allocation, boosting confidence among the donor community. At the time of publication, the Fund was in the process of completing its third Reserve Allocation for COVID-19 and was the first pooled fund in the world to release resources for the pandemic. OCHA publishes regular public information products on COVID-19 and other elements of the response. OCHA has been working closely with WHO since the onset of the pandemic to publish dedicated briefs on COVID-19 multiple times a week. These are proving a vital and regularly updated source of information about the response for both donors and fellow-responders. At the same time, in recognition of the increasing long-term impacts of the pandemic, OCHA has expanded its cooperation and advocacy with development actors to advocate for needs that go beyond the scope of humanitarian activities. To support coordination in 2020, OCHA requires $10.76 million.

### Evidence-based response

The HRP also includes funding for common data collection. management and analysis services to support an evidence-based response. IOM's Displacement Tracking Matrix requests $2.78m to continue its work on monitoring and analysing population flows both across borders and within the country. This includes additional resources needed for increased tracking of movements in light of COVID-19. The REACH Initiative requests $1.2m to support its data collection, including the vital WoA and Hard-to-Reach Areas assessments on which collective needs analysis is based each year. in 2020, this includes efforts to better reflect and capture the views of women in the WoA Assessment through the hiring of more female enumerators that will enable separate data collection from women living in male-headed households. REACH Initiative will also be supporting the CVWG on a Joint Market Monitoring Initiative (JMMI) to standardise partners' market monitoring tools to facilitate more comprehensive analysis and support the production of a single monthly factsheet on market trends. This will support more effective analsyis of the potential for cash-based responses and appropriate setting of cash assistance packages. REACH Initiative is also expanding its data collection on the situation facing displaced people living in informal settlements for protracted periods– locations of increasing importance in the COVID-19 response but places where the aid community has not traditionally collected comprehensive data in the past. The overall ask also includes $200,000 for iMMAP to continue their support on ReportHub which is commonly used by all actors in the response to monitor performance against the HRP targets.

### UNHAS

In order to maintain essential domestic and international air services by UNHAS for the wider humanitarian community in the context of COVID-19 and on-going flight restrictions, UNHAS' updated budget is estimated at $25m for 2020. This will allow UNHAS to maintain its regular daily domestic operations and provide reliable access across the country to meet the needs of aid organisations to send staff members on essential missions. The revised budget also includes the international airbridge between Kabul and Doha, Qatar, as all commercial airlines have ceased their flights to Afghanistan, and it is expected that full resumption of commercial flights will take some time. This airbridge ensures reliable entry and exit to and from Afghanistan for personnel working with UN agencies, NGOs and diplomats. With the updated budget, UNHAS will also be able to respond to relocation requests of aid workers returning to their field duty stations and to manage an increase of transport needs for the COVID-19 response, both for aid workers and humanitarian cargo.

# 3.9 Refugee Chapter

**PEOPLE IN NEED**
72K

**PLANNED REACH**
72K
COVID-19: 63K
NON-COVID-19: 71K

**REQUIREMENTS** (US$)
$11.6M
COVID-19: 1.1M
NON-COVID-19: 10.5M

### Needs Analysis

There are approximately 72,465 refugees in Afghanistan. Nearly all of these people are in Khost and Paktika, with the exception of some 400 people in urban areas. At present, there is no legal framework to define the rights of refugees and asylum-seekers and ensure their access to basic services, despite UNHCR's work with the Government to develop a draft law. In the absence of a national asylum law, asylum-seekers and refugees in Afghanistan often face significant challenges in exercising their basic rights and accessing government-provided services. Their lack of legal status, in combination with the absence of community structures that may have provided some level of protection in their places of origin, renders this population particularly vulnerable as compared to other populations in Afghanistan. The 2019 WoA Assessment showed that refugee families registered higher needs across all sectors and indicators. Refugee households were significantly more likely to have a poor/borderline Food Consumption Score (FCS) (92 per cent), compared to other non-recent displaced populations, including IDP households (78 per cent) and cross-border returnees (73 per cent). It is anticipated that food insecurity among refugees will likely worsen, moreover, due to recent increases in food prices. According to the 2019 WoA Assessment, refugees are, additionally, less able to produce their food: only 20 per cent of refugee households reported producing the majority of their family's food for consumption, while at least half (50-58 per cent) of non-recent IDP and returnee households were able to do so. While most refugee households reported improved access to sources of drinking water, refugee households remained twice as likely to lack access to a functioning latrine (30 per cent lacked access to a functioning latrine in the prior seven days, as compared to 18 per cent of non-recent IDPs and 16 per cent of returnees). Refugees were also twice as likely to live in makeshift shelters or tents (68 per cent), as compared to other non-recent displaced populations (35 per cent of IDP households and 13 per cent of cross-border returnee households). Furthermore, the proportion of refugee households that reported to have a functional health facility within 5km of their home was significantly lower (44 per cent) as compared to non-recent IDP households (81 per cent) and cross-border returnee households (70 per cent).

From a protection perspective, heightened vulnerabilities of refugees are apparent: 30 percent of refugee households reported that at least one adult was unable to move freely to another district or province in the three months prior to the 2019 WoA assessment (compared to 12 per cent of non-recent IDP households and 8 per cent of returnee households). Some 31 per cent of refugee households stated that in the 30 days preceding the survey, they were worried about the psychological well-being of household members (compared to 23 per cent of non-recent IDPs and 22 per cent of returnees) and nearly one-third of refugee households reported that a child under 16 in their household was married (28 per cent for boys and 30 per cent for girls), as compared to less than 5 per cent for non-recent IDP and returnee households.

### Refugee response strategy

Encouraged by a series of discussions with the authorities and relevant stakeholders, UNHCR determined in early 2018 to transition coordination of the response to the 72,000 refugees in Khost and Paktika to the Government of Afghanistan. The assumption of responsibility for this population by the Government was considered a positive development, in accordance with the Comprehensive Refugee Response Framework and Afghanistan's obligations as a signatory to the 1951 Refugee Convention. It also takes into account the strong social and cultural ties between the displaced people (primarily from the Waziri, Dawar, Saidgi and Masood tribes) and their host communities. While progress has been made toward this transition, UNHCR recognises that additional support to the Government is still required to ensure their capacity to assume responsibility for this population. The re-inclusion of a refugee chapter in the revised 2020 HRP reflects the need for continuing support and assistance to the refugee population in Afghanistan.

Currently, approximately 12,000 refugees reside in Gulan settlement in Khost, while the remainder of the refugees from North Waziristan in Pakistan live among communities outside the settlement, in Khost or in neighboring Paktika. The Provincial Government will require continued support from humanitarian and development actors, including UNHCR, to address the needs of these people. UNHCR has assured the Government of its technical and financial support and will continue to provide assistance to vulnerable families through its 'Persons with Specific Needs' (PSN) programme. The Government has indicated its intention to register and issue legal documentation to these refugees and UNHCR has assured the Government of its support for these efforts. It is anticipated that the population of concern in Khost and Paktika will have improved access to education and employment, as well as greater freedom of movement enabling them to become more self-reliant over time.

In addition, 400 refugees and asylum-seekers from various countries of origin live in Kabul and other urban settings in Afghanistan. Humanitarian actors continue to advocate for and provide assistance to facilitate their access to education in public schools and health services, and the most vulnerable among this group receive financial assistance to meet their basic needs. On behalf of this group and the refugee population in Khost and Paktika, advocacy will continue in favour of the passage of a national asylum law in line with Afghanistan's obligations as a signatory to the 1951 Refugee Convention.

The direct impact of COVID-19 in Khost and Paktika has been limited to date, with relatively few confirmed cases in the two provinces. This could change as community-level transmission continues, and as the population struggles to observe physical distancing and limit movements in a context where many families rely on daily wage labor to meet their basic needs. Furthermore, it is expected that the indirect impact of the COVID-19 crisis on the refugee population will be severe. With refugees already facing serious obstacles to exercising rights and accessing basic services, the socio-economic impact of losing income for a period of weeks or months creates a serious risk of propelling this population into negative coping mechanisms.

Ensuring refugees' access to risk information and hygiene messaging, WASH facilities and health care will be paramount. At the same time, it will be necessary to identify and assist the most vulnerable families among the refugees, as a means of avoiding the protection risks associated with severe socio-economic stress and accumulation of debt. Refugee families, with limited community support, may find themselves in difficult circumstances more quickly than other population groups. Prompt identification of vulnerability and provision of assistance will help to avoid negative protection consequences, particularly for women and girls, who tend to be particularly at risk as their families' socio-economic circumstances deteriorate.

**Response plan**

In line with the existing refugee response strategy, the response plan will continue to focus on supporting the authorities to integrate refugees into Government programmes and services. Advocacy and assistance to ensure that refugees can access documentation, education and health services in particular, will continue to be central to the response, with a view to the Government assuming full responsibility for provision of these services in the longer-term. Addressing serious gaps in refugees' and host community members' immediate access to shelter, food, nutrition, and WASH services in line with a whole-of-community approach, will also be important. For the remainder of 2020, all clusters have planned to reach refugees with a multi-sector response. Some clusters (such as FSAC) have planned

## Planned reach and requirements 2020

| SECTOR | PLANNED REACH | REQUIREMENTS (US$) |
|---|---|---|
| Education in Emergencies | 2.2 K | 250 K |
| Emergency Shelter and NFI | 34 K | 2.8 M |
| Food Security and Livelihoods | 72 K | 4.6 M |
| Health | 24 K | 1.1 M |
| Nutrition | 3 K | 197 K |
| Protection | 72 K | 2.1 M |
| Water, Sanitation and Hygiene | 63 K | 613 K |
| **OVERALL** | **72 K** | **11.6 M** |

* Requirements for the refugee chapter are also included in the cluster totals.

to reach the entire population, while other clusters (Education and Nutrition) will reach part of the refugee population with assistance. Over time, access to education and livelihoods opportunities will help to facilitate refugees' integration and self-sufficiency. For those refugees in Khost and Paktika who may choose to voluntarily return to Pakistan, assistance will be provided to facilitate their transportation and durable reintegration in their areas of origin.

In the context of COVID-19, it is expected that the authorities may require additional support, as portions of the host community, facing limited work opportunities and rising prices for basic goods, slip into deeper poverty and acute need. Supporting the Government to lead the COVID-19 response with an integrated, whole-of-community lens will be critical, both to ensure that gaps in access to services do not accelerate transmission of the virus and that no segment of the population is left behind. Humanitarian actors will include refugees in information dissemination activities, hygiene kit distributions, WASH support, and cash for protection as part of their COVID-19 response.

### Cost

The total cost for the refugee chapter is $11.6 million. This includes $4.5 million for food and livelihoods assistance; $197,000 for nutrition services, $2.8 million for shelter and NFI assistance; $613,000 for WASH; $2.1 million for Protection; $1.1m for Health; and $250,000 for Education. This is an extracted summary of refugee responses which are also costed in the relevant clusters' requirements. While they appear in two different places in the HRP, these costs are only included in the overall total once.

### Inter-sector linkages and links with development programming

As noted above, the refugee response strategy is built around enabling and supporting the assumption of responsibility for refugees by the Government at the provincial and national levels. Developing the capacity of the Government to effectively accommodate and integrate the refugee population will serve to ensure the sustainability of the response and associated support, as well as peaceful co-existence between the refugee population and host communities. Engagement with refugee-hosting communities, particularly through community development councils, shuras, and civil society organisations to promote inclusion and participation, especially of youth, girls and women, and to support development through a whole-of-community approach, will be central.

## Contacts

**ANGELA MOORE**

Senior Protection Officer

UNHCR

moorea@unhcr.org

Part 4

# Annexes

**JALALABAD, EASTERN AFGHANISTAN**

*October 2019. IDPs receive cash assistance to help them get through the winter in Jalalabad city. Photo: OCHA/Fariba Housaini*

# 4.1 Costing Methodology and Sectoral Activity Costing

Afghanistan's HRP is costed on an activity basis by clusters. Each cluster produces a cost-per-beneficiary estimate, which combines the costs associated with in-kind supplies, cash provision (where appropriate), and costs associated with the physical delivery of assistance (logistics, staff and other overheads). These are outlined in the table below.

The mid-2020 revision of the HRP substantially increases planned reach (by 56 per cent) with a near equivalent increase in costs (54 per cent). Despite an arguably more demanding operating environment, including higher input costs for critical items such as PPE, the need to adopt alternate delivery approaches to safeguard beneficiary and staff health, and the additional measures required to navigate an incredibly dynamic security environment, the average cost-per-beneficiary for 2020 has stayed largely static ($103 at the beginning of the year to now $102) in this revision.

It is anticipated, however, that for many clusters costs-per-beneficiary will fluctuate seasonally and may also be heavily dependent on the stage of the COVID-19 outbreak allowing paused activities to resume. For example, the shift towards providing support for distance-learning and the temporary scale-back of in-school activities until at least the fourth quarter has enabled education partners to sustain the provision of quality education for an increased number of students while managing a decrease in cost-per-beneficiary. It is anticipated however that this will be offset in quarter four by an extension of the school year, the need to prepare schools to re-open with enhanced hygiene facilities and an expanded winterisation plan.

Despite FSAC significantly expanding planned reach in order to address food insecurity due to COVID-19, its overall cost-per-beneficiary will drop from $41 to $38 because the Cluster is planning shorter-term relief for the specific COVID-19 caseload, meaning not all included populations will receive the same volume of assistance. Similarly, while the Health Cluster's planned reach will nearly triple, its cost-per-beneficiary will actually decrease from $34 to $24 per person. In spite of price hikes in critical health items due to global short-supply and generally higher costs associated with expanding support to community health facilities, these higher costs will be offset by the high-reach/high-impact and low-cost nature of the Health Cluster's risk communication activities.

At the same time, the ask of some other clusters has increased significantly due to the inclusion of a broader range of costlier durable solutions-type assistance, which will save funds and help people recover more quickly in the longer-term. This is particularly true in terms of shelter responses which are shifting towards transitional shelter over emergency tents. The ES-NFI Cluster will also face a moderate rise in cost-per-beneficiary due to the inclusion of increased volumes of NFIs in standard packages to discourage sharing of common household items which can more easily spread COVID-19, an increase in market prices, the introduction of housing extension kits to support self-isolation and physical distancing needs, and a scaled-up winterisation response in quarter four due to COVID-19-related vulnerabilities.

Similarly, more expensive but durable WASH activities are planned such as the building of more flood-resilient water and sanitation infrastructure in COVID-19 and other disaster-prone areas. A significant rise in input costs and the need to incorporate COVID-19-specific elements within existing programmes has also contributed the moderate increase in the WASH cost-per-beneficiary. For example, all WASH packages are being tailored specifically for COVID-19 and will contain additional supplies to enable people to better protect themselves through good hygiene. A wider range of more costly refugee responses have also been incorporated in the re-inserted refugee chapter. More expensive mobile approaches are also being planned to overcome COVID-19-related issues with service delivery in the Health, Protection and Nutrition sectors in particular.

Historic under-estimation of costs for Protection activities, particularly for child-protection, have been corrected in this revision. The corrections will enable Protection partners to more comprehensively respond to increasingly complex protection cases, expand coverage for monitoring and service provision and further integrate prevention approaches across all sector responses. Moreover, in the first two years of the multi-year HRP (2018-19), the Protection Cluster used an inadequate aggregation rule to measure its reach which may have caused double counting and resulted in an overestimate of individuals reached across its sub-clusters. The fact remains that without a common beneficiary registration system, it is impossible to come to an accurate number of people reached when deploying multiple forms of assistance resulting in either over counting and

undercounting depending on which methodology is used. The Cluster has now employed a conservative approach to mitigate against past overestimation. At sub-cluster level, to avoid double counting of people receiving continued assistance over a certain period of time or multiple types of assistance, reporting partners mark people reached as 'new' or 'existing' beneficiaries accordingly. To avoid overlap and double counting of beneficiaries across sub-clusters, the standard aggregation methodology is now used at the cluster level. Figures are aggregated across mutually exclusive categories (i.e. gender, age, and population type) using the maximum reached at the lowest administrative level where data is available (i.e. district,) across sub-clusters. Employing this approach means that the calculated figure represents an underestimate of the actual number of people reached, however it drastically reduces the risk of double counting. While this course correction will eliminate overlaps, it will mean that results from the first two years of the HRP will not be comparable to the second two years.

Finally, the suspension of international flights due to COVID-19 prevention measures has also required the establishment of an international airbridge between Kabul and Doha, Qatar. The airbridge is critical as it ensures that personnel working with UN agencies, NGOs and diplomatic missions are able to maintain regular rotations to and from the duty station and/or are able to bring in surge staff and critical humanitarian cargo despite the suspension of commercial air services. An additional $7.5 million has been added to the original UNHAS requirement for 2020 to maintain operational costs of the international airbridge as well as domestic UNHAS flights to carry staff and critical cargo throughout the country, taking their total needs to $25m.

## Average Cost-per-Beneficiary (US$)

| SECTOR | 2018 | 2019 | 2020 | REVISED 2020 |
|---|---|---|---|---|
| Education in Emergencies | $76 | $97 | $111 | $76 |
| Emergency Shelter and NFI | $74 | $59 | $81 | $88 |
| Food Security and Livelihoods | $60 | $71 | $41 | $38 |
| Health | $27 | $34 | $34 | $24 |
| Nutrition | $83 | $60 | $54 | $48 |
| Protection | $65 | $33 | $34 | $40 |
| Water, Sanitation and Hygiene | $24 | $28 | $36 | $40 |
| **OVERALL** | **$115** | **$136** | **$103** | **$102** |

# Sectoral Activities and Costing

## Education in Emergencies

| | NON-COVID-19 RESPONSE | | | COVID-19 RESPONSE | | |
|---|---|---|---|---|---|---|
| **ACTIVITY/OUTPUT** | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) |
| Acitivity 1: Establishment of Community Based Classes (CBCs) or Temporary Classrooms (TCs) with minimum WASH package(drinking and hand washing water) | 13,261 | 500 | 6,630,500 | | | |
| Acitivity 2: Recruitment, training and deployment of teachers | | | 18,141,048 | | | |
| Acitivity 2.1: Teacher incentive | 13,261 | 1200 | 15,913,200 | | | |
| Acitivity 2.2: Teacher training | 13,261 | 168 | 2,227,848 | | | |
| Acitivity 3: Training of School Management Shuras (SMS). | 13,261 | 200 | 2,469,198 | | | |
| Acitivity 4: The distribution of teaching and learning materials and Winterization supplies. | | | 20,040,507 | | | |
| Acitivity 4.1: Teachers kit | 13,261 | 15 | 198,915 | | | |
| Acitivity 4.2: Text book pack | 403,224 | 7 | 2,822,568 | | | |
| Acitivity 4 .3: Classroom Heating and cooling | 13,261 | 216 | 2,864,376 | | | |
| Acitivity 4.4: Student kit | 403,224 | 14 | 5,645,136 | | | |
| Acitivity 4.5: Classroom kits | 13,261 | 216 | 2,864,376 | | | |
| Acitivity 4.6: Winterisation kits for children | 403,224 | 14 | 5,645,136 | | | |
| Acitivity 5: Develop audio-visual learning materials and broadcasts through available national and local media platforms | | | | 4,000,000 | 0.20 | 800,000 |
| Acitivity 6: Develop and distribute home-based self-learning material | | | | 539,000 | 15 | 8,085,000 |
| Acitivity 7: Conduct community awareness campaign to promote prevention measures with specific focus on high risk areas | | | | 1,050 | 250 | 262,500 |
| Acitivity 8: Support schools and CBEs to access clean water through the provision of water storage and water chlorination and distribution of hygiene kits in high risk areas | | | | | | 2,100,000 |
| Acitivity 8.1: Installation of water storage (drinking and hand washing water) | | | | 1,050 | 1,500 | 1,575,000 |

| | NON-COVID-19 RESPONSE | | | COVID-19 RESPONSE | | |
|---|---|---|---|---|---|---|
| **ACTIVITY/OUTPUT** | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) |
| Acitivity 8.2: Distribution of hygiene kits in high risk areas | | | | 1,050 | 500 | 525,000 |
| Acitivity 9: Promote the improvement of hygiene and sanitation situation in schools/CBEs in high risk areas | | | | 1,050 | 150 | 157,500 |
| Acitivity 10: Distribution of winterization supplies. | | | | | | 9,168,000 |
| Acitivity 10.1: Classroom heating and cooling | | | | 18,000 | 150 | 2,700,000 |
| Acitivity 10.2: Winterisation kits for children | | | | 539,000 | 12 | 6,468,000 |
| Activity 11: Ensure access to education for refugee children (distance learning) | | | | 2,231 | 112 | 250,000 |
| **Total** | **403 K** | **117.25** | **47.3 M** | **539 K** | **36.60** | **20.8 M** |

## Emergency Shelter and NFI

| | NON-COVID-19 RESPONSE | | | COVID-19 RESPONSE | | |
|---|---|---|---|---|---|---|
| **ACTIVITY/OUTPUT** | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) |
| Emergency shelter assistance (tent+ 2 pcs tarpaulin) | 31,183 | 500 | 2,227,364 | 31,183.09 | 500 | 2,227,364 |
| Emergency shelter assistance (tent+ reconstruction toolkit) | 4,475 | 565 | 361,158 | 10,440.55 | 565 | 842,701 |
| Emergency shelter assistance (cash for rent) | 113,846 | 293 | 4,757,118 | 113,845.56 | 293 | 4,757,118 |
| Support to construct transitional shelter | 74,749 | 1,625 | 17,352,342 | 74,748.55 | 1,625 | 17,352,342 |
| Shelter repair / reconstruction | 66,328 | 390 | 3,695,429 | 154,765.85 | 390 | 8,622,669 |
| Non-food items assistance | 346,846 | 137 | 6,763,489 | 346,845.61 | 137 | 6,763,489 |
| Assistance to cover energy needs (winterisation) | 546,158 | 260 | 20,285,857 | 723,976.48 | 260 | 26,890,555 |
| **Total** | **694 K** | **87.99** | **55.4 M** | **694 K** | **87.99** | **67.5M** |

## Food Security and Agriculture

| | NON-COVID-19 RESPONSE | | | | COVID-19 RESPONSE | | | |
|---|---|---|---|---|---|---|---|---|
| **ACTIVITY/OUTPUT** | **PLANNED REACH** | **UNIT COST** (US$) | **DURATION OF ASSISTANCE** | **TOTAL ACTIVITY COST** (US$) | **PLANNED REACH** | **UNIT COST** (US$) | **DURATION OF ASSISTANCE** | **TOTAL ACTIVITY COST** (US$) |
| Food asistance to IDPs | 400,000 | 19 | 3 months | 22,800,000 | | | | |
| Food assistance to people affected by natural disasters | 115,000 | 19 | 2 months | 4,370,000 | | | | |
| Food asistance to returnees | 152,500 | 19 | 4 months | 11,590,000 | | | | |
| Food asistance to refugees | 70,665 | 19 | 6 months | 4,239,900 | | | | |
| Seasonal food support | 4,601,000 | 10 | 4 months | 184,040,000 | | | | |
| Livelihoods assistance to IDPs | 50,000 | 35 | 1 month | 1,750,000 | | | | |
| Livelihoods assistance to people affected by natural disasters | 92,000 | 20 | 1 month | 1,840,000 | | | | |
| Seasonal livelihoods support | 1,918,092 | 20 | 1 month | 38,361,840 | | | | |
| Assets creation | 330,000 | 20 | 6 months | 39,600,000 | | | | |
| Livelihoods support to refugees | 2,800 | 179 | | 240,000 | | | | |
| Food support to COVID-19-affected people | | | | | 3,000,004 | 10 | 2 months | 60,000,080 |
| Livelihoods support to COVID-19-affected people | | | | | 60,000 | 12 | 8 months | 743,000 |
| Cost of assessment -SFSA 2020 | | | | 200,000 | | | | |
| Coordination - FSAC | | | | 550,000 | | | | |
| **Total** | **6.7 M** | **46.00** | | **309.6 M** | **3.1 M** | **19.85** | | **60.7 M** |

## Health

| | NON-COVID-19 RESPONSE | | | COVID-19 RESPONSE | | |
|---|---|---|---|---|---|---|
| **ACTIVITY/OUTPUT** | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) |
| Support risk communication activities to ensure clear messaging on Covid 19 is widely available to all communities and all Afghans. | | | | 2,081,738 | 7 | 15,433,698 |
| Strengthen surveillance systems for early detection, isolation and confirmation of suspected cases; ensure rapid detection and confirmation of suspected cases for immediate isolation and treatment of confirmed cases; support rapid response teams and provide technical guidance at all levels; ensure availability of stockpiles of PPE and consumables for surveillance and diagnostic and case management facilities | 50,000 | 20 | 1,000,000 | 200,000 | 20 | 4,000,000 |

| | NON-COVID-19 RESPONSE | | | COVID-19 RESPONSE | | |
|---|---|---|---|---|---|---|
| **ACTIVITY/OUTPUT** | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) |
| Support of health and other teams for screening at the Points of Entry (PoE) and ground crossings and airports | | | | 50,000 | 40 | 2,000,000 |
| Support the expansion of diagnostic facilities for Covid 19 confirmatory testing at the national and sub-national levels | | | | 200,000 | 25 | 5,000,000 |
| Support IPC at identified health facilities, isolation centres and designated PoE; IPC training of health workers, support staff, cleaners and ambulance staff in designated health facilities and isolation centres | | | | 2,500 | 25 | 62,500 |
| Support and equip isolation wards/ICUs in the designated national, regional and provincial hospitals; ensure availability of stockpiles of PPE and consumables | | | | 300,000 | 120 | 36,000,000 |
| Strengthen health facilities for better preparedness and more effective response; expand services to underserved and hard to reach areas through mobile health teams and contribute improved surveillance and response to any outbreaks | 1,950,000 | 29 | 56,397,625 | 2,255,905 | 20 | 45,118,100 |
| Establish trauma care facilities in conflict affected provinces; provide physical rehabilitation, equipment, training and human resource support | 14,572 | 45 | 655,740 | | | |
| Improve blood banks at district level including equipment and training | 8,745 | 55 | 480,975 | | | |
| Establish FATPs in high risk priority districts; provide equipment and train staff | 14,572 | 45 | 655,740 | | | |
| Provide equipment, infrastructure and human resource support in physiotherapy, rehabilitation and prosthesis for war-related trauma | 12,934 | 55 | 711,370 | | | |
| Provide psychosocial support for shock affected people | 14,990 | 15 | 224,850 | | | |
| Procure emergency trauma kits | 80 | 11,845 | 947,600 | | | |
| Procure basic interagency emergency health kits | 800 | 621 | 496,800 | | | |
| Procure supplementary interagency emergency health kits | 80 | 7,116 | 569,280 | | | |
| Procure Cholera and pneumonia kits | 40 | 4,656 | 186,240 | | | |
| Improve hospital waste management and infection control | 10 | 40,000 | 400,000 | | | |
| Fill vaccination gaps for U5 children | 50,000 | 15 | 750,000 | | | |
| **Total** | **1.9 M** | **31.00** | **63.5 M** | **5.1 M** | **21.10** | **171.1 M** |

## Nutrition

| | NON-COVID-19 RESPONSE | | | COVID-19 RESPONSE | | |
|---|---|---|---|---|---|---|
| **ACTIVITY/OUTPUT** | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) |
| Outpatient treatment of SAM (U5 children) | 294,435 | 101 | 29,737,935 | 106,214 | 101 | 10,727,617 |
| Inpatient treatment of SAM (U5 children) | 29,444 | 129 | 3,798,212 | 15,932 | 129 | 2,055,241 |
| Treatment of MAM (children 6-59 months) | 423,874 | 35 | 14,835,590 | 284,688 | 35 | 9,964,082 |
| Tragated supplementary feeding programmes for PLW | 149,608 | 69 | 10,322,952 | 87,298 | 69 | 6,023,533 |
| Blanket supllmentary seeding programme (BSFP) for children in emergencies | 158,211 | 30 | 4,746,337 | 166,402 | 30 | 4,992,062 |
| BSFP for PLW affected by emergency | 74,452 | 37 | 2,754,737 | 78,307 | 37 | 2,897,354 |
| Micronutrinet supplmentation to U5 children in emergencies | 212,229 | 2 | 424,458 | 223,216 | 2 | 446,433 |
| Infant and young child feeding services in emergencies (IYCF-E) | 113,500 | 15 | 1,702,506 | 119,377 | 15 | 1,790,648 |
| Training for service providers on maternal and child care | 1,300 | 125 | 162,500 | 1,300 | 50 | 65,000 |
| Provincial integrated SMART nutrition surveys | 10 | 19000 | 190,000 | | | - |
| Rapid nutrition assessments in new emergencies | 10 | 9000 | 90,000 | | | - |
| Cluster coordination at national and sub-national levels | | | 700,000 | | | - |
| Counseling on maternal health and child care for mothers of at-risk U5 children | 202,037 | 15 | 3,030,556 | 212,497 | 15 | 3,187,453 |
| **Total** | **1.4 M** | **51.94** | **72.5 M** | **1M** | **40.79** | **42.1 M** |

## Protection

| | NON-COVID-19 RESPONSE | | | COVID-19 RESPONSE | | |
|---|---|---|---|---|---|---|
| **ACTIVITY/OUTPUT** | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) |
| MA: Mine risk education | 239,016 | 2 | 478,032 | 141,148 | 2 | 282,295 |
| MA: Mine clearance | 164,016 | 35 | 5,740,560 | | | |
| MA: EOD & Survey | 239,016 | 2 | 478,032 | | | |
| GBV: Assistance to GBV survivors and at-risk people through multi-sectoral response (legal, safety, health and psychosocial) | 694,933 | 24 | 16,797,856 | | | |
| GBV: Community dialogues to prevent and respond to GBV | 100,000 | 6 | 600,000 | | | |
| GBV: Dignity kits for GBV survivors | 443,910 | 28 | 12,429,480 | 43,090 | 28 | 1,206,520 |

| | NON-COVID-19 RESPONSE | | | COVID-19 RESPONSE | | |
|---|---|---|---|---|---|---|
| **ACTIVITY/OUTPUT** | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) |
| GBV: Economic empowerment | 40,500 | 25 | 1,012,500 | | | |
| CP: Psychosocial support for children | 150,000 | 30 | 4,500,000 | 100,000 | 30 | 3,000,000 |
| CP: Community-based awareness on child protection and COVID-19 prevention | 200,000 | 10 | 2,000,000 | 300,000 | 10 | 3,000,000 |
| CP: Awarenes to parents, care-givers, children and adolescents on COVID-19 | 20,000 | 10 | 200,000 | 80,000 | 10 | 800,000 |
| CP: Case management, PSS and referrals for at-risk children | 6,000 | 150 | 900,000 | 1,000 | 150 | 150,000 |
| CP: Family tracing and reunification of unaccompanied and separated children | 750 | 150 | 112,500 | 250 | 150 | 37,500 |
| CP: Provide alternative care to separated and unaccompanied children, develop guidance and monitoring tools and provide capacity building | 750 | 200 | 150,000 | 250 | 200 | 50,000 |
| CP: Trainings for child protection specialists on child protection standards | 300 | 500 | 150,000 | 1,200 | 300 | 360,000 |
| CP: Victim assistance for children in conflict | 1,529 | 1000 | 1,529,000 | | | |
| CP: Advocacy and response to child recruitment | 1,042 | 300 | 312,600 | | | |
| HLP: Information sharing on HLP, durable solutions, legal identity | 175,370 | 9 | 1,578,330 | 8,380 | 9 | 75,420 |
| HLP: Counselling on HLP, legal identity | 16,129 | 13 | 209,677 | 1,840 | 13 | 23,920 |
| HLP: Legal assistance on HLP & legal identity | 26,775 | 26 | 696,150 | 3,100 | 26 | 80,600 |
| HLP: Capacity-building of duty-bearers | 2,750 | 40 | 110,000 | | | |
| HLP: Land identification & allocation | 1,000 | 80 | 80,000 | | | |
| GP: Protection assistance for people with specific needs or heightened vulnerability | 69,090 | 84 | 5,832,432 | 180,910 | 84 | 15,272,041 |
| GP: Protection monitoring, sensitisation and advocacy | 820,000 | 6 | 4,709,359 | 582,520 | 6 | 3,345,483 |
| GP: Community-based protection-related activities | 693,789 | 3 | 1,734,715 | 740,131 | 3 | 1,850,587 |
| **Total** | **1.5 M** | **41** | **63.2 M** | **789 K** | **37** | **29.5 M** |

## Water, Sanitation and Hygiene

| | NON-COVID-19 RESPONSE | | | COVID-19 RESPONSE | | |
|---|---|---|---|---|---|---|
| **ACTIVITY/OUTPUT** | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) |
| Safe drinking water, including water trucking, hand pump & well construction and water purification | 746,832 | 24.75 | 18,484,092 | | 24.75 | |
| Gender appropriate emergency latrine and bathroom facilities | 301,416 | 20.35 | 6,133,816 | | 20.35 | |
| Hygiene promotion | 2,131,194 | 9.90 | 21,098,822 | 2,028,329 | 9.90 | 20,080,459 |
| Pre-positioning of stocks | 912,492 | 6.60 | 6,022,444 | 611,976 | 4.95 | 3,029,280 |
| WASH in temporaty learning centres, child-friendly spaces and schools | 46,331 | 40.15 | 1,860,172 | 305,988 | 9.90 | 3,029,280 |
| WASH in health facilities and child-feeding centres | 118,598 | 17.60 | 2,087,325 | 458,982 | 17.60 | 8,078,081 |
| Rapid needs assessments | 1,677,762 | 2.50 | 4,194,405 | 1,563,929 | 2.50 | 3,909,823 |
| In-depth needs assessments | 1,111,827 | 3.50 | 3,891,396 | 469,179 | 3.50 | 1,642,126 |
| Coordination / workshops with MRRD / partners on operationalisation of the National WASH in Emergency Guidelines and EP&R / lessions learned on COVID-19 | | | 130,000 | | | 130,000 |
| Provision of safe drinking water through rehabilitation, upgarade or extension of water supply infrastructure, including handwashing promotion | 513,006 | 32.45 | 16,647,041 | 674,227 | 32.45 | 21,878,674 |
| Provision of improved sanitation facilities; improvement of existing community facilities, including handwashing promotion | 171,883 | 24.75 | 4,254,115 | 225,901 | 24.75 | 5,591,047 |
| **Total** | **2 M** | **43.45** | **84.8 M** | **1.8 M** | **37.20** | **67.4 M** |

## Refugee Chapter

| | NON-COVID-19 RESPONSE | | | COVID-19 RESPONSE | | |
|---|---|---|---|---|---|---|
| **ACTIVITY/OUTPUT** | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) |
| Ensure access to education for refugee children (distance learning) | | | | 2,231 | 112 | 250,000 |
| Coordination and assessment | 72,065 | 8.05 | 580,000 | | | |
| Cash assistance for PSN | 1,720 | 581.4 | 1,000,000 | | | |

| | NON-COVID-19 RESPONSE | | | COVID-19 RESPONSE | | |
|---|---|---|---|---|---|---|
| **ACTIVITY/OUTPUT** | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) | **PLANNED REACH** | **UNIT COST** (US$) | **TOTAL ACTIVITY COST** (US$) |
| Support voluntary return of refugee population | 500 | 200 | 100,000 | | | |
| Support access to livelihoods | 2,800 | 178.57 | 240,000 | | | |
| Provision of safe drinking water, including by water trucking (where critically necessary), handpump and well construction,and or provision of water purification to the population in need | 8,000 | 25 | 200,000 | | | |
| Affected people are reached with safe hygiene messages focusing on proper handwashing with soap at critical times and safe water chain | | | | 10,000 | 10 | 100,000 |
| Prepositioning of WASH NFIs in line with ICCT pipeline stock strategy and Cluster Contingency Plan | | | | 62,600 | 5 | 313,000 |
| Cash for protection | | | | 14,000 | 28.57 | 400,000 |
| Provision of emergency shelter assistance (tent + 2 pcs Tarpaulin) | 8,035 | 500 | 573,944 | | | |
| Provision of emergency shelter assistance, including through cash for rent | 5,584 | 292.5 | 233,323 | | | |
| Support to construct transitional shelters | 2,135 | 1625 | 495,625 | | | |
| Shelter repair/upgrade allowing for safer and dignified living conditions | 5,619 | 390 | 313,059 | | | |
| Provsion of basic household items (NFIs) to meet immediate needs | 34,365 | 136.5 | 670,118 | | | |
| Support during winter period with heating materials and winter clothing kits | 13,722 | 260 | 509,659 | | | |
| In-kind food assistance to Pakistani refugees to cover their seasonal food insecurity needs | 70,065 | 10 | 4,323,900 | | | |
| Outpatient treatment of SAM | 1,034 | 101 | 104,434 | | | |
| Inpatient treatment of SAM | 110 | 129 | 14,190 | | | |
| Treatment of MAM | 1,422 | 35 | 49,770 | | | |
| TSFP for undernourished PLW | 411 | 69 | 28,359 | | | |
| Strengthen health facilities for better preparedness and more effective response; expand services to underserved and hard to reach areas through mobile health teams and contribute improved surveillance and response to any outbreaks | 24,026 | 45 | 1,081,170 | | | |
| **TOTAL** | **72,065** | **146** | **10.5 M** | **63 K** | **17** | **1.1M** |

# 4.2 Participating Organisations

| SECTOR | PARTICIPATING ORGANISATIONS | COUNT |
|---|---|---|
| Education in Emergencies | ACTED, AWEC, BEST, BRAC, COAR, IRC, IRW, NRC, OHW, RETI, SCI, SVA, TLO, WADAN, WCC, WVI and ZOA | 17 |
| Emergency Shelter and NFI | AAH, ACTED, ADA, AFGHANAID, ANDMA, ARCS, BDN, BVWO, CARE, COAR, CORDAID, CRDSA, CWW, DHSA, DRC, HRDO, HRHHAC, IMC, IOM, IRC, ME, MRRD, NCRO, NERDO, NPO/RRAA, NRC, OHW, ORD, OXFAM, PIN, PU-AMI, RAA, SCI, SC-USA, SHPOUL, UNHCR, UNICEF, WAW, WHH and ZOA | 40 |
| Food Security and Livelihoods | AAH, ACTED, ADA, AFGHANAID, ANCC, AOAD, APA, CAHPO, CARE, CG, CHA, COAR, CRDSA, CRS, CWSA, CWW, DRC, FAO, FGA, HRDA, IRC, MEDAIR, NAC, NCRO, NPO/RRAA, NRC, OHW, OXFAM, RI, SCI, SFL, SHPOUL, SI, WFP, WHH, WSTA, WVI and ZOA | 38 |
| Health | AADA, ACF, ACTD, ACTED, ADAA, AHAD, AHDS, AHEAD, AKHS, BARAN, BDN, BRAC, CHA, CORDAID, DAO, DRC, EMERGENCY, HADAAF, HEWAD, HI, HN-TPO, IMC, INTERSOS, IOM, JACK, JOHANNITER, KAF, MA, MEDAIR, MOVE, MRCA, NAC, NRC, OHPM, OHW, ORCD, OXFAM, PU-AMI, RI, SAF, SCA, SDO, SDO IOM, SHDP, SI, SM, TDH, UNFPA, UNHCR, UNICEF, WVI and YHDO | 38 |
| Nutrition | AADA, AAH, ACF, AFC, AHDS, AHEAD, AKF, AKHS, AYSO, BARAN, BDN, BRAC, CAF, CHA, HEWAD, HNTPO, INTERSOS, JACK, MEDAIR, MMRCA, MOPH, MOVE, MRCA, MSF, OCE, OCEI, OHPM, ORCD, SAF, SCA, SDO, SHDP, UNICEF, WFP, WHO, WVI and YHDO | 37 |
| Protection | AAA, AABRAR, AADA, AAH, ACHRO, ACTED, ADA, ADOA, ADWSO, AFGHANAID, AIHRC, AKF, AOAD, APA, ARAA, ASCHIANA, ATC, AWC, AWEC, AWRC, AWRO, BEST, BLUMONT, BRAC, CAF, CAID, CARE, CARITAS-G, CAWC, CF, CHA, CIC, CIVIC, CONCERN, CORDAID, CRDSA, CWSA, DAFA, DAO, DDG, DOLSA, DRC, EA, ECW, ETCPGWA, FRDO, HADAAF, HALO, HAPA, HELP, HEWAD, HI, HN TPO, HRDA, HRRAC, HTAC, ICRC, ILF, IMC, INTERSOS, IOM, IPSO, IRC, IRW, JACK, JCSSO, JOHANNITER, LEFAO, MCPA, MOVE, MSF, MWA, NRC, OHD, OHW, ORCD, ORD, OXFAM, PAC.O, PIN, PU-AMI, RAADA, RI, RSSAO, SAF, SCA, SCI, SDO, SHAO, SHUHADA, SKATEISTAN, SOUND, STARS, SVA, TABISH, TACT, TAF, TDH, UNAMA, UNFPA, UN-HABITAT, UNHCR, UNICEF, UNMAS, VOPOFA, WADAN, WASSA, WAW, WC-C, WC-UK, WHH, WSTA, WVI, WW, YHDO, ZOA | 116 |
| Water, Sanitation and Hygiene | AAH, ACTED, ADA, APA, CAID, CARE, CARITAS-G, COAR, CORDAID, DACAAR, HAPA, INTERSOS, IRC, MEDAIR, MERCY CORPS, NPO/RRAA, NRC, ORD, OXFAM, RCDC, RI, UNICEF, WVI and ZOA | 24 |

4.3

# Planning Figures by Sector

| SECTOR | PEOPLE IN NEED 2020 | PLANNED REACH 2020 | REQUIREMENTS 2020 (US$) |
|---|---|---|---|
| Education in Emergencies | 2.6M | **0.9M** | **68.1M** |
| Emergency Shelter and NFI | 5.3M | **1.4M** | **122.9M** |
| Food Security and Agriculture | 13.2M | **9.8M** | **370.3M** |
| Health | 10.1M | **7.0M** | **171.1M** |
| Nutrition | 4.6M | **2.4M** | **114.6M** |
| Protection | 11.5M | **2.3M** | **91.9M** |
| Water, Sanitation and Hygiene | 7.2M | **3.8M** | **152.2M** |
| **Total** | **14M** | **11.1M** | **$1,131M** |

| **BY SEX (%)** FEMALE / MALE | **BY AGE (%)** CHILDREN / ADULTS / ELDERS | **WITH DISABILITY** | **IDPS** | **RETURNEES** | **SHOCK-AFFECTED** | **VUL. PEOPLE** | **REFUGEES** |
|---|---|---|---|---|---|---|---|
| 56 / 44 | 100 / 0 / 0 | 33 K | 140 K | 73 K | 53 K | 0.69 M | 2 K |
| 49 / 51 | 55 / 42 / 3 | 118 K | 220 K | 171 K | 42 K | 0.90 M | 34 K |
| 49 / 51 | 55 / 42 / 3 | 808 K | 405 K | 153 K | 170 K | 9.05 M | 72 K |
| 48 / 52 | 55 / 42 / 3 | 583 K | 270 K | 221 K | 314 K | 6.42 M | 25 K |
| 58 / 42 | 82 / 18 / 0 | 177 K | 100 K | 53 K | 52 K | 2.25 M | 6 K |
| 42 / 58 | 62 / 36 / 2 | 204 K | 160 K | 199 K | 34 K | 1.91 M | 23 K |
| 49 / 51 | 56 / 41 / 3 | 319 K | 410 K | 451 K | 144 K | 2.76 M | 58 K |
| **49 / 51** | **55 / 42 / 3** | **931 K** | **405 K** | **460 K** | **180 K** | **10.19 M** | **72 K** |

4.4

# Planning Figures by Region

| REGION | PEOPLE IN NEED 2020 | PLANNED REACH 2020 | REQUIREMENTS 2020 (US$) |
|---|---|---|---|
| Capital | 2.8M | **2.09M** | **$74.2 M** |
| Central Highland | 0.5M | **0.36M** | **$41.8 M** |
| Eastern | 1.8M | **1.41M** | **$112.8 M** |
| North Eastern | 2.0M | **1.65M** | **$91.6 M** |
| Northern | 1.8M | **1.43M** | **$95.7 M** |
| South Eastern | 1.5M | **0.98M** | **$45.8 M** |
| Southern | 1.7M | **1.41M** | **$106.5 M** |
| Western | 2.3M | **1.95M** | **$178.6 M** |
| **Total** | **14M** | **11.1M** | **$1,131M** |

| **BY SEX (%)**<br>FEMALE / MALE | **BY AGE (%)**<br>CHILDREN / ADULTS / ELDERS | **WITH DISABILITY** | **IDPS** | **RETURNEES** | **SHOCK-AFFECTED** | **VUL. PEOPLE** | **REFUGEES** |
|---|---|---|---|---|---|---|---|
| 49 / 51 | 55 / 42 / 3 | 79 K | 20 K | 44 K | 11 K | 2.01M | 0.4 K |
| 49 / 51 | 54 / 42 / 3 | 45 K | 4 K | 6 K | 3 K | 0.34M | - |
| 49 / 51 | 55 / 43 / 2 | 120 K | 93 K | 29 K | 21 K | 1.26M | - |
| 48 / 52 | 55 / 42 / 3 | 98 K | 104 K | 58 K | 19 K | 1.47M | - |
| 49 / 51 | 55 / 42 / 3 | 102 K | 85 K | 47 K | 30 K | 1.27M | - |
| 49 / 51 | 56 / 41 / 2 | 49 K | 32 K | 18 K | 21 K | 84 K | 72 K |
| 48 / 52 | 55 / 44 / 2 | 114 K | 25 K | 230 K | 41 K | 1.11M | - |
| 48 / 52 | 54 / 43 / 3 | 191 K | 42 K | 234 K | 35 K | 1.63M | - |
| **49 / 51** | **55 / 42 / 3** | **931 K** | **405 K** | **460 K** | **180 K** | **10.19 M** | **72 K** |

4.5

# What if We Fail to Respond?

The stakes for people in Afghanistan could not be higher with COVID-19 colliding with a protracted conflict, repeated natural disasters and grinding poverty. Failure to meet the needs of the 11.1 million vulnerable and shock-affected people identified for support in 2020 could have catastrophic consequences not only for these people as individuals, but also in terms of the country's development overall. Timely delivery of safe, appropriate and cost-effective assistance, including to those affected by COVID-19, is critical to ensuring people's well-being and survival, providing safe and dignified living conditions, reducing protection threats and supporting resilience and recovery. Aid agencies have demonstrated their commitment to these goals through their sustained presence in-country despite security risks, but they can only continue this work with early and generous support from donors. Failure to act on urgent humanitarian and wider need for social safety net-type assistance, risks eroding decades of hard-fought development gains that have started to improve millions of lives. Failure to invest in alleviating humanitarian needs also has implications for peace-building efforts by increasing tensions as stressed, impoverished communities compete for scarce resources.

## Health

Without a well-funded and well-coordinated health response to COVID-19 and other risks, Afghanistan faces a substantial death toll and unnecessary suffering for people across the country. There is currently no reliable scenario on the spread of COVID-19 in Afghanistan, however, even the most conservative estimates expect hundreds of thousands of people to become seriously ill and thousands to die. There are already reports of clusters of deaths with unknown causes. The longer the outbreak spreads unchecked by widespread testing, contact tracing and physical distancing measures, the longer people will be confined to their homes and unable to earn an income. Without funding for health services, other disease outbreaks may not be prevented, detected and contained, causing avoidable suffering, sickness and death, especially among vulnerable children. Without a sufficient scale-up of risk communication, awareness-raising activities, and rumour tracking, millions of additional people may be unnecessarily be exposed to COVID-19 and spread it to others, causing additional suffering and prolonging the crisis.

With the conflict continuing to rage alongside COVID-19, people are still dying from traumatic injuries and suffering from permanent disability if extended emergency health services are not provided. Inability to offer the planned post-trauma rehabilitation services would mean that nearly half of all trauma patients may be left with life-altering permanent disability and no ongoing support. With one in three people, mostly in hard-to-reach areas, unable to access a functioning health centre close to their home, the risk of death and disease was already unacceptably high before COVID-19 and the health system has become reliant on humanitarian support to keep people alive. Considering the enormous needs and sustained pressures generated by COVID-19 on top of decades of conflict and under-investment, the fragile health system has little capacity to cope independently if humanitarian support is not forthcoming. Routine vaccinations, the polio programme, antenatal care, mental health services and psychosocial support have either stopped or reduced their coverage because of COVID-19. Without action and funding, in the mid- to long-term, this could lead to re-emergence of diseases, deteriorating mental health, worsening maternal mortality and increased deaths overall.

## WASH

The provision of water, sanitation and hygiene services and supplies is crucial to fighting the spread of COVID-19 and may result in avoidable loss of life if not delivered on the expanded scale now planned. If adequate WASH assistance is not provided, millions will be deprived of the safe water they need for their survival and will be susceptible to preventable disease outbreaks, including COVID-19, that are associated with poor sanitation and hygiene conditions. This is particularly concerning for displaced households, 57 per cent[66] of whom are reported to have insufficient or barely enough water to survive and more than two-thirds of whom have no access to hygiene materials. Without funding to provide cash support to vulnerable families in informal settlements to purchase water and hygiene supplies these locations may become hotspots for transmission of deadly diseases, including COVID-19. Emerging evidence also shows that the COVID-19 virus may remain in the feces of infected and recovering patients. With only 43 per cent of the population having access to basic sanitation facilities, early investment in safe sanitation facilities is paramount. Lessons learned from the post-earthquake cholera response in Haiti shows that for every dollar invested in improving access to water, sanitation and hygiene, the economic rate of return regained in extra time that can be spent at work and school, in time saved at home by not traveling far to haul water, in increased productivity and in reduced health costs, would be as much as $8.46.

## Food and Livelihoods

Without timely access to food, particularly during the COVID-19 period ahead, people not only risk hunger and malnutrition but will also be pushed to employ negative coping mechanisms that often have serious protection implications, such as forced labour and early marriage, for children. Failing to respond to the current food insecurity and livelihood needs of the most vulnerable who are now in IPC 3 and 4, may cause an unsustainable spike in humanitarian needs, potentially leading to social unrest, malnutrition, inescapable poverty and an irreversible downward slide of food insecurity. Each passing day without delivering food aid has physical, emotional and cost implications for families that are struggling to cope with the cumulative impact of four decades of war and uncertainty. Providing food assistance with supplementation in the short-term is cheaper than responding in the longer-term to severe acute malnutrition – a life-threatening condition requiring additional specialised nutrition commodities and medicines to avert high child mortality. Where access to food is not guaranteed, families are more likely to keep their children out of school due to the expense, send them to work, or forcibly marry them to reduce food consumption costs.

## Nutrition

A staggering one-in-three children under five and one-in-five pregnant and lactating women is suffering from acute malnutrition and are at high risk of death without the provision of treatment services to save their lives. These risks are exacerbated by COVID-19. Without a timely humanitarian response, children with SAM are at a nine times higher risk of dying than their healthy peers and face a high chance of stunting, which impairs growth and can cause lifelong cognitive deficits. About 2.9 million acutely malnourished children under five years old require timely life-saving treatment in Afghanistan. Despite scale-up of treatment of acute malnutrition services, a significant proportion of children with acute malnutrition continue to have no access to treatment. Without timely treatment, as many as half of all children with SAM may die. Data on nutrition treatment provision shows a disturbing drop in people attending these services in health facilities primarily due to fear, and this may have serious implications for people's survival if funding for alternative mobile services is not forthcoming.

Children[67] suffering from prolonged undernutrition who do survive often become locked in a cycle of recurring illness and faltering growth, with irreversible damage to their development and cognitive abilities. In the long-term, failure to act on these

needs will impact on their ability to attend school and get a job. Studies[68] estimate that undernourished children are at risk of losing more than 10 per cent of their lifetime earning potential, creating huge implications for national productivity. For those suffering as a result of stunting, estimates suggest their adult earning capacity may be reduced by as much as 22 per cent.[69] In addition, women of reproductive age and adolescent girls affected by undernutrition suffer adverse impacts on their own health as well as, later, on the birth outcome of infants. Without assistance, the 560,000 PLW who are undernourished may have children who are predisposed to low birth weight, short stature, have low resistance to infections, and high risk of disease and mortality, placing further burden on the overstretched health system.

## Protection

Without immediate protection and multi-sectoral support, the lives of hundreds of women and children will be put at urgent risk, as COVID-19 dynamics conspire to exacerbate vulnerabilities pre-dating the pandemic. Without assistance, many destitute families will resort to negative coping strategies, putting the lives of more children at risk as a result of being sold, forcibly married off, or forced to do hazardous work. Without safe places to turn for support, women will bear a disproportionate brunt of the crisis as their exposure to GBV will increase drastically during measured lockdowns. In the absence of comprehensive mental health and psychosocial support services, people's emotional well-being and chances of recovery will be jeopardised. Returnees from neighbouring countries, and individuals perceived as being ill with COVID-19, will be at heightened risk of stigmatisation, compounding their risk of forced eviction and their inability to support themselves.

Mine action activities will remain crucial to protect thousands of lives from explosive hazards, including people who are returning to Afghanistan in increasing numbers since the outbreak of COVID-19. Without a comprehensive package of protection and mine risk education services, hundreds more people (especially children) are likely to die from landmines each year and millions will suffer protection violations with ongoing impact on their safety, dignity and mental well-being. Without humanitarian assistance, more children will be exposed to violence, separation from their families, risks of recruitment by parties to the conflict, severe psychosocial distress, child labour, early and forced marriages (especially girls), denial of education opportunities, and sexual exploitation. The estimated 3.5 million people with insecure land tenure and at risk of forced eviction will continue to live in limbo without access to their housing, land and property rights and unable to support their own recovery from conflict and natural disaster. A particularly vulnerable group is the large number of low-income renters – often returnees or IDPs – in urban informal settlements. 28 per cent of people who live in Kabul informal settlements are renters.

## ES-NFI

Without comprehensive shelter support, the health, safety and dignity of millions of people will remain under threat, particularly at the height of the COVID-19 pandemic. Failure to improve the availability of safe shelter and essential household items means that people will be left to live in open spaces, risking their lives and health through exposure to harsh weather conditions. It would also mean that people are forced to live with limited or no privacy and in conditions that lack dignity, exposing vulnerable people – women, children, people with disability and the elderly – to health protection risks. This is particularly concerning for IDPs, two-thirds of whom currently reside in non-permanent shelters.[70] Furthermore, failure to invest in transitional shelter would have ongoing financial implications for the humanitarian response in Afghanistan. A one-off additional investment of $19 per person to provide transitional shelter (lasting two to five years) would save $59 every year for each emergency shelter beneficiary. Inability to distribute sufficient household supplies to reduce sharing between family members could aid the spread of the virus. Due to the impact of COVID-19 on livelihoods, it is expected that more than 1.3 million people will not have access to heating/

fuel to cope with the winter, leaving them extremely vulnerable. Funding for winterisation support in 2020 is thus more critical than ever with deadly consequences if resources are not made available.

## Education

Efforts to support children and parents to continue learning under lockdowns are critical to keeping students engaged in school. When education is interrupted or denied, children's safety and mental health are placed at grave risk. Recovering lost hours through catch-up classes later in the year will be critical to overcoming the turmoil caused by COVID-19 on children's learning. There are also enormous safety risks if children return to school without access to the WASH services they need to maintain good hygiene and protect themselves from COVID-19. Funding for this work is critical to the return to normality. When denied education over the long-term, as a result of conflict or poverty, children's cognitive development may be impaired with potentially irreversible consequences for their mental capacity and future prospects. This limits their earning potential and economic contribution, as well as their quality of life. School-age children who have access to education are less vulnerable to recruitment by parties of conflict, trafficking and abusive work. Missing out on the critical early childhood benefits of school (a formative phase for the emotional, social and physical growth of young children) undermines cognitive development. Afghanistan's labour market already suffers from a workforce that is poorly educated, informal and lacking the requisite skills to develop their career further. For a child, it is estimated that poor pre-primary and primary education could reduce their adult income by as much as a quarter. Adequate funding for complementary humanitarian and development education initiatives is critical to ensuring children can transition from emergency education to more regular hub schools.

## Social Safety Net

The COVID-19 outbreak is exerting socio-economic pressure on vulnerable households. Even prior to the pandemic, an estimated 93 per cent of people in Afghanistan were living on less than $2 per day. Without humanitarian and development assistance, many will struggle to meet their basic needs, undermining the dignity of their living conditions and eroding the community's resilience to shock. COVID-19-associated lockdowns are having particularly severe economic impacts on IDPs and returnees because many work in low-paying informal livelihoods. While those with the most acute needs may be supported with short-term, life-saving humanitarian assistance, many more require a targeted relief or social assistance package – by Government and development actors – to help them weather the effects of the pandemic and prevent them from slipping into humanitarian needs.

4.6

# How to Contribute

### Contribute to the HRP

To see the country's humanitarian needs overview, humanitarian response plan and monitoring reports, and donate directly to organisations participating to the plan, please visit:

**afg.humanitarianresponse.info**

### Emergency Response Fund (CERF)

The CERF provides rapid initial funding for life-saving actions at the onset of emergencies and for poorly funded, essential humanitarian operations in protracted crises. The OCHA-managed CERF receives contributions from various donors – mainly governments, but also private companies, foundations, charities and individuals – which are combined into a single fund. This is used for crises anywhere in the world. Find out more about the CERF and how to donate by visiting the CERF website:

**cerf.un.org/donate**

### Contribute through Afghanistan Humanitarian Fund (AHF)

The AHF is a country-based pooled fund (CBPF). CBPFs are multi-donor humanitarian financing instruments established by the Emergency Relief Coordinator and managed by OCHA at the country level under the leadership of the Humanitarian Coordinator. Find out more about CBPFs and how to make a contribution by visiting: For information about the AHF, please contact:

**www.unocha.org/our-work/humanitarian-financing/country-based-pooled-funds-cbpf/**

For information about the AHF, please contact:

**ahf-afg@un.org**

### In-kind relief

The United Nations urges donors to make cash rather than in-kind donations, for maximum speed and flexibility, and to ensure the supplies that are most needed are the ones delivered. If you can make only in-kind contributions in response to disasters and emergencies, please contact:

**logik@un.org**

### Registering and recognising your contributions

OCHA manages the Financial Tracking Service (FTS), which records all reported humanitarian contributions (cash, in-kind, multilateral and bilateral) to emergencies. Its purpose is to give credit and visibility to donors for their generosity, to show the total amount of funding, and to expose gaps in humanitarian plans. Please report yours to FTS, either by email to fts@un.org or through the online contribution report form at

**fts.unocha.org**

# 4.7 Logframe

## Strategic Objective 1: Lives are saved in the areas of highest need

Legend:
↑ numbers have increased in revision of HRP due to COVID-19 response
↓ numbers have decreased in revision of HRP due to COVID-19 response

| 1.1 | EDUCATION | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | Children access alternative learning opportunities that promote their protection and wellbeing | # of girls and boys targeted for assistance reached through access to distance learning, home-based learning materials and small group learning schemes | Total:<br>Boys:<br>Girls: | | 539,000<br>215,600<br>323,400 | COVID-19 4WS |
| OUTPUTS | Girls and boys, teachers and education staff have the awareness and hygiene supplies to prevent the spread of COVID-19 | # of educational facilities provided with safe and adequate drinking water and hygiene kits | Total:<br>Men:<br>Women: | | 17,967 | COVID-19 4WS |
| | Male and female teachers trained on safe schools protocols on how to prevent and control COVID-19 | # of teachers trained on safe schools protocols related to COVID-19 prevention | Total:<br>Men:<br>Women: | | 17,967<br>7,187<br>10,780 | COVID-19 4WS |
| ACTIVITIES | 1. Development of home-based self-learning materials and audio-visual learning materials<br>2. Broadcasting of distance learning curriculum through available national and local media platforms<br>3. Conducting community awareness campaigns to promote COVID prevention measures among school aged children and their communities with specific focus on COVID-19 high risk areas<br>4. Supporting schools and CBEs to access clean water through the provision of water storage, water chlorination and hygiene kits in COVID-19 high risk areas<br>5. Training teachers on prevention and control of COVID-19 and basic psychosocial support | | | | | |

| 1.2 | ES-NFI | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | Ensure affected population groups (IDPs, returnees, refugees, conflic-affected non-displaced and natural disaster-affected people) of all ages affected by COVID-19 and /or any other new emergencies have access to adequate shelter and NFI assistance. | Proportion of IDP, returnee, refugee and non-displaced conflict-affected women, men and children of all ages receiving shelter assistance who express satisfaction about this support | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | ↑98%<br>32%<br>29%<br>18%<br>19% | ↑100%<br>↑32%<br>↑30%<br>19%<br>↓19% | PDM |
| | | # of people receiving winterisation assistance including heating / insulation and winter clothing kits. | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 45,857<br>11,526<br>12,165<br>11,094<br>11,072 | ↑1,359,792<br>↑401,789<br>↑342,594<br>↑323,898<br>↑291,511 | ReportHub |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | # of people receiving basic household items / NFIs to meet their immediate needs | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 442,583<br>133,025<br>120,042<br>95,008<br>94,508 | ↑ 779,390<br>↑ 242,670<br>↓ 187,860<br>↑ 193,638<br>↓ 155,222 | ReportHub |
| | Shelter materials and maintenance tool kits provided to affected communities and people in a timely manner | # of people whose shelter was upgraded, allowing for safer and more dignified living conditions | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 11,280<br>3,216<br>3,325<br>2,245<br>2,494 | ↓ 213,408<br>↓ 63,874<br>↓ 52,070<br>↓ 52,658<br>↓ 44,806 | ReportHub |
| | Risk communication and information awareness campaigns on COVID-19 provided to affected people with ES-NFI needs in a timely manner | # of people with ES-NFI needs reached through risk communication and information campaigns on COVID-19 | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | | 1,405,027<br>386,063<br>350,502<br>375,684<br>292,777 | |

**ACTIVITIES**

1. Distribution to and installation of emergency shelter kits for displaced households
2. Rehabilitation, repair or upgrade of existing shelters that are in poor conditions
3. Distribution of standard NFI packages and seasonal household items (such as warm clothing, heating materials and thermal blankets in winter)
4. Provision of a one-off winterisation assistance package
5. Advocacy for the establishment of a pipleine system to improve emergency response time

| 1.3 | FSAC | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| **OUTCOME** | Shock affected people (IDPs, returnees, refugees, natural disaster affected, people affected by COVID-19 and seasonaly food insecure IPC phase 3 and 4 people) of all ages have a minimum household food consumption score of above 42.5 | % of households with acceptable food consumption | **Total:** | 81% | 40%[1] | SFSA, SMART survey and PDM reports of partners. |
| **OUTPUTS** | Necessary food assistance is provided to affected households in a timely manner | # of shock affected and vulnerable (IDPs, returnees, refugees, natural disaster affecteds, people affected by COVID-19, and seasonaly food insecure IPC phase 3 and 4 people) women, men and children of all ages who receive adequate food/cash responses in a timely manner | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 3,252,427<br>910,680<br>845,631<br>748,058<br>748,058 | ↑ 8,339,169<br>↑ 2,334,967<br>↑ 2,168,184<br>↑ 1,918,009<br>↑ 1,918,009 | Quarterly reports of partners |
| | Necessary food assistance is provided to affected households in a timely manner | # of affected people receiving in-kind food assistance | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 2,768,841<br>775,275<br>719,899<br>636,833<br>636,833 | ↑ 6,254,377<br>↑ 1,751,226<br>↑ 1,626,138<br>↑ 1,438,507<br>↑ 1,438,507 | Quarterly reports of partners |

1. At the beginning of 2020, both 'acceptable' and 'borderline' food consumption scores (FCS) were combined to inform FSAC's target value. Under SFSA 2019, 'acceptable' FCS is 41% and 'borderline' FCS is 40%. The sum of all thresholds of food consumption (acceptable, borderline and poor) makes 100%. In its revised planning, FSAC has considered only 'acceptable' FCS threshold. Therefore, while the target figure presented here seems like it has reduced from what was presented at the start of 2020, it has – in reality – remained the same for 'acceptable' FCS.

| | | | | | | |
|---|---|---|---|---|---|---|
| | | # of affected people receiving cash transfers for food | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 483,586<br>135,404<br>125,732<br>111,225<br>111,225 | ↑ 2,084,792<br>↑ 583,742<br>↑ 542,046<br>↑ 479,502<br>↑ 479,502 | Quarterly reports of partners |
| | | # of calls related to food assistance responded to and resolved within a week | **Total:** | 45 | >80 | Awaaz monthly, quarterly and annual report |
| **ACTIVITIES** | 1. Timely provision of (in-kind) food assistance to meet the immediate survival needs of people<br>2. Timely provision of (cash) food assistance to meet the immediate survival needs of people<br>3. Provision of information on agroclimatic conditions, crop and livestock diseases and market trends to monitor the food security situation, guide response preparedness and fasciliate decision on response modality | | | | | |
| **1.4** | **HEALTH** | **INDICATORS** | | **BASELINE** | **TARGET 2020** | **MEANS OF VERIFICATION** |
| **OUTCOME** | People suffering from conflict related trauma injuries receive life-saving treatment within the province where the injury was sustained | % of victims who receive life-saving trauma care within the province where the injury was sustained | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 45%<br>45%<br>45%<br>45%<br>45% | 45%<br>45%<br>45%<br>45%<br>45% | ReportHub data |
| **OUTPUTS** | People suffering from conflict related trauma injuries receive life-saving treatment within the province where the injury was sustained | # of trauma cases treated within 24 hours | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 106,000<br>10,000<br>6,000<br>50,000<br>40,000 | 120,000<br>12,000<br>8,000<br>55,000<br>45,000 | ReportHub data |
| | Additional FATPs are accessible to treat people with traumatic injuries | # of trauma cases treated through FATPs (m/w/b/g) | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 119,000<br>12,000<br>8,000<br>55,000<br>44,000 | 135,000<br>15,000<br>10,000<br>60,000<br>50,000 | ReportHub data |
| **OUTCOME** | People exposed to GBV, experiencing mental health or psychosocial issues, and pregnant women in conflict areas receive appropriate ans professional support | # of health facilities providing clinical management of rape (CMR) to survivors | **Total:** | 15 | ↑ 30 | HMIS data |
| **OUTPUTS** | People with mental health and psychosocial problems access appropriate and focused care | # of women, men, girls and boys who receive focused psychosocial and psychological care | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 83,000<br>10,000<br>8,000<br>25,000<br>40,000 | ↓ 83,000<br>↓ 10,000<br>↓ 8,000<br>↓ 25,000<br>↓ 40,000 | ReportHub data |
| | # of women provided with antenatal care in high-risk provinces | # of women provided with antenatal care in high-risk provinces | **Women:** | 30,000 | ↑ 40,000 | ReportHub data |

| | | | | | | |
|---|---|---|---|---|---|---|
| | # of women, men, girls and boys who receive focused psychosocial and psychological care | # of women, men, girls and boys who receive clinical management of mental, neurological or substance use disorders through medical services (primary, secondary or tertiary health care) | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 6,000<br>500<br>500<br>2,000<br>3,000 | ↓ 4,100<br>↓ 300<br>↓ 300<br>↓ 1,500<br>↓ 2,000 | ReportHub |
| **OUTCOME** | Immediate assistance is provided to people to reduce morbidity and mortality related to COVID-19 infection | # of people received essential health services through mobile health teams | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 385,000<br>15,000<br>20,000<br>150,000<br>200,000 | 600,000<br>20,000<br>30,000<br>200,000<br>350,000 | ReportHub |
| **OUTPUTS** | # of risk communication campaigns reaching targeted vulnerable people | # of risk communication campaigns reaching targeted vulnerable people | **Total:** | | 300 | ReportHub/RCCE WG |
| | Healthcare workers are protected from COVID-19 infection | % of healthcare workers provided with essential Personal Protective Equipment | **Total:**<br>**Men:**<br>**Women:** | 10<br>10<br>10 | 70<br>70<br>70 | MoPH data |
| **ACTIVITIES** | 1. Provision of out-patient care and consultations<br>2. Provision of major and minor surgeries<br>3. Establishment of FATPs, stabilisation of FATP services and referral of patients in conflict-affected areas<br>4. Provision of mental health and psychosocial support<br>5. Extension of mobile health services<br>6. Provision of antenatal care by trained personnel<br>7. Provision of health services to GBV survivors and training of health personnel on GBV response<br>8. Provision of essential supplies, equipment, diagnostic tools and life-saving training to doctors, nurses and health professionals working in hospitals and primary healthcare clinics<br>9. Advocacy for improved access to emergency services and life-saving treatment<br>10. Risk communication and community engagement activities to disseminate health information and address rumor<br>11. Provision of essential Personal Protective Equipment to frontline workers | | | | | |

| **1.5** | **NUTRITION** | **INDICATORS** | | **BASELINE** | **TARGET 2020** | **MEANS OF VERIFICATION** |
|---|---|---|---|---|---|---|
| **OUTCOME** | Decline in GAM among IDP, returnee, refugee and non-displaced, conflict-affected children under 5 and a decline in PLW suffering from acute malnutrition | # of IDP, returnee, refugee and nondisplaced children under five with SAM who are cured and PLW with improved nutritional status | **Total:**<br>**Boys:**<br>**Girls:** | 238,000<br>107,100<br>130,900 | ↑ 340,552<br>↑ 176,203<br>↓ 164,348 | Nutrition online database |

| **1.6** | **NUTRITION** | **INDICATORS** | | **BASELINE** | **TARGET 2020** | **MEANS OF VERIFICATION** |
|---|---|---|---|---|---|---|
| **OUTCOME** | Decline in GAM among IDP, returnee, refugee and non-displaced, conflict-affected children under 5 and a decline in PLW suffering from acute malnutrition | # of IDP, returnee, refugee and nondisplaced children under five with MAM who are cured and PLWs with improved nutritional status | **Total:**<br>**Boys:**<br>**Girls:** | 209,300<br>93,800<br>115,500 | ↑ 602,278<br>↑ 311,616<br>↑ 290,662 | Nutrition online database |

| | | | | | | |
|---|---|---|---|---|---|---|
| OUTPUTS | More boys and girls (6-59 months) with SAM are enrolled in outpatien and inpatient SAM treatement programmes | # of boys and girls (6-59 months) from IDP, returnee, refugee, and nondisplaced families with SAM receiving outpatient and inpatient SAM treatment | **Total:**<br>**Boys:**<br>**Girls:** | ↓ 308,282<br>↓ 138,727<br>↓ 167,555 | ↑ 400,649<br>↓ 207,298<br>↓ 193,351 | Nutrition online database |
| | More boys and girls (6-59 months) with MAM are enrolled in MAM treatment programmes | # of boys and girls (6-59 months) from IDP, returnee, refugee, and nondisplaced families with MAM receiving MAM treatment | **Total:**<br>**Boys:**<br>**Girls:** | ↑ 270,718<br>↑ 121,823<br>↑ 148,895 | ↑ 708,562[1]<br>366,607<br>341,955 | Nutrition online database |
| | More PLW are enrolled in targeted supplementary feeding programmes (TSFP) | # of PLW with acute malnutrition enrolled in TSFP | **Total:**<br>**Women:** | ↑ 110,000<br>↑ 110,000 | ↑ 236,906 | Nutrition online database |
| | More boys and girls (6-59 months) with MAM are enrolled in BSFPs | # of boys and girls (6-59 months) from IDP, returnee, refugee, and nondisplaced families with MAM receiving BSFP | **Total:**<br>**Boys:**<br>**Girls:** | 62,802<br>28,261<br>34,541 | 324,614<br>167,954<br>156,660 | Nutrition online database |
| | More boys and girls (6-59 months) have accesse to increased treatment with RUTF | # of BPHS clinics supplied with ready to- use therapeutic foods (RUTF) over 12 months | **Total:** | 1,308 | 1,400 | Nutrition online database |
| ACTIVITIES | 1. Provision of out-patient and in-patient treatment of SAM children under five<br>2. Treatment of MAM children under between 6 and 59 months<br>3. Provision of targeted supplementary feeding for PLW<br>4. Provision of emergency blanket supplementary feeding for children aged between 6 and 59 months | | | | | |

| 1.7 | PROTECTION | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | Civilian casualties from explosive devices[2] are reduced | % reduction in civilian casualties from explosive devices compared to the same time last year | **Total:** | 1,057 | 5-10% | 1. Information Management System for Mine Action (IMSMA) database<br>2. UNAMA Reports on Protection of Civilians in Armed Conflict |
| OUTPUTS | Land is cleared of known explosive hazards | # of people living within one kilometre of a known explosive hazard benefitting from the removal of those explosive hazards | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | N/A | 164,016<br>46,021<br>42,926<br>37,567<br>37,502 | Information Management System for Mine Action (IMSMA) database |
| | | Square metres of area cleared from known explosive hazards | **Total:** | N/A | 7,106,935 | Information Management System for Mine Action (IMSMA) database |

1. Due to past miscalculations, the target value for # of children receiving MAM in the original HRP was presented with a higher figure. After adjustments, the real value is 423,883, therefore, showing that the revised target is an increase in Nutrition Cluster's reach.

2. Explosive Remnants of War (ERW), Victim Operated Improvised Explosive Devices (VOIEDs) and anti-personnel and anti-tank mines.

| | | | | | | |
|---|---|---|---|---|---|---|
| | Behavioural change focused Explosive Ordnance Risk Education (EORE) programmes are provided to vulnerable people[1] | # of vulnerable people receiving EORE | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | N/A | 380,164<br>111,371<br>104,063<br>81,224<br>83,506 | Information Management System for Mine Action (IMSMA) database |
| | Conflict-affected people[2] benefit from Explosive Ordnance Disposal and survey actvities | # of conflict-affected people benefitting from Explosive Ordnance Disposal and survey activities | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | N/A | 239,016<br>70,021<br>65,426<br>51,067<br>52,502 | Information Management System for Mine Action (IMSMA) database |

| | |
|---|---|
| **ACTIVITIES** | 1. Provision of land clearance<br>2. Provision of explosive ordnance disposal activities<br>3. Expansion of Mine Risk Education |

| 1.8 | WASH | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| **OUTCOME** | Affected people have access to COVID-19 tailored water, sanitation and hygiene services, facilities and supplies they need | # of affected people receiving water, sanitation and hygiene assistance as per cluster standard | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 1,306,108<br>403,171<br>367,190<br>269,689<br>266,058 | ↑ 4,144,223<br>↑ 1,226,507<br>↑ 1,021,392<br>↑ 1,012,820<br>↑ 883,504 | WASH partners reports/ Cluster reports |
| **OUTPUTS** | Conflict-affected, IDPs and returnees have access to sanitation services and facilities they need | # of affected people with access to functioning and gender-segregated sanitation facilities | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 250,000<br>77,376<br>71,092<br>50,574<br>50,958 | ↑ 794,150<br>↑ 239,556<br>↑ 199,644<br>↑ 188,997<br>↑ 165,953 | WASH partners reports/ Cluster reports |
| | Necessary hygiene assistance and supplies are provided to conflict-affected, IDPs and returnees in a timely manner | # of affected people receiving hygiene supplies and promotion as per cluster standard | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 1,306,108<br>403,171<br>367,190<br>269,689<br>266,058 | ↑ 4,076,723<br>↑ 1,204,907<br>↑ 1,001,142<br>↑ 1,000,670<br>↑ 870,004 | WASH partners reports/ Cluster reports |
| | Conflict-affected, IDPs and returnees have access to safe water supply services and facilities they need | # of affected people with access to safe water supply services and facilities | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 1,100,000<br>339,551<br>309,246<br>227,131<br>224,072 | ↑ 2,053,766<br>↑ 612,356<br>↓ 527,990<br>↑ 476,702<br>↑ 436,990 | WASH partners reports/ Cluster reports |
| | Natural disaster affected and displaced people are provided with the WASH support they need | # of natural disaster-affected people receiving WASH assistance | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 560,078<br>169,525<br>158,540<br>115,931<br>116,082 | ↓ 82,800<br>↓ 23,233<br>↓ 21,670<br>↓ 18,965<br>↓ 18,932 | WASH partners reports/ Cluster reports |

1. Conflict IDPs, returnees, refugees and vulnerable people with humanitarian needs (as defined in the HRP).
2. People living in communities that have been affected by armed conflict in six months prior to the visit.

| 1.9 | WASH | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | WASH assistance is delivered to women, men, boys and girls living in hard-to-reach areas and overcrowded settlements | # of hard-to-reach districts and overcrowded settlements where underserved people have received WASH assistance | Total: | 68 | 80 | WASH partner's reports/ Cluster reports |
| OUTPUT | The humanitarian system facilitates a timely and effective response to people in need | # of underserved people in hard-to-reach districts and overcrowded settlements receiving WASH assistance | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 250,000<br>78,251<br>73,936<br>47,485<br>50,328 | 1,000,000<br>313,000<br>296,000<br>190,000<br>201,000 | WASH partner's reports/ Cluster reports |
| ACTIVITIES | 1. Provision of safe drinking water by tankering, rehabilitation of existing water systems or installation of new infrastructure<br>2. Provision of emergency sanitation facilities (with focus on sex-segregated and protection sensitive models)<br>3. Supply of water treatment chemicals and training on their use<br>4. Hygiene promotion with particular focus on densely populated sites / settlements - scaling up handwashing promotion in COVID19 response<br>5. Improvement of water and sanitation facilities, and distribution of hygiene kits and essential supplies at border crossing points (Iran and Pakistan) | | | | | |

| 1.1 | COORDINATION | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | The coordination structure is fit for purpose and facilitates a timely and effective response to people in need | # of HCT Compact progress updates delivered to the HCT | Total: | 4 | 4 | |
| OUTPUTS | The coordination structure is fit for purpose and facilitates a timely and effective response to people in need | # of joint ICCT/HCT meetings held | Total: | 4 | 4 | |
| | | # of mandatory area of responsibility presentations to the HCT | Total: | 14 | 48 | |
| | | # of ICCT updates delivered to the HCT | Total: | 14 | 12 | |
| | | # of ICCT field trips | Total: | 2 | 2 | |
| | The annual HNO is evidence-based with data drawn from a range of coordinated, inter-sectoral needs assessments which accurately identify people in need | # of rapid (HEAT) assessments completed in relation to displaced populations | Total: | 320 | 320 | |
| | Decision-makers have access to robust and rigorous data on internal and cross-border population movements, needs, response and gaps enabling them to make informed funding and programme decisions | # of sector-specific and inter-sectoral needs assessments completed | Total: | 56 | 60 | |
| | Decision-makers have access to robust and rigorous data on internal and cross-border population movements, needs, response and gaps enabling them to make informed funding and programme decisions | # of households assessed as part of the annual WoA Assessment | Total: | 31,114 | 30,000 | |

## Strategic Objective 2: Protection violations are reduced and respect for International Humanitarian Law is increased

| 2.1 | EDUCATION | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | School-aged girls and boys affected by shocks have access to quality, basic education in a safe learning environment | # of school-aged girls and boys affected by shocks have access to quality, basic education | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 168,569<br>74,297<br>94,272<br>-<br>- | ↓ 418,991<br>↓ 208,631<br>↓ 196,844<br>↓ 6,954<br>↓ 6,561 | 4Ws, field monitoring visits |
| OUTPUTS | Formal and/or non-formal quality learning opportunities are provided for emergency-affected, school-aged children | # of TLS (CBE with minimum WASH package, ALC, TLS) established and maintained) | Total: | 5,808 | ↓ 13,516 | 4Ws, field monitoring visits |
| | | # of school-aged children benefitting from teaching and learning materials (student kits, teaching kits, classroom kits) and winterisation supplies | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 329,353<br>172,470<br>156,883<br>-<br>- | ↓ 418,991<br>↓ 208,631<br>↓ 196,844<br>↓ 6,954<br>↓ 6,561 | 4Ws, field monitoring visits |
| ACTIVITIES | 1. Establishment of Community Based Classes (CBCs), Temporary Classrooms (TCs) or Temporary Learning Spaces (TLS) with a minimum WASH package<br>2. Distribution of teaching and learning materials and winter-sensitive supplies<br>3. Provision of water and gender segregated latrines in schools / learning spaces<br>4. Training teachers on basic psychosocial support and group activities | | | | | |

| 2.2 | PROTECTION | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | Impact of armed conflict and natural disasters on civilians and civilian facilities is reduced | % of surveyed population reporting a feeling of safety and dignity | Total: | 80% | 85% | WoA Assessment, protection monitoring reports |
| OUTPUTS | Enhanced protection analysis of the environment | # of people reached through protection monitoring | Total:<br>Boys:<br>Girls:<br>Men:<br>Women | 97,726<br>16,797<br>16,994<br>35,367<br>28,567 | ↑ 1,402,520<br>↑ 241,063<br>↑ 243,890<br>↑ 507,571<br>↑ 409,996 | Protection Monitoring reports |
| | Enhanced protection analysis of the environment | # of protection monitoring reports circulated for protection advocacy and programme response | Total: | 10 | 24 | Monitoring reports, confirmation emails to Protection Cluster |
| | Individuals with specific needs or heightened vulnerability are reached with protection oriented direct or referral assistance | # of people who were provided with direct and referral assistance | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 55,15<br>305<br>233<br>1816<br>3,160 | ↑ 250,000<br>↑ 13,830<br>↑ 10,588<br>↑ 82,320<br>↑ 143,262 | Coded referral matrix, Monthly reporting ReportHub, PDMs, monitoring reports |
| ACTIVITIES | 1. Undertaking regular protection monitoring (including incidence monitoring)<br>2. Carrying out protection analysis (including risk analysis) and produce monthly protection monitoring dashboard<br>3. Provision of direct protection and referral services (Individual protection assistance, provision of PSS, cash for protection outcome, case identification and referrals) | | | | | |

| 2.3 | PROTECTION | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | An appropriate coordinated response provides necessary protection assistance to affected communities and people, including children, in a timely manner | # of women, girls, boys and men from affected communities (IDPs, returnees, conflict/disaster affected non-displaced host communities) are supported with GBV prevention and response services under COVID-19 response | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 85,476<br>2,439<br>14,505<br>6,408<br>62,124 | ↑ 1,152,433<br>↑ 59,829<br>↑ 382,304<br>↑ 39,831<br>↑ 670,468 | ReportHub monthly reports, Activity reports, WFHS, FPCs, PSS Outreach teams reports, dignity kit distribution reports |
| OUTPUTS | At-risk vulnerable population receiving multisector GBV response (psychosocial, safety, health and legal) through facility and community based interventions | # of at-risk IDP, returnee and non-displaced conflict or natural-disaster-affected people receiving multi-sectoral GBV services (psycho-social, legal, safety, health & case management) | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 85,476<br>2,439<br>14,505<br>6,408<br>62,124 | ↓ 694,933<br>↑ 36,078<br>↓ 230,535<br>↑ 24,019<br>↓ 404,302 | ReportHub monthly reports, WFHS, FPCs, PSS Outreach teams reports, referral reports, regional case management quantitative summary reports |
| | Increased community awareness of and capacity to respond to GBV | # of community members mobilised through community dialogues to prevent and respond to GBV | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 572,792<br>107,936<br>75,169<br>107,367<br>282,320 | ↓ 100,000<br>↓ 5,192<br>↓ 33,174<br>↓ 3,456<br>↓ 58,179 | Community dialogue agency activity reports, advocay events reports |
| | Dignity and protection of women, girls is ensured | # of women and girls in need are reached with dignity kits | Total:<br>Girls:<br>Women: | 2,708<br>299<br>2,409 | ↑ 493,910<br>↑ 189,489<br>↑ 304,421 | Dignity kits distribution reports |
| | Improved economic empowerment and community leadership for women and girls | # of women and girls reached with livelihood and leadership interventions | Total:<br>Girls:<br>Women: | 0<br>0<br>0 | 40,500<br>15,538<br>24,962 | Monthly ReportHub reports, project reports |
| | Increased opportunities for children to develop, learn, play, and strengthen resilience and psychosocial wellbeing, and families are provided with information and tools to create a safe and nurturing environment at home | # of children and their caregivers reached with center, mobile and home based activities to improve their mental health and psychosocial well-being following program completion | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 105,709<br>47,140<br>38,569<br>12,000<br>8,000 | ↑ 250,000[1]<br>↑ 118,144<br>↑ 99,714<br>↑ 18,942<br>↑ 13,200 | CFS attendance records and Activity reports |
| | Children with protection needs are identified and have their needs addressed through provision of case management, including alternative care, family tracing and reunification, and integrated psychosocial support and referrals to relevant service providers | # of girls and boys at risk, including unaccompanied and separated children, and child survivors of SGBV identified, documented, and received case management services | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 10,571<br>4,714<br>3,857<br>1,200<br>800 | ↑ 7,000[1]<br>↑ 3,796<br>↑ 3,204 | Case management records |
| | Communities and families understand the Child Protection risks related to COVID-19 and actively prevent children from being exposed to abuse, exploitation, violence, and neglect | # of people who have been reached by information on COVID-19 and the danger and consequences of hazardous child labor, child marriage, trafficking and other negative coping mechanisms | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 43,139<br>12,754<br>11,746<br>10,451<br>8,188 | 500,000<br>236,288<br>199,429<br>37,885<br>26,398 | Activity reports |

1. Historic miscalculations had led to an overestimation of this target in the original HRP logframe. A course adjustment shows that the actual target value in the original HRP logframe should have been 65,961, therefore, showing an increase in Child Protection's revised planned reach through mental health and psycosocial support.

| | |
|---|---|
| ACTIVITIES | 1. At-risk vulnerable population receiving multisector response (psychosocial, safety, health and legal) including provision of PEP kits, enhanced PSS outreach through mobile teams<br>2. Community members (women, girls, men, boys, community elders, religious leaders, community gatekeepers) involved in community dialogues and awareness raising on key GBV issues focusing social and behavioral aspects of COVID-19 and advocacy at all levels for GBV iss<br>3. Women and girls in need are reached with dignity kits<br>4. Economic empowerment programming, community leadership models<br>5. Provide psychosocial support to children by designing and provide pedagogical material for girls, boys, and family members to use in their homes and other safe spaces to strengthen coping and resilience mechanisms when public health measures preclude face-to-face contact<br>6. Provide case management services, PSS and referrals to children at risk of abuse, neglect, exploitation, violence, including SGBV survivors and children in risk of marriage<br>7. Carry out community-based awareness raising on child protection issues and disseminate COVID prevention and wellbeing messaging and support community capacity building on these topics |

| 2.4 | PROTECTION | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | Displaced communities are able to claim HLP rights and/or possess HLP documents | % of people who report possessing a security of tenure document for their house/land/property | Total: | 80% | 70% | "Quartely outcome surveys Beneficiary feedback and reporting" |
| OUTPUTS | Displaced communities are able to claim HLP rights and/or possess HLP documents | % of people who received HLP support (awareness raising, advocacy and legal counselling) who then went on to access land, security of tenure, adequate housing or HLP documentation, in line with their legal rights | Total: | 74% | 60% | "Quartely outcome surveys Beneficiary feedback and reporting" |
| | | # of individuals receiving information on HLP rights | Total:<br>Men:<br>Women: | 60,000<br>35,000<br>25,000 | ↑ 183,750<br>↑ 110,250<br>↑ 73,500 | "Case files Cases database Photos" |
| | | # of individuals receiving counselling and/or legal assistance on HLP rights | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 6,000<br>3,600<br>2,400 | ↑ 47,844<br>4,784<br>4,784<br>↑ 22,966<br>↑ 15,310 | "Case files Cases database" |
| | | # of government, humantiarian and other partners receiving training and/ or technical support on HLP | Total:<br>Men:<br>Women: | 3,000<br>1,800<br>1,200 | ↑ 2,750<br>↑ 1,650<br>↑ 1,100 | "Attendance sheets Training Reports Photos" |

| | |
|---|---|
| ACTIVITIES | 1. Provision of emergency legal support and advocacy for communities under immediate threat of eviction<br>2. Technical support to the Government in the implementation of regulations and procedures to identify and make state land available for allocation to IDPs, returnees and other vulnerable groups.<br>3. Conducting awareness raising campaigns on land allocation schemes, application processes and eligibility requirements. |

| 3.1 | ES-NFI | INDICATORS | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|

1. Historic miscalculations had led to an overestimation of this target in the original HRP logframe. A course adjustment shows that the actual target value in the original HRP logframe should have been 5,277, therefore, showing an increase in Child Protection's revised planned reach through case management services.

| | | | | | | |
|---|---|---|---|---|---|---|
| OUTCOME | Vulnerable IDP, returnee, refugee and non-displaced conflict and natural disasters-affected women, men and children of all ages are protected through provision of transitional shelter aimed at building their resilience and preventing recovering communities from slipping back into humanitarian need | Proportion of IDP, returnee and nondisplaced conflict-affected women, men and children of all ages receiving shelter assistance who express satisfaction about this support | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 98%<br>32%<br>29%<br>18%<br>19% | 100%<br>32%<br>30%<br>19%<br>19% | PDM |
| OUTPUT | Transitional shelter support is provided to affected people in a timely manner | # of people receiving support to construct transitional shelters | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 21,001<br>6,625<br>5,613<br>4,614<br>4,148 | ↑ 152,330<br>↑ 44,477<br>↑ 39,787<br>↑ 34,751<br>↑ 33,316 | ReportHub |
| ACTIVITIES | 1. Support to construct transitional and permanent shelters<br>2. Provision of technical guidance and training on shelter construction to people receiving assistance | | | | | |

## Strategic Objective 3: Vulnerable people are supported to build their resilience

| 3.2 | EDUCATION | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTPUT | Formal and/or non-formal quality learning opportunities are provided for emergency-affected, school-aged children | # of teachers (f/m) recruited | **Total:**<br>**Men:**<br>**Women:** | 5,979<br>3,230<br>2,749 | ↓ 13,516<br>↓ 6,954<br>↓ 6,561 | 4Ws, field Monitoring visits |
| | Formal and/or non-formal quality learning opportunities are provided for emergency-affected, school-aged children | # of teachers (f/m) trained on standardised Teacher training manual including PSS | **Total:**<br>**Men:**<br>**Women:** | 7,942<br>3,914<br>4,028 | ↓ 13,516<br>↓ 6,954<br>↓ 6,561 | 4Ws, field Monitoring visits |
| | Formal and/or non-formal quality learning opportunities are provided for emergency-affected, school-aged children | # of community members (including school management shuras) sensitised on the importance of EiE | **Total:**<br>**Men:**<br>**Women:** | 20,885<br>9,404<br>11,481 | ↓ 67,579<br>↓ 34,772<br>↓ 32,807 | 4Ws, field Monitoring visits |
| ACTIVITIES | 1. Recruitment, training and deployment of teachers, particularly women<br>2. Provision of professional development training on child-centered, protective and interactive methodologies, classroom management, training on psychosocial needs of the learners and available referral arrangements to detect and refer children in need of psychosocial support, social cohesion as well as peace education<br>3. Training of School Management Shuras and other community members and awareness raising on the importance and right to education for every child, especially for children with disability and girls | | | | | |

| 3.3 | FSAC | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | Livelihoods are protected and rehabilitated for vulnerable people at risk of hunger and malnutrition | Percentage of the targeted people reporting increase in food production or income | **Total:** | 0 | 80% | SFSA and PDM reports of partners. |

| | | | | | | |
|---|---|---|---|---|---|---|
| OUTPUTS | Necessary livelihoods assistance is provided to affected people in a timely manner | # of shock affected and vulnerable (natural disaster affecteds, people affected by COVID-19, and food insecure IPC phase 3 and 4 people) women, men and children of all ages who receive adequate livelihoods assistance in a timely manner | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 1,386,893<br>388,330<br>360,592<br>318,985<br>318,985 | ↑ 2,400,092<br>↑ 672,026<br>↑ 624,024<br>↑ 552,021<br>↑ 552,021 | Quarterly reports of partners |
| | Necessary livelihoods assistance is provided to affected people in a timely manner | # of women, men and children assisted through livelihoods asset creation/rehabilitation activities | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 0<br>0<br>0<br>0<br>0 | 330,000[1]<br>92,400<br>85,800<br>75,900<br>75,900 | Quarterly reports of partners |
| | Necessary livelihoods assistance is provided to affected people in a timely manner | # of women, men and children receiving livelihoods assistance in-kind | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 1,295,838<br>362,835<br>336,918<br>298,043<br>298,043 | ↓ 1,920,074<br>↓ 537,621<br>↓ 499,219<br>↓ 441,617<br>↓ 441,617 | Quarterly reports of partners |
| | Necessary livelihoods assistance is provided to affected people in a timely manner | # of women, men and children receiving livelihoods assistance in cash | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 91,055<br>25,495<br>23,674<br>20,943<br>20,943 | ↑ 480,018<br>↑ 134,405<br>↑ 124,805<br>↑ 110,404<br>↑ 110,404 | Quarterly reports of partners |
| | Necessary livelihoods assistance is provided to affected people in a timely manner | # of women, men and children assisted through vocational skills livelihoods training activities | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 0<br>0<br>0<br>0<br>0 | ↓ 50,000<br>↓ 14,000<br>↓ 13,000<br>↓ 11,500<br>↓ 11,500 | Quarterly reports of partners |

**ACTIVITIES**

1. Provision of food/cash assistance to rehabilitate or construct livelihoods and mitigate asset depletion
2. Provision of assorted crop seeds (wheat, maize, pulses and vegetables), basic tools and fertilisers to small-scale vulnerable farmers
3. Extension of animal feed and disease control support to ensure livestock survival
4. Provision of backyard poultry, asset creation (through cash- and food-for-work); and vocational skills training to vulnerable families at risk of hunger
5. Through asset creation activities, construct or rehabilitate communities' productive assets and structures such as irrigation systems, canals, flood protection schemes, and water ponds in drought- prone areas
6. Provision of off-farm livelihoods support for returnees (such as vocational training)

| 3.4 | HEALTH | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | Additional FATPs are accessible to treat people with traumatic injuries | # of new FATPs established in high-risk provinces | **Total:** | 28 | ↓ 28 | HMIS data |
| OUTPUTS | Health staff can provide services according to the national GBV protocol | # of health staff trained on national GBV protocol | **Total:**<br>**Men:**<br>**Women:** | 4,600<br>800<br>3,800 | 4,800<br>800<br>4,000 | Cluster data on training |
| | People living in hard-to-reach areas with access to health care | % of people living in hard to reach district who is 2 hr away from access to health services | **Total:** | 30% | ↑ 40% | HMIS data |

1. In the original HRP logframe, asset creation was merged with conditional seasonal support and vocational skills training. In this revision, this target value has been corrected to better match with the indicator description. The planned reach through asset creation activities has remained the same since the beginning of the year - 330,000 people.

| | | | | | | |
|---|---|---|---|---|---|---|
| | Female health staff are available in health facilities | %of health facilities with female health staff | **Total:** | 40% | 45% | HMIS datra |
| | People receive post trauma rehabilitative care | # or people receive rehabilitative care from conflict related traumatic injuries | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 3,600<br>200<br>100<br>2,500<br>800 | ↓3,600<br>↓200<br>↓100<br>↓2,500<br>↓800 | Report Hub |
| | Health facilities are scaled-up to manage infectious diseases | # of isolation ward established | **Total:** | 0 | 20 | Report Hub/HMIS |
| **ACTIVITIES** | 1. Provision of post-trauma physical rehabilitation services and assistive devices (such as prosthetics)<br>2. Expansion of primary health care in hard-to-reach districts<br>3. Establishment of additional FATPs, stabilisation of FATP services and referral of patients in high-risk provinces<br>4.Training of health personnel on GBV protocol<br>5. Establish isolation ward and scale-up health failities | | | | | |

| **3.5** | **NUTRITION** | **INDICATORS** | | **BASELINE** | **TARGET 2020** | **MEANS OF VERIFICATION** |
|---|---|---|---|---|---|---|
| **OUTCOME** | More PLWs are practicing optimal maternal nutrition recommendations | # of IDP, returnee, refugee and nondisplaced PLWs received Matenal Infant and Young Child Nutrition (MIYCN) | **Women:** | | 414,534 | Nutrition online database |
| **OUTPUT** | More children (6-59 months) affected by emergency have increased accessed to micornutrient supplementation | # of children (6-59 months) receiving micronutrient supplementation | **Total:**<br>**Boys:**<br>**Girls:** | | 19,001<br>9,743<br>9,258 | Training report |
| **OUTCOME** | More PLWs are follwing optimal Infant and Young Child Feeding practices | # of IDP, returnee, refugee and nondisplaced PLW received Infant and Young Child Feeding services in Emegencies (IYCF-E) | **Women:** | 71,546 | ↑232,877 | Nutrition online database/ Rapid Nutrition Assessment (e.g 24 hour recall) |
| **OUTPUT** | Service providers trained on promotion of maternal and child caring practices | # of service providers trained on promotion of maternal and child caring practices | **Total:**<br>**Men:**<br>**Women:** | 150<br>45<br>105 | ↑2,600<br>0<br>↑2,600 | Training report |
| **ACTIVITIES** | 41. Provision of infant and young child feeding practices in emergency support (IYCF-E) for mothers and children among emergency-affected populations<br>2. Provision of MIYCN to PLWs from IDP, returnee, refugee, and non displaced households<br>3. Capacity building of frontline nutrition workers<br>4. Provision of micronutrient supplements to children aged between 6 and 59 months among shock-affected populations | | | | | |

| **3.6** | **PROTECTION** | **INDICATORS** | | **BASELINE** | **TARGET 2020** | **MEANS OF VERIFICATION** |
|---|---|---|---|---|---|---|
| **OUT-COME** | Community-based protection systems are strengthened to reduce community vulnerabilities | % of assisted communities reporting living in strengthened protection environment | **Total:** | 80% | 85% | Community Based Protection reports, PDM reports |
| **OUTPUT** | Community-based Protection Initiatives (including DRR) are conducted with affected communities to prevent and mitigate the effect of armed conflict and/ or natural disasters | # of people benefiting from Community-Based Protection initiatives | **Total:**<br>**Boys:**<br>**Girls:**<br>**Men:**<br>**Women:** | 535,763<br>132,634<br>144,131<br>111,718<br>147,280 | ↑1,433,920<br>↑354,983<br>↑385,753<br>↑299,003<br>↑394,181 | Community Based Protection reports, PDM reports, Monthly reporting ReportHub |

| | |
|---|---|
| ACTIVITY | 1. Provision of community-based protection assistance<br>2. Advocacy with and sensitisation of authorities; community members, community /religious leaders, humanitarian actors and parties to the conflict on protection risks and COVID-19 |

| 3.7 | WASH | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | Vulnerable people have access to safe drinking water system supporting handwashing promotion led by development networks. | Proportion of people gaining access to safe drinking water as a result of resilience assistance/Activities | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 0<br>0<br>0<br>0<br>0 | 100%<br>28%<br>26%<br>23%<br>23% | Monthly reports (ReportHub) |
| OUTPUTS | Improved availability of sustainable safe water supply facilities | #of vulnerable people having access to atleast 15 litres per person per day of safe drinking water | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 0<br>0<br>0<br>0<br>0 | 1,189,961<br>333,189<br>309,390<br>273,691<br>273,691 | Monthly reports (ReportHub) |
| | increased availability of sustainable sanitation facilities | # of vulnerable people having access to improved sanitation facilities | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 0<br>0<br>0<br>0<br>0 | 397,784<br>111,614<br>104,108<br>91,109<br>90,953 | Monthly reports (ReportHub) |

| 3.8 | WASH | INDICATORS | | BASELINE | TARGET 2020 | MEANS OF VERIFICATION |
|---|---|---|---|---|---|---|
| OUTCOME | WASH comprehensive package of resilient services is delivered to women, men, boys and girls living in hard-to-reach areas and overcrowded settlements | # of hard-to-reach districts and overcrowded settlements where underserved people have received WASH assistance | Total: | 68 | 80 | WASH partner's reports/ Cluster reports |
| OUTPUT | The humanitarian system facilitates a timely and effective response to people in need | # of underserved people in hard-to-reach districts receiving WASH assistance | Total:<br>Boys:<br>Girls:<br>Men:<br>Women: | 250,000<br>78,251<br>73,936<br>47,485<br>50,328 | 1,000,000<br>313,000<br>296,000<br>190,000<br>201,000 | WASH partner's reports/ Cluster reports |
| ACTIVITIES | 1. Establishment and rehabilitation of durable WASH facilities for vulnerable people and in areas of origin<br>2. Upgrade of existing water infrastructure in priority informal settlement sites and installation of new infrastructure to expand capacity to cope with new returnee arrivals<br>3. Provision of safe drinking water by tankering, rehabilitation of existing water systems or installation of new infrastructure for underserved people in hard-to-reach districts | | | | | |

# Acronyms

| | |
|---|---|
| **AAP** | Accountability to Affected Populations |
| **ALP** | Accelerated Learning Programme |
| **AHF** | Afghanistan Humanitarian Fund |
| **ALCS** | Afghanistan Living Conditions Survey |
| **AMRF** | Access Monitoring and Reporting Framework |
| **ANSF** | Afghan National Security Forces |
| **AWD** | Acute Watery Diarrhoea |
| **BPHS** | Basic Package of Health Services |
| **BHCs** | Basic Health Centres |
| **BSF** | Blanket Supplementary Feeding |
| **CACE** | Collective Approach to Community Engagement |
| **CBC** | Community Based Class |
| **CBE** | Community Based Education |
| **CCS** | global Common Cash System |
| **CERF** | Central Emergency Response Fund |
| **CFSs** | Child Friendly Spaces |
| **CLTS** | Community-Led Total Sanitation |
| **CSSF** | Comprehensive School Safety Framework |
| **CVWG** | Cash and Voucher Working Group |
| **DHS** | Demographic and Health Survey |
| **DMAC** | Directorate of Mine Action Coordination |
| **DTM** | Displacement Tracking Matrix |
| **EA$E** | Economic and Social Empowerment |
| **EiE** | Education in Emergencies |
| **EiEWG** | Education in Emergencies Working Group |
| **ECW** | Education Cannot Wait |
| **ENETAWF** | Early Warning, Early Finance, Early Action |
| **EORE** | Explosive Ordnance Risk Education |
| **ERM** | Emergency Response Mechanism |
| **ERW** | Explosive Remnants of War |
| **EXO** | Explosive Ordnance |
| **ES-NFI** | Emergency Shelter and Non-Food Items |
| **FATP** | First Aid Trauma Post |
| **FCS** | Food Consumption Score |
| **FPCs** | Family Protection Centers |
| **FSAC** | Food Security and Agriculture Cluster |
| **FTS** | Financial Tracking Service |
| **GAM** | Global Acute Malnutrition |
| **GBV** | Gender Based Violence |
| **GHRP** | Global Humanitarian Response Plan |
| **GiHA** | Gender in Humanitarian Action |
| **HAG** | Humanitarian Access Group |
| **HEAT** | Household Emergency Assessment Tool |
| **HCT** | Humanitarian Country Team |
| **HH** | Household |
| **HLP** | Housing Land and Property |
| **HMIS** | Health Management Information System |
| **HNO** | Humanitarian Needs Overview |
| **HPC** | Humanitarian Programme Cycle |
| **HRP** | Humanitarian Response Plan |
| **HRTs** | Humanitarian Response Teams |
| **HTR** | Hard-to-reach |
| **ICCT** | Inter-Cluster Coordination Team |
| **ICRC** | International Committee of the Red Cross |
| **ICUs** | Intensive Care Units |
| **IDP** | Internally Displaced Person |
| **IEC** | Information, Education and Communication materials |
| **IED** | Improvised Explosive Devices |
| **IHL** | International Humanitarian Law |
| **IHRL** | International Human Rights Law |
| **IMAM** | Integrated management of acute malnutrition |
| **IMF** | International Military Forces |
| **IMSMA** | Information Management System for Mine Action |
| **IOM** | international Organisation for Migration |
| **IPA** | Individual Protection Assistance |
| **IPC** | Integrated Food Security Phase Classification |
| **IYCF** | Infant and Young Child Feeding |
| **ISK** | Islamic State of Khorasan |
| **JMMI** | Joint Market Monitoring Initiative |
| **JOPs** | Joint Operating Principles |
| **JRCs** | Juvenile Rehabilitation Centers |
| **KII** | Key Informant Interview |
| **LCSI** | Llivelihoods Coping Strategy Index |
| **MAM** | Moderate Acute Malnutrition |
| **MHPSS** | Mental Health and Psychosocial Support |
| **MHNTs** | Mobile Health and Nutrition Teams |
| **MHTs** | Mobile Health Teams |
| **MoE** | Ministry of Education |
| **MoPH** | Ministry of Public Health |
| **MPC** | Multi-Purpose Cash |

| | |
|---|---|
| **MRRD** | Ministry of Rural Rehabilitation and Development |
| **MUAC** | Mid-Upper Arm Circumference |
| **NFI** | Non-Food Items |
| **NGO** | Non-Governmental Organisation |
| **NSAGs** | Non-State Armed Groups |
| **OCHA** | Office for the Coordination of Humanitarian Affairs |
| **PACAP** | Protection Assessment of Conflict-Affected Populations |
| **PDM** | Post-distribution monitoring |
| **PEDs** | Provincial Education Directors |
| **PFA** | Psychological First Aid |
| **PiN** | People in Need |
| **PLW** | Pregnant and Lactating Women |
| **PND** | Public Nutrition Directorate |
| **PPE** | Personal Protective Equipment |
| **PSEA** | Protection Against Sexual Exploitation and Abuse |
| **PSNs** | Persons with Specific Needs |
| **RCCE** | Risk Communication and Community Engagement |
| **REACH** | Relief Effort to Afghan Communities and Households (World Bank) |
| **RPM** | Response Planning and Monitoring Module |
| **SADD** | Sex and Age Disaggregated Data |
| **SAM** | Severe Acute Malnutrition |
| **SFSA** | Seasonal Food Security Assessment |
| **SGBV** | Sexual and Gender Based Violence |
| **SHC** | Sub Health Centre |
| **SMS** | School Management Shura |
| **SOP** | Standard Operating Procedure |
| **SO** | Strategic Objective |
| **TFU** | Therapeutic Feeding Units |
| **TLC** | Temporary Learning Classrooms |
| **UN** | United Nations |
| **UNAMA** | United Nations Assistance Mission in Afghanistan |
| **UNHCR** | United Nations High Commissioner for Refugees |
| **UNICEF** | United Nations Children's Fund |
| **UNMAS** | United Nations Mine Action Service |
| **VOIED** | Victim Operated Improvised Explosive Device |
| **WASH** | Water Sanitation and Hygiene |
| **WFHS** | Women Friendly Health Spaces |
| **WFP** | World Food Programme |
| **WHO** | World Health Organisation |
| **WoA** | Whole of Afghanistan (Assessment) |

# End Notes


1 2020 Global Humanitarian Overview, https://reliefweb.int/sites/reliefweb.int/files/resources/GHO-2020_v8.8.pdf

2 2020 Afghanistan Humanitarian Needs Overview, https://www.humanitarianresponse.info/en/operations/afghanistan/document/afghanistan-humanitarian-needs-overview-2020

3 Ibid

4 UNAMA, First Quarter Report On the Protection Of Civilians In Armed Conflict, April 2019, https://unama.unmissions.org/sites/default/files/unama_protection_of_civilians_in_armed_conflict_-_2020_first_quarter_report_english.pdf

5 Afghanistan Central Statistics Organization, Afghanistan Living Conditions Survey, 2016/17, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/alcs_2017.pdf

6 Flowminder population projection 2020

7 Afghanistan Central Statistics Organization, Afghanistan Living Conditions Survey, 2016/17, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/alcs_2017.pdf

8 Ibid

9 Afghanistan Statistical Yearbook 2018/19, https://www.nsia.gov.af:8080/ wp-content/uploads/2019/11/Afghanistan-Statistical-Yearbook-2018-19_ compressed.pdf

10 International Organization for Migration (IOM) Displacement Tracking Matrix (DTM), unpublished cross-analysis of Baseline Mobility Assessment Summary Results, Round 8, Mar – Jun 2019 data (IOM, Afghanistan, 2019)

11 REACH Initiative, WOA Assessment 2019. Note that this figure may be over-estimated due to the difficulty of sampling non-recent IDP households and that efforts are being made in 2020 to address this shortcoming.

12 Samuel Hall and the Norwegian Refugee Council (2016), Access to Tazkera and other civil documentation in Afghanistan, https://www.nrc.no/ globalassets/pdf/reports/af_civil-documentation-study_081116.pdf

13 REACH Initiative, ISET mapping, 2017

14 Transparency International, The 2018 Corruption Perceptions Index, https://www.transparency.org/cpi2018

15 European Commission INFORM Index for Risk Management. https://drmkc.jrc.ec.europa.eu/inform-index/Results-and-data/INFORM-2019-Results-and-data

16 Notre Dame Global Adaptation Initiative, 2019, https://gain.nd.edu/our-work/country-index/rankings/

17 UN Common Guidance on Helping Build Resilient Societies, version of 12 December 2018

18 REACH Initiative, WOA Assessment, 2019

19 UNAMA, First Quarter Report On the Protection Of Civilians In Armed Conflict, April 2019, https://unama.unmissions.org/sites/default/files/unama_protection_of_civilians_in_armed_conflict_-_2020_first_quarter_report_english.pdf

20 Ibid

21 Save the children, Stop the War on Children report, 2019, https://www.savethechildren.org.uk/content/dam/gb/reports/stop_the_war_on_children_ report_2019.pdf

22 A global average of $30-$130 per person for a scheme serving serving 15,000 people Vs $20-$60 per person for a hand pump-operated borehole serving 500 people, Source: WASH Cluster

23 UNAMA, First Quarter Report On the Protection Of Civilians In Armed Conflict, April 2019, https://unama.unmissions.org/sites/default/files/unama_protection_of_civilians_in_armed_conflict_-_2020_first_quarter_report_english.pdf

24 UN Women, UNFPA, WHO, UNDOC and UNDP (2020). COVID-19 and Essential Services Provision for Survivors of Violence Against Women and Girls.

25 IASC (March 2020). Interim Technical Note: Protection from Sexual Exploitation and Abuse (PSEA) During COVID-19 Response.

26 IASC (2015). Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Food Security and Agriculture.

27 UNGA A/70/723. Protecting Humanity from Future Health Crises: Report of the High-Level Panel on the Global Response to Health Crises; UNICEF Helpdesk, "GBV in Emergencies: Emergency Responses to Public Health Outbreaks," September 2018, p. 2.

28 New Scourge to Afghan Women: COVID-19 https://reliefweb.int/sites/reliefweb.int/files/resources/COVID%2019.%20A%20New%20Scourge%20to%20Afghan%20Women_OXFAM.pdf

29 29. Community Perception Survey – COVID 19 Knowledge, Attitude and Practice Survey in Kabul, Kunduz and Khost Provinces https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/assessments/afg_community_perception_survey_covid-19_final_report_johanniter_20042020.pdf

30 The Asia Foundation, Model Disability Survey of Afghanistan 2019.

31 *UN DESA Policy Brief: A Disability-Inclusive Response to COVID-19. May 2020. https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2020/05/sg_policy_brief_on_persons_with_disabilities_final.pdf*

32 *Ibid*

33 *Inter-Agency Standing Committee, Guidelines: Inclusion of Persons with Disabilities in Humanitarian Action, July 2019, https://interagencystandingcommittee.org/system/files/2019-11/IASC%20Guidelines%20on%20the%20Inclusion%20of%20Persons%20with%20Disabilities%20in%20Humanitarian%20Action%2C%202019.pdf*

34 *European Union, National Mental Health Survey and Assessment of Mental Health Services in Afghanistan, 2018*

35 *REACH Initiative, WOA Assessment, 2019*

36 *Ibid*

37 *By the end of April 2019, 22 aid workers had been injured, whereas during the same period in 2020, the number has dropped to 12.*

38 *COVID-19 Multi-Sector Humanitarian Country Plan: Afghanistan, 24 March 2020. Pp. 15.*

39 *https://www.impact-repository.org/document/reach/864a6ab5/AFG_REACH_RCCE_Rapid-Communications-Assessment_Tabulated-Analysis_April-2020.xlsx*

40 *The microsimulation utilises data from the Afghanistan Living Conditions Survey (ALCS) of 2016-17; analysis from Oxford Poverty and Human Development Initiative (OPHI) and UNICEF Afghanistan Country Office (April 2020).*

41 *https://www.unicef.org/afghanistan/media/2471/file/afg-report-oocs2018.pdf%20.pdf*

42 *Ibid*

43 *Ministry of Education internal data*

44 *MPC response will be designed in close coordination with CVWG and EIE partners will follow CVWG guidance on Minimum Expenditure Basket (MEB).*

45 *REACH Initiative, WOA Assessment, 2019*

46 *Ibid*

47 *UNHABITAT and WHH - Kabul Informal Settlement Survey 2018-2019 (not yet published)*

48 *A composite analysis from SFSA 2019, ALCS 2016-17 and FSMS 2020*

49 *WFP Market price heads up note 5 May: wheat +15%, wheat flour +15% to +21%, rice +4% to 7%, cooking oil +22%, pulses +14% compared to 14 March 2020.*

50 *WFP Market price heads up note 21 may*

51 *http://www.emro.who.int/afg/afghanistan-infocus/situation-reports.html*

52 *REACH Initiative, WOA Assessment, 2019*

53 *Health Cluster 3W data*

54 *National Nutrition Survey, 2013 https://reliefweb.int/sites/reliefweb.int/files/resources/Report%20NNS%20Afghanistan%202013%20(July%2026-14).pdf*

55 *Wasting among infants under 6-months: a silent public health problem in Afghanistan https://www.humanitarianresponse.info/en/operations/afghanistan/document/wasting-among-infants-under-6-months-silent-public-health-problem*

56 *Action Against Hunger COVID-19: The Impact of the Outbreak (https://www.actionagainsthunger.org.uk/blog/coronavirus-impact-outbreak)*

57 *International Food Policy Research Institute (IFPRI). Lessons from the AIDS epidemic on how COVID-19 may impact food and nutrition security. March 30, 2020. Stuart Gillespie and Alan Whiteside. Issue Post (https://www.ifpri.org/blog/lessons-aids-epidemic-how-covid-19-may-impact-food-and-nutrition-security) Roberton, T., Carter, E. D., Chou, V. B., Stegmuller, A. R., Jackson, B. D., Tam, Y., ... & Walker, N. (2020). Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study. The Lancet Global Health.*

58 *These provinces are – 1) Kapisa, 2) Wardak, 3) Nangarhar, 4) Laghman, 5) Bamyan, 6) Paktika, 7) Paktya, 8) Kunar, 9) Nuristan, 10) Badakhshan, 11) Takhar, 12) Kunduz, 13) Samangan, 14) Balkh, 15) Sar-e-Pul, 16) Ghor, 17) Daykundi, 18) Uruzgan, 19) Zabul, 20) Jawzjan, 21) Faryab, 22) Hilmand, 23) Badghis, 24) Hirat, 25) Kabul (rural) and 26) Kandahar.*

59 *Sectoral Area Need (SAN): SAN 1. Treatment of SAM; SAN 2. Treatment of MAM; SAN 3: TSFP for undernourished PLW; SAN 4. BSFP for children 6-23 months old; SAN 5. Micronutrient supplementation in emergency; SAN 6. IYCF in Emergency; SAN 7. MIYCN for at-risk under five children; SAN 8. BSFP for PLW affected by emergency*

60 *UN Joint Statement on Nutrition in the Context of COVID-19. https://www.unicef.org/eap/media/5211/file*

61 *Nutrition Information Management, Surveillance and Monitoring in the Context of COVID-19. 14 April 2020. https://www.nutritioncluster.net/sites/default/files/2020-04/Nutrition-Information-COVID-Brief%201_0.pdf*

62 *An analysis from the Violence Against Women and Girls (VAWG) Helpdesk study and Global GBV AoR*

63 *COVID-19 and ending violence against women and girls, UN Women (2020).*

64 *Najat Maalla M'jid, UN Special Representative of the Secretary-General on violence against children.*

65 *REACH Initiative, WOA Assessment, 2019*

66 *Ibid*

67 *Saul Guerrero et al., No Wasted Lives: Accelerating action for children with acute malnutrition, July 2017, https://www.ennonline.net/fex/55/nwlactionchildrenacutemalnutrition*

68 *World Bank. 2006. Repositioning Nutrition as Central to Development A Strategy for Large-Scale Action*

69 *Population Reference Bureau, Stunting Limits Learning and Future Earnings of Children, October, 2012. https://www.prb.org/stunting-among-children/*

70 *REACH Initiative, WOA Assessment, 2019*

# HUMANITARIAN RESPONSE PLAN
AFGHANISTAN

ISSUED JUNE 2020