

2017

HUMANITARIAN NEEDS OVERVIEW

PEOPLE IN NEED

9.3M

NOV 2016



AFGHANISTAN

Photo: Janus Engel

This document is produced on behalf of the Humanitarian Country Team and partners.

This document provides the Humanitarian Country Team's 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.

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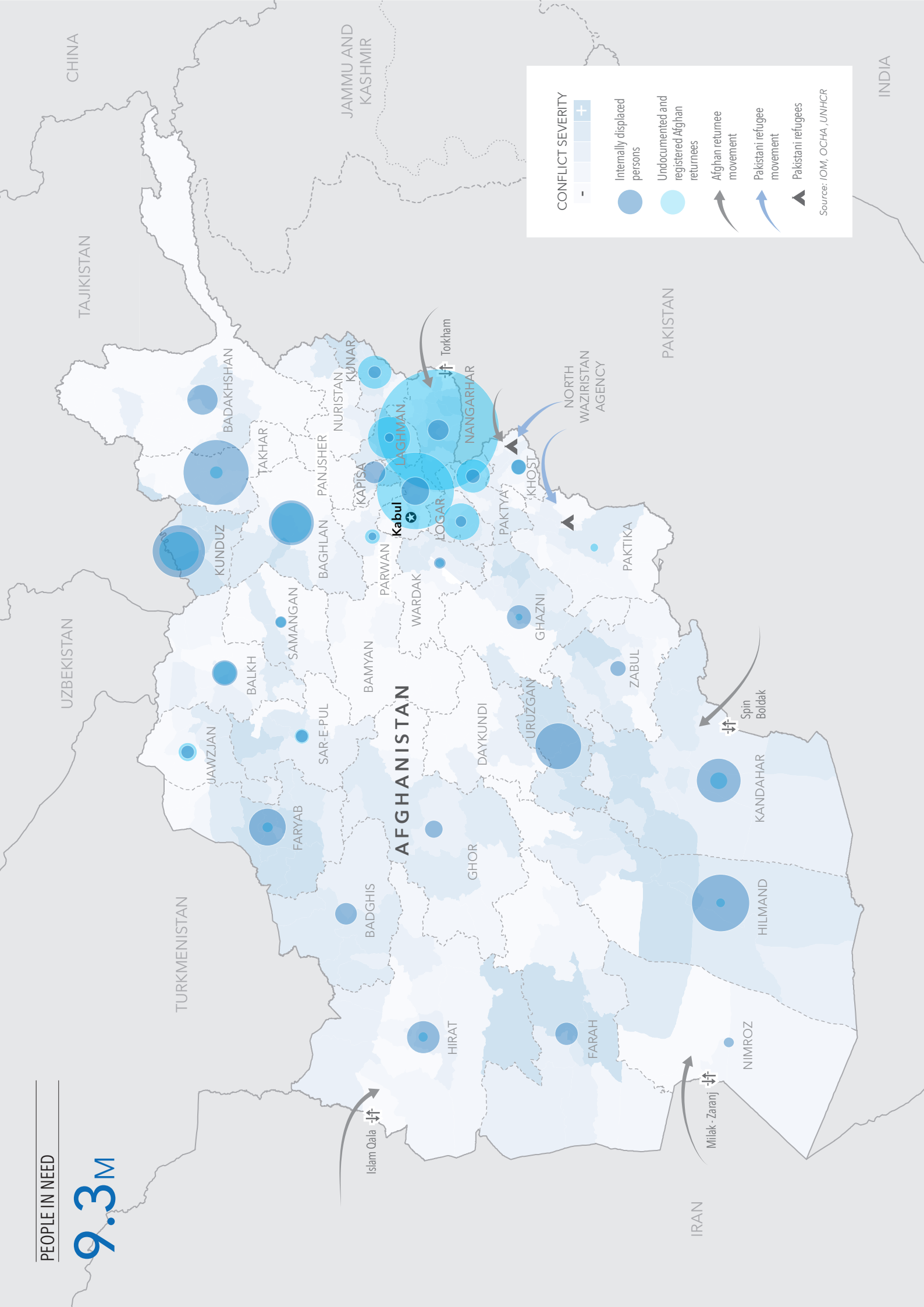
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PART ONE: SUMMARY

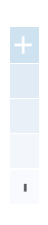
- 
-  Humanitarian needs & key figures
 -  Impact of the crisis
 -  Breakdown of people in need
 -  Severity of need

PEOPLE IN NEED

9.3M



CONFLICT SEVERITY



- Internally displaced persons
- Undocumented and registered Afghan returnees
- Afghan returnee movement
- Pakistani refugee movement
- Pakistani returnees

Source: IOM, OCHA, UNHCR

HUMANITARIAN

NEEDS SUMMARY

Afghanistan remains one of the most **dangerous, and most violent**, crisis ridden countries in the world.¹ The continued **deepening and geographic spread of the conflict** has prompted a 13% increase in the number of people in need of humanitarian assistance in 2017, now **9.3 million**. Violations of International Humanitarian Law (IHL) and Human Rights Law (HRL) occur regularly - including, targeted killings, forced recruitment² and **attacks on health and education facilities**.³ The **8,397 civilian casualties** in the first nine months of 2016 is the highest recorded, and included a **15% increase in child casualties** compared to 2015.⁴ In 2016 increasingly frequent ground engagements continued to be the main cause of civilian casualties,⁵ while also **limiting freedom of movement** for civilians and **contaminating areas with explosive remnants of war (ERW)** which disproportionately affect children.⁶ Health partners reported **57,346 weapon wounded cases** between January and September alone, compared to 19,749 in 2011, representing almost a three-fold increase.⁷

The country is facing increasing numbers of people on the move. In 2016 the conflict has led to **unprecedented levels of displacement, reaching half a million** in November - the highest number recorded to date. **56% of the displaced are children** and face particular **risk of abuse,⁸ and exploitation,⁹** as well as interrupted school attendance and harmful child labour.¹⁰ Multiple forms of **GBV, particularly early and forced marriage,¹¹ domestic,¹² psychological,¹³ and sexual abuse¹⁴** are reported, affecting individuals in hosting and displaced communities alike.¹⁵ Further, a lack, or loss of civil documentation, with difficulties in obtaining documents outside of the province of origin, regularly results in hindered access to services for considerable numbers of affected individuals.

Recent estimates suggest over **9 million people have limited or no access to essential health services**.¹⁶ Rates of infant and maternal mortality remain among the highest in the world at 73/1000 live births and 327/100,000 live births respectively¹⁷ with reports of maternal mortality ratio (MMR) rates as high as 417/100,000¹⁸ in rural parts of the country. **Severe food insecurity is on the rise** with 1.6 million people severely food insecure.¹⁹ 2016 nutrition surveys show global acute malnutrition (GAM) prevalence ranging from 10.9 to 20.7%. **Severe acute malnutrition (SAM)** has breached emergency thresholds in 20 of 34 provinces. 1.8 million people require treatment for acute malnutrition, of which **1.3 million are children under five**.²⁰

Magnifying this crisis of forced displacement, 2016 saw the unprecedented return of some **600,000 registered refugees and undocumented Afghans** from Pakistan. For the majority, **return is triggered by shrinking asylum space and community acceptance, and the experience often abrupt and distressing**. After more than 30 years living in Pakistan, many have arrived into an unfamiliar country with few possessions, assets or social support networks.

HUMANITARIAN

KEY FIGURES

The overall population and people in need figures are representative of the projected humanitarian situation for 2017.

TOTAL POPULATION



NUMBER OF PEOPLE LIVING IN THE HIGHEST CONFLICT AFFECTED DISTRICTS



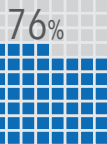
NUMBER OF PEOPLE WHO NEED HUMANITARIAN ASSISTANCE



BY STATUS

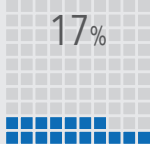
ACCESS TO ESSENTIAL SERVICES

7M



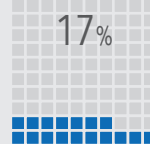
REFUGEES AND VUL. RETURNEES

1.6M



SEVERELY FOOD INSECURE

1.6M



CONFLICT DISPLACED

835,000

9%

HOST COMMUNITIES

277,000

3%

NATURAL DISASTER AFFECTED

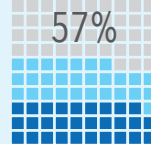
211,000

2%

BY AGE & SEX

CHILDREN (<18 YEARS)

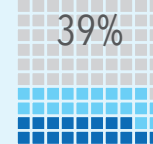
5.3M



2.6M girls
2.7M boys

ADULT (18-59 YEARS)

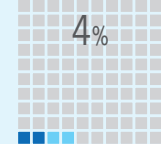
3.6M



2.0M women
1.7M men

ELDERLY (>59 YEARS)

0.4M



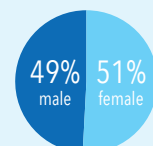
0.15M women
0.21M men

TOTAL MALE

4.6M

TOTAL FEMALE

4.7M



KEY

DRIVERS



Emergencies Escalating

Households in Afghanistan are constantly exposed to conflict and natural disasters, often compelling them to flee their homes abruptly. In 2016 all regions of the country have been affected by the conflict. On average, every day sees another 1,500 people forced to leave their homes, escaping violence. Over half a million displaced families are scattered across 34 different provinces - with approximately 20% extremely hard to reach in gradually expanding areas of non-government controlled territory. On top of the continual threat of conflict, more than 70,000 people lost family members, lost their homes or suffered damage and destruction of property due to natural disasters; more than 600,000 Afghans living in Pakistan had their lives uprooted and arrived with scarce resources and limited community linkages. Once here, they add to the ranks of internally displaced, as conflict and lost community networks prevent them returning to any ostensive place of origin. With no obvious prospects for an improved state of affairs, 2017 is likely to see at least 450,000 new IDPs and potentially as many as a million more Afghan returns from Pakistan.



Health in Crisis

Active conflict continues to threaten the physical safety and health of Afghans, disproportionately so for women and children. Indiscriminate attacks against health facilities, patients, medical staff and vehicles continue to disrupt and deprive people of life-saving treatment.²¹ Four and a half million people live in conflict affected districts with extremely constrained access to health services.²² Despite the decades of fighting, Afghanistan's health system still has nominal provision to ensure adequate trauma care capacity or mass casualty management. The influx of IDPs and refugee returns to district centres and cities is straining existing services and proliferating living conditions in which infection and disease is exacerbated, contributing to emergency levels of malnutrition among displaced children.²³ Years of conflict have severely hampered development progress and in more remote and impoverished rural areas, where some 75% of women live,²⁴ maternal and child health remains dangerously overlooked. Women are dying at home, especially during childbirth. Lack of security further reduces women's access to health services, thwarts efforts to educate and employ female health professionals, and further limits family acceptance for women to work in remote areas.



Resilience Shattered

Unrelenting displacement and exposure to repetitive shocks continues to intensify humanitarian needs. Concurrent exposure to violence as well as high economic vulnerability places Afghan households at high risk. Most households experience multiple and repetitive shocks within a year²⁵ resulting in food insufficiency and adoption of negative, often harmful coping strategies - including arranged and underage marriage.²⁶ With so many families in poverty, or experiencing forced displacement over the past decades, informal community support mechanisms have lost potency. Mounting vulnerability and multiple shocks simply plunge families deeper into crisis. Displacement is becoming more protracted for more people. In December 2015, 48% of IDP households living in the Kabul Informal Settlements were found to be severely food insecure.²⁷ The secondary displacement seen among both IDPs and returnees raises concerns around the country's capacity to absorb and reintegrate additional flows amid continued deterioration of the security situation and potentially negligible economic growth.

UNDERLYING

FACTORS

Resource Constrained, Aid-Dependent, Fragile State

In the years preceding 2012, Afghanistan experienced a decade of near double-digit economic growth. Since 2014, political uncertainties coupled with the withdrawal of international security forces have led to significant deceleration in economic growth which fell to 0.8% in 2015, and is expected to reach only 1.2% in 2016.²⁸ When accounting for the average annual population growth rate of 3% and an estimated 400,000 individuals entering the labour market each year, this growth essentially drops to zero. Further, if the contribution of the illicit economy (opium production, people trafficking) is omitted, the formal economy alone shows negative growth.

This has serious implications for the prospects of the country pulling itself out of poverty. The most recent Afghanistan Living Conditions Survey (ALCS) showed an increase in the number of people living in poverty from 36% in 2007-8 to 39% in 2013-14.²⁹ Without economic growth, the prospects for the people remaining in Afghanistan are bleak.

Even without the challenges generated by the growing conflict, Afghanistan remains one of the least developed countries in the world, ranked 171 in the Human Development Index. High fertility rates drive rapid population growth, while maternal and under five mortality rates are among the highest globally, nearly 60% of children are stunted, and more than 9% are acutely malnourished.³¹ Averaging US\$5 per capita, the international donor funded

health system is insufficiently resourced to address these exceptionally poor health indicators.

The Brussels Conference on Afghanistan in October 2016 assured the continued financing of the state. The Government presented its five year strategic Afghanistan National Peace and Development Framework (ANPDF) towards achieving self-reliance and development aid of US\$ 3.8 billion per year for the next four years was pledged. Despite this funding, prospects for an immediate improvement in the lives of everyday Afghans remain slight. The Government's efforts to contain the growing insurgency absorbs the most part of international community contributions and only a tiny proportion is available to fund development activity through the 'discretionary development budget'. Development spending is further constricted by the ability of Government institutions to actually make expenditures. The execution rate for the development budget was 16.8% in the first half of the year, down from 20% recorded for the same period last year.³²

The peace talks that started at the beginning of 2016 have now stalled and they are unlikely to resume in the near future, or to bring any immediate peace dividends to the population. Put together, the continuing conflict, the low expectation of peace, and with no prospective for economic growth or a reduction in poverty, the proportion of the population facing crises is growing. This has been exacerbated by 600,000 new people returning from Pakistan to an uncertain and unfamiliar future.

Vulnerability to natural disasters

Afghanistan is prone to earthquakes, flooding, drought, landslides, and avalanches. Over three decades of conflict, coupled with climate change, environmental degradation, and insufficient investment in disaster risk reduction strategies, have contributed to increasing vulnerability of the Afghan people to cope with the sudden shock of natural disasters and increased risks posed to livelihoods. On average, each year around 230,000 people are affected by natural disasters. Destruction of shelters, crops, food stocks and damage to household and community assets such as water and sanitation infrastructure, result in the need for emergency support to protect people from the elements. At the same time, emergency assistance is required to ensure food security, prevent use of unsafe drinking water and open defecation causing health and vector borne disease outbreak concerns, as well as to protect vulnerable persons including women and children and prevent a reliance on negative coping strategies.

IMPACT OF THE CRISIS

Deepening Conflict

Afghanistan's security situation continued to deteriorate throughout 2016. 33 of 34 provinces have experienced increasingly intense confrontations between Non State Armed Groups (NSAGs) and the Afghan National Defense and Security Forces (ANDSF). 2016 has seen the most reported security incidents, driven by a 23% increase in NSAG initiated armed clashes compared to 2015.³³ The impact on the civilian population has been severe as parties to the conflict continue to disregard their obligations under International Law to protect civilians. Use of explosive weapons in populated areas, military use of civilian infrastructure, schools and medical facilities, forced recruitment, targeted killings, destruction

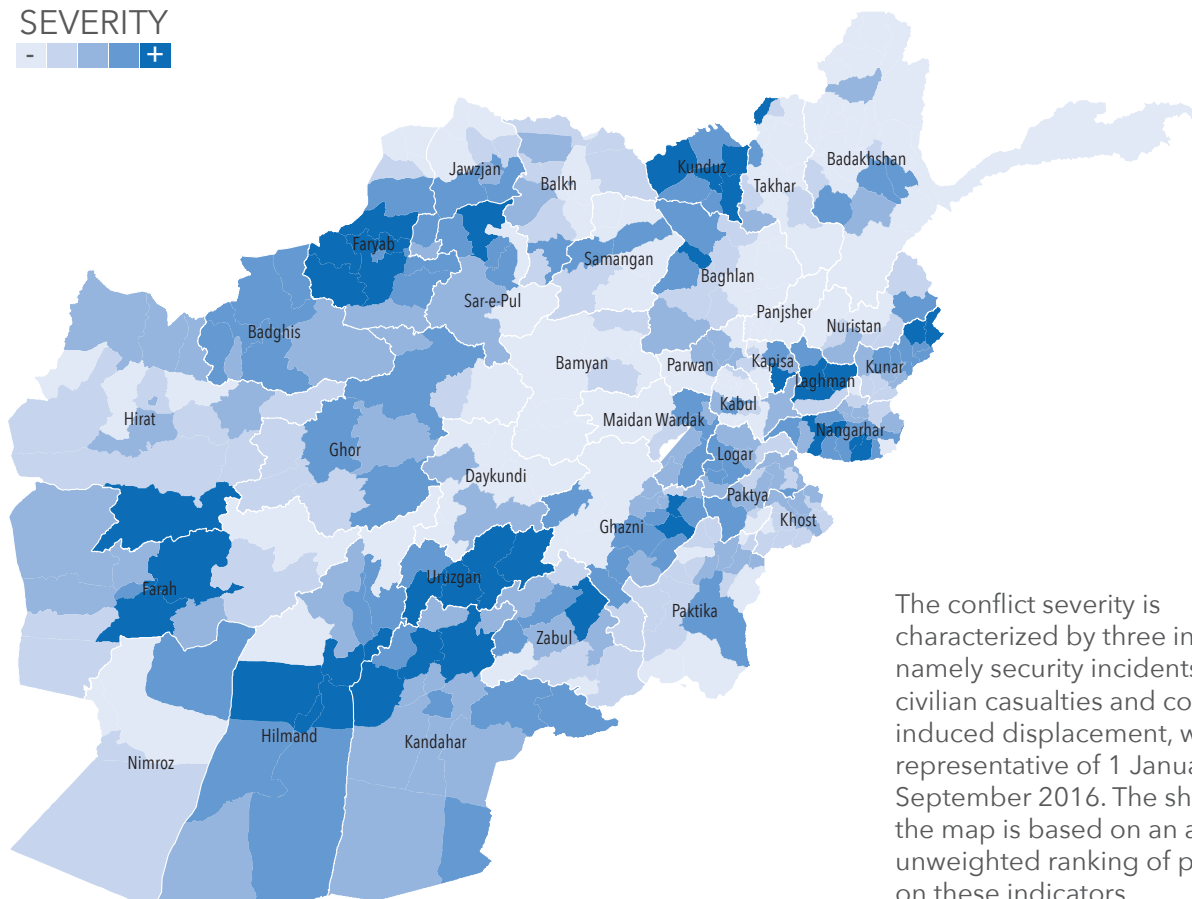
of property, and hampered access to affected populations for humanitarians are widely documented. The amount of civilian casualties in the first nine months of 2016³⁴ was the highest recorded since UNAMA started counting in 2009, with 8,397 civilian casualties (2,562 deaths and 5,835 injuries). Of the total killed and injured, almost 1 out of 3 victims was a child (2,461), an increase of 15% compared to the same period in 2015.

EMERGENCY NGO, who provide medical and surgical treatment to Afghan victims of war, report record numbers of war wounded. In October 2016, staff at their specialised surgical facility in Hilmand operated on 402 war wounded patients, a marked increase from the previous average of

CONFLICT SEVERITY IN 2017

09

SEVERITY



The conflict severity is characterized by three indicators, namely security incidents, civilian casualties and conflict induced displacement, which are representative of 1 January to 30 September 2016. The shading on the map is based on an average of unweighted ranking of provinces on these indicators.

300 casualties per month. The horrific nature of some of the injuries seen, particularly resulting from IEDs, have on many occasions left patients with triple amputations.

In 2016 NSAG tactics increasingly targeted district administrative centres (DACs) and provincial capitals.³⁵ This conflict dynamic of violent clashes within populated areas, even if only for short periods of time, has created volatile and uncertain environments for civilians, causing immense psychological distress and contributing to a 25% increase in the number of people displaced in comparison to the same time in 2015.

Crisis of Displacement

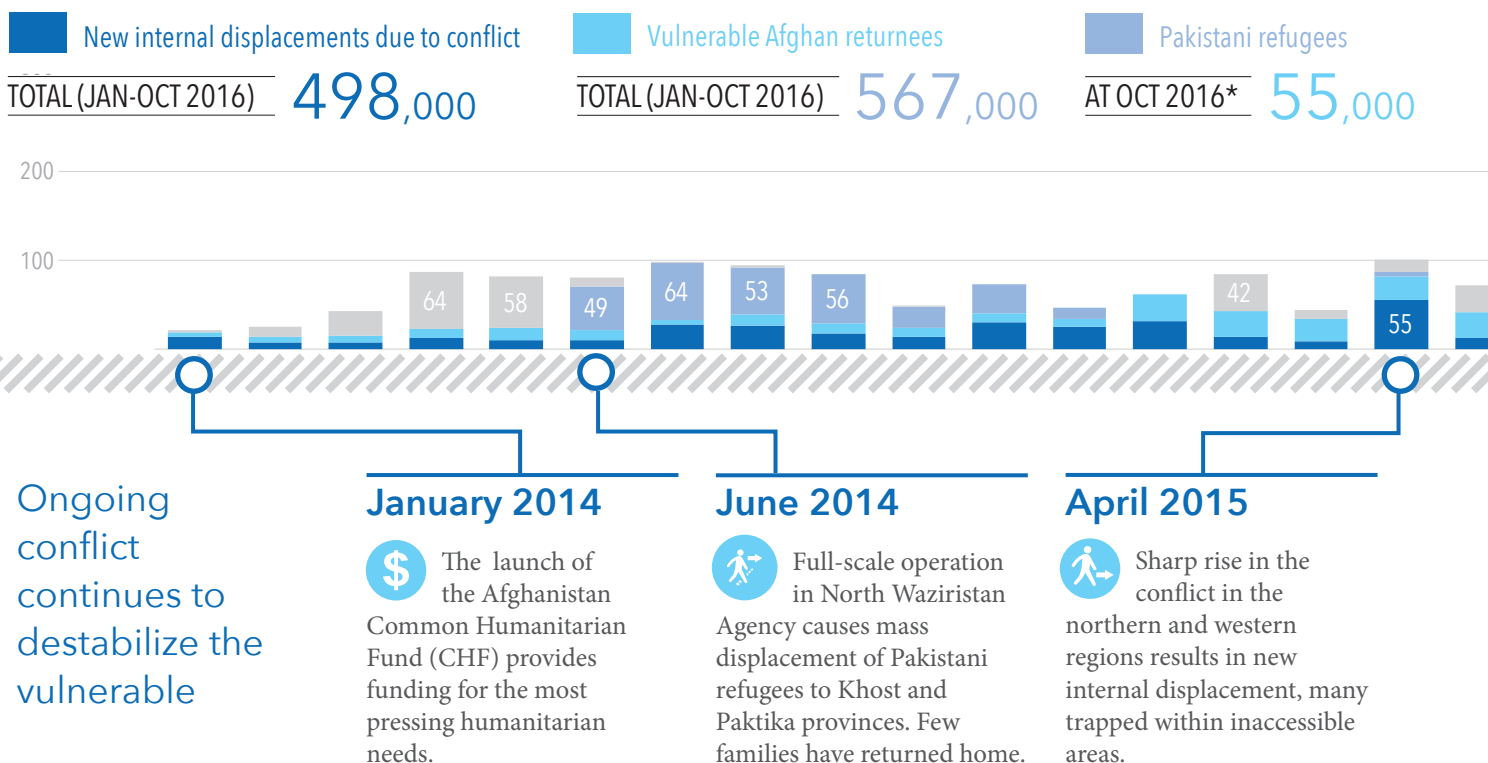
As in 2015, October this year again saw Taliban fighters battle to briefly control the northern provincial capital of Kunduz. Urban warfare, use of explosive weapons and reported aerial bombardments in populated areas contributed to civilian casualties, endangered civilian movement within the city, and further hindered the flight of those trying to escape. The fighting led to the sudden displacement of nearly 118,000 people across the Northern provinces and as far as Kabul. Families fleeing the conflict faced a host of protection concerns, both during their flight and at their place of displacement. As families fled Kunduz, fighting continued around the city. Many reported extortionate prices

for transport to escape, encounters with unidentified armed groups on the roads as well as high risk of ERW and mines.³⁶ The high cost of leaving the city along with apprehensions about the safety of women and girls, increased the incidence of family separation. At the place of displacement protection assessments highlighted inadequate accommodation and traumatised, fatigued children, who, exposed to winter conditions had contracted seasonal diseases and diarrhoea.³⁷

Despite the fall of Kunduz, the crisis is typically characterised by unremitting streams of new families displaced, on average 8,000 a month. As of November, every single week in 2016 had recorded displacement of families due to conflict somewhere across the country. The Taliban's ability to sustain more direct and prolonged confrontations, gain increasing control over major road arteries, thus controlling access and movement, has led to more prolonged periods of displacement³⁸ and interrupted access to basic services.

Months of ongoing attacks, skirmishes and clearing operations around Lashkargah, Tirinkot, Pul-i-Kumri and Maimana have effectively resulted in besieged city scenarios. Retaliatory battles and analogous gains and losses between ANDSF and NSAGs have resulted in drawn out clashes with fluid frontlines. These clashes, played out surrounding main population centres have meant families become trapped, prevented from returning to their homes, access to basic services is cut off and markets are disrupted.

INTERNALLY DISPLACED PERSONS, PAKISTANI REFUGEES, VULNERABLE AFGHAN RETURNEES AND NAT. DISASTERS (IN THOUSANDS)



* Reverified refugees as of Oct 2016

Humanitarian access and operational capacity to reach the displaced is a major concern in many parts of the country with 90,000 people displaced into inaccessible, or hard to reach, areas so far in 2016.³⁹ The conflict dynamic poses serious challenges for humanitarian access: the main highway from Kandahar to Lashkargah was cut off for nearly 6 weeks between August and September; all district routes out of Tirinkot city, while open to civilian traffic, remain under NSAG control from early October; and the main route into Maimana has been cut off from mid-September. Furthermore, reduced levels of confidence in ANSF ability to secure DACs and provincial capitals has led to displaced populations searching for safer more remote refuge. During the summer offensives around Hilmand's Lashkargah city, IDPs reportedly sought safety in the northern Taliban controlled districts of the province. As these areas are further from active frontlines, many IDPs perceive the north of the province as safer, and more stable, despite being almost completely out of reach for humanitarian assistance.

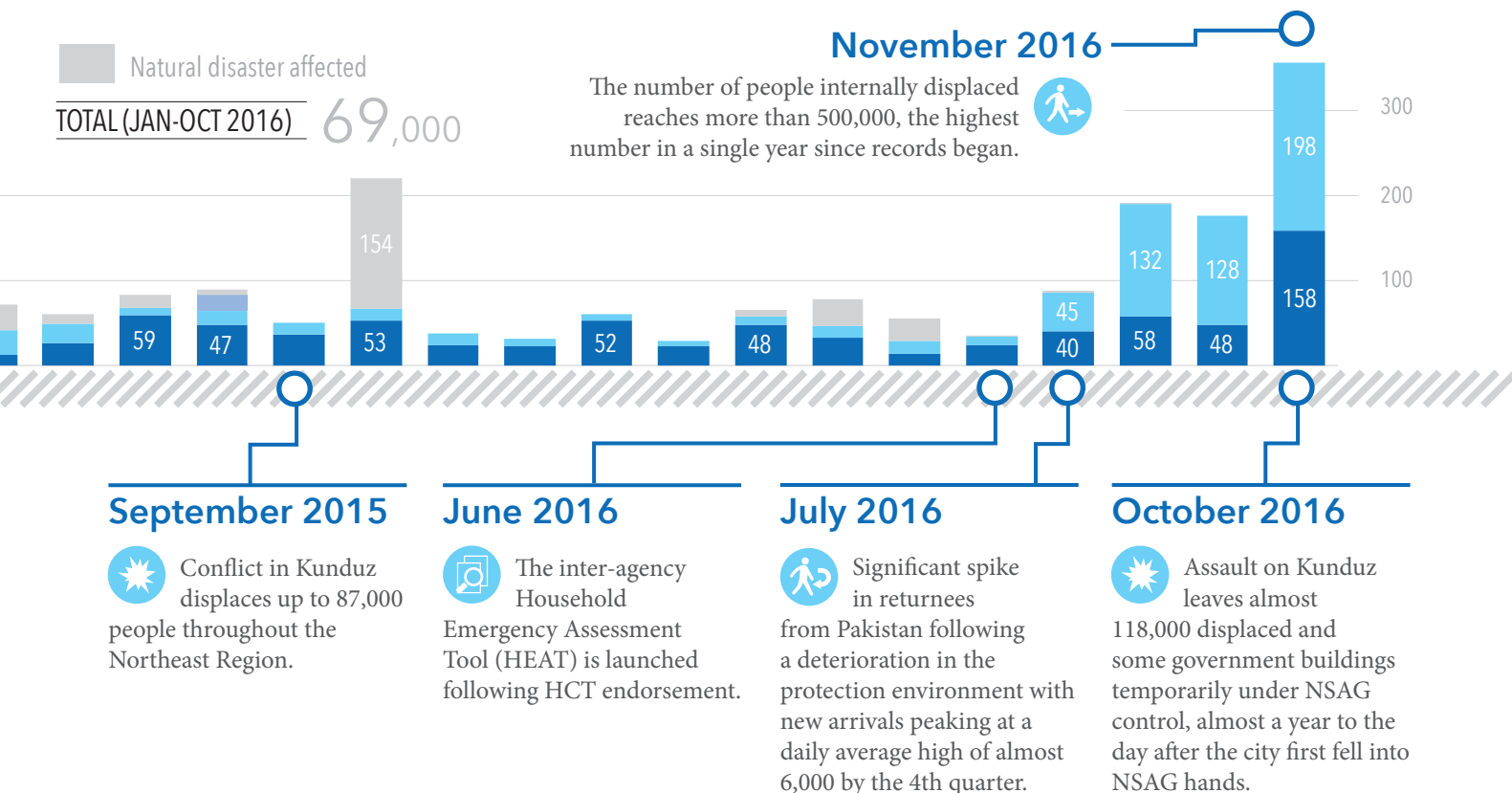
In 2016 the presence of the Islamic State in Khorasan (IS-K) remains in a handful of Nangarhari districts and with it the execution of summary justice, forced displacement, and targeted killings. As well as causing families to flee, IS-K presence has prompted increased restriction and confinement of women and girls amid concerns about sexual violence. In the face of brutal summary punishments, including the use of

explosives as a common method of killing, any public support has diminished and combined efforts of Taliban offensives, ad hoc community uprisings, engagement of Afghan security forces and pro-government militias appear to have halted any further territorial expansion.⁴⁰

Afghan Returns

From July 2016 onwards Afghanistan has experienced a sudden large increase in return of documented refugees and undocumented returnees from Pakistan. Growing regional tensions have led to a recent intensified repatriation effort by the Pakistan government who have warned they will forcefully expel thousands of refugee families if they don't leave on their own initiative. Between July and November, some 560,000 documented refugees and undocumented Afghans crossed the border, representing a 1,250% increase from the period January to June.

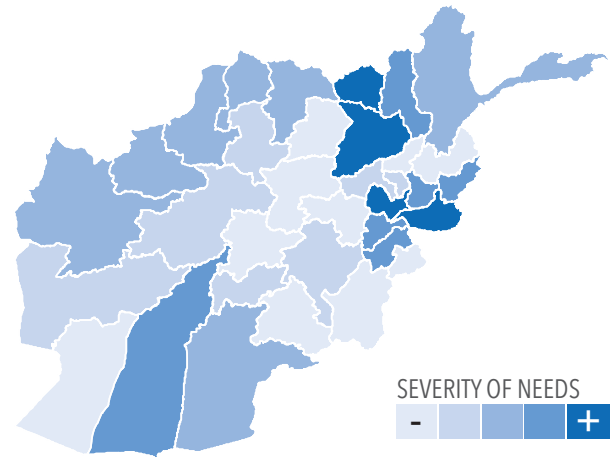
In some cases returning families are given as little as 48 hours to pack up their lives and businesses after as many as 40 years. There are numerous cases reported of both documented refugees and undocumented Afghans being arbitrarily arrested and detained in Pakistan before in some cases being transferred to the border and deported. Many returnees are arriving in Afghanistan with few possessions, assets or social support networks. The surge in returns has overstretched



existing services and severely hampered humanitarian capacity to adequately identify the more vulnerable returns. Only 21% of undocumented returns arriving since July have received a basic assistance package; typically one month's food and some basic household items.

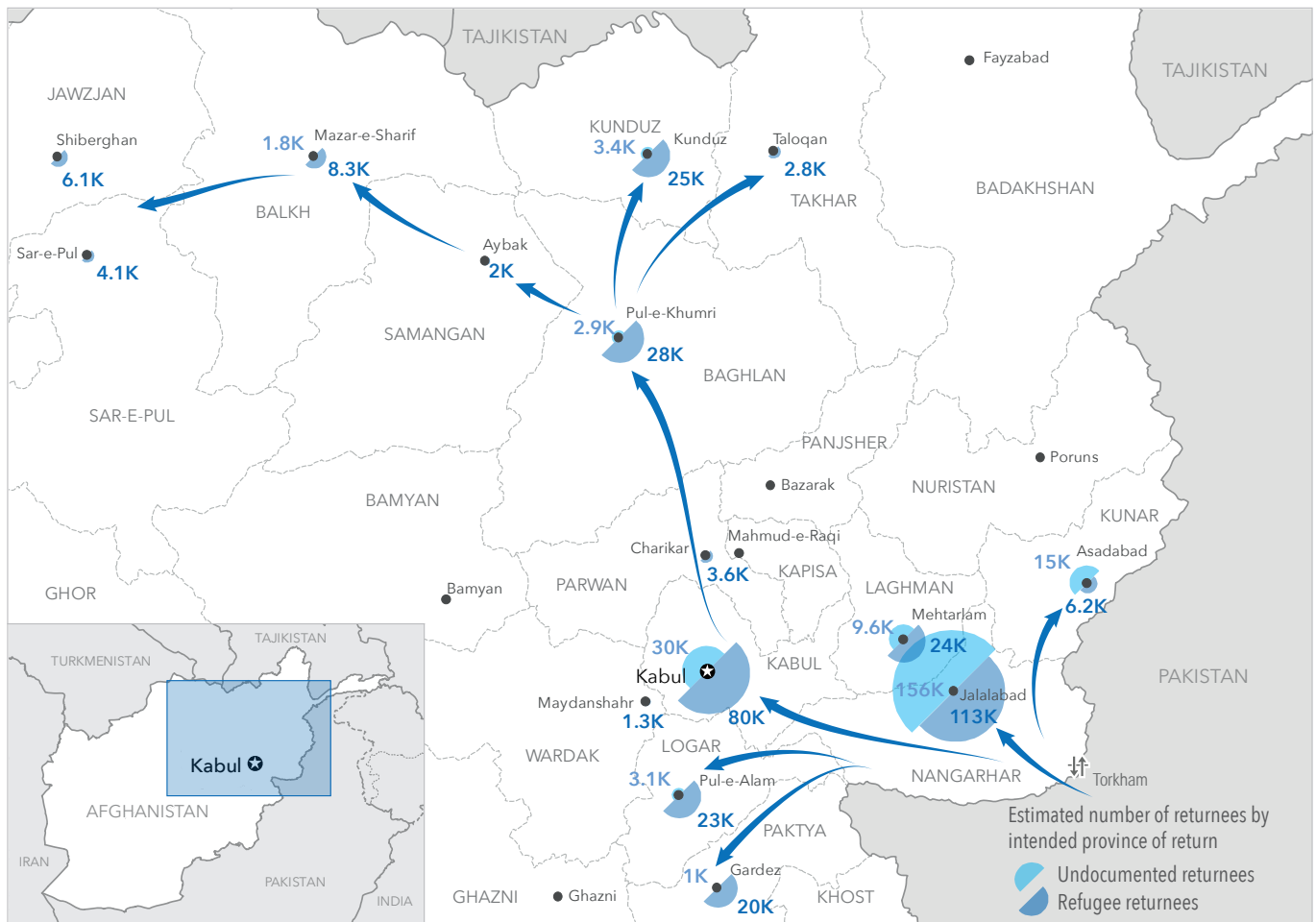
In October 2016 inter-agency assessment reached nearly 6,000 returnee families in Nangarhar. Approximately 10% were found to be living in tents or open air. Another 25% of undocumented returnee families are living in households or within very basic walled compound areas with three or more families together, often forcing some members to have to sleep in the open.⁴¹ In a joint protection assessment conducted through 395 focus group discussions, 68% of the groups identified a lack of privacy as one of the key protection risks associated with returns, and a specific concern voiced by women living in ten overcrowded hosting situations and tents.⁴² Furthermore, high levels of distress are reported, with inadequate specialised identification and response capacity to assist severely affected persons. Poor household sanitation and hygiene, particularly high rates of open defecation in urban areas with high density living arrangements, poses grave

SUDDEN ONSET EMERGENCY NEEDS



concerns for potential disease outbreaks. Host community obstruction has also been reported as a common constraint in terms of limiting returnees' access to a stable and safe water supply.⁴³

ESTIMATED NUMBER OF RETURNEES BY INTENDED PROVINCE OF RETURN (JAN-OCT 2016)



Source: IOM, UNHCR

Adoption of negative food security coping mechanisms is apparent amongst almost all the undocumented return population from reducing food consumption to sending children to work.⁴⁴ Market assessments furthermore identify negative influence on local market dynamics.⁴⁵ The return influx has significantly reduced the daily rate for unskilled labour and created competition among small scale traders, decreasing market prices for common goods and heightening tensions between host communities and returnees. The accumulation of debt, incurred both through the process of return and as a result of rising rents and depletion of assets will likely lead to high levels of secondary displacement.

2016 has seen over 410,000 undocumented Afghan returnees from Iran with a large caseload of unaccompanied minors. In contrast to Pakistan, the number of deportations from Iran are significant and conditions in detention are a major concern.

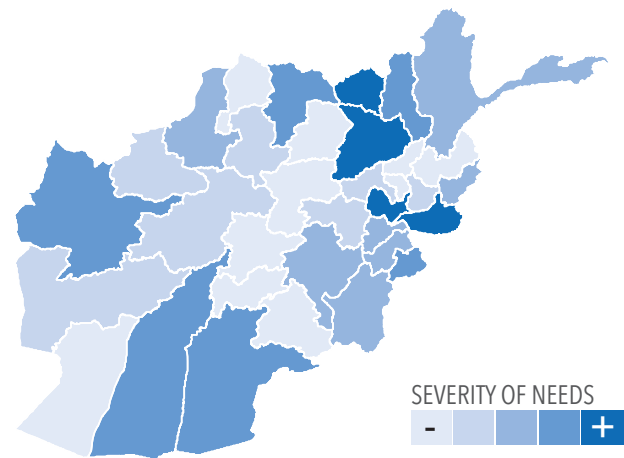
Pakistan Refugees

More than two years on from their initial displacement into Khost and Paktika provinces, refugee and undocumented returnee populations from North Waziristan in Pakistan continue to require humanitarian assistance. Access to adequate shelter and safe water continues to be of concern, especially for those living in makeshift settlements. Provision of health and nutrition services, including vaccinations for children, treatment for severe acute malnutrition and ante-natal care, is challenged due to limited capacity of existing services and basic infrastructure. A Rapid Nutrition Assessment (RNA) conducted in Gulan camp in Khost province identified emergency levels of acute malnutrition and a significant deterioration in stunting between 2015 and 2016. The scattered and remote locations in which the refugees are being hosted, in particular in Paktika, is problematic due to constrained access and limited presence of partners, as well as inadequacy of healthcare facilities available to support the refugees and host communities.

Health in Crisis

Rates of maternal and child mortality in Afghanistan remain among the highest in the world.⁴⁶ Widespread conflict, prohibitive costs, poor quality and inadequate coverage all conspire to delay or prevent people from accessing the healthcare they need. Recent estimates reveal that approximately nine million people have limited or no access to essential health care services both owing to insufficient coverage of nationally led health services and direct interruption of services owing to the conflict. As a direct result of conflict, at least 41 health facilities have at some point been forced to close in Nangarhar, Hilmand, Kandahar and Uruzgan, effectively depriving over half a million people in these provinces from accessing basic health services.⁴⁷ The volatile security situation in many parts of the country has also limited the ability of Polio vaccination teams to reach targeted children. During the August 2016 campaign a total of eight districts were completely

ACCESS TO ESSENTIAL SERVICES



inaccessible and almost 350,000 children were not able to be reached and vaccinated, primarily in the East and North East regions.⁴⁸ Across the country immunisation coverage is sub-optimal with regular and widespread outbreaks of measles and pertussis among children under five; most major outbreaks are reported from conflict affected locations along with higher incidence of diarrhoea and pneumonia.⁴⁹

More than a quarter of all Afghanistan's provinces have acute malnutrition rates above 15%, thus classifying them above emergency thresholds. An estimated 1.8 million people are affected by malnutrition including 1.3 million children under five. As of September 2016, only 250,000 children had been admitted for treatment, a fraction of those estimated to be in need.⁵⁰ Health facilities currently reach only 60% of the population and Nutrition Cluster analysis suggests only 54% of these health facilities provide any form of nutrition services.

Women and girls must overcome additional specific obstacles to obtain the health care they need. Lack of security not only makes it dangerous for women to access health services, but also perpetuates social attitudes that women are vulnerable and thus should not leave the home. The continuing conflict and socio-cultural barriers, especially prevalent in rural areas, thwarts efforts to educate and employ more female health professionals and impacts family acceptance to allow women to work in remote districts. In comparison to the almost 9.5 million female population over 15 years old there are just 7,000 female health staff and 11 districts of the country have no female health staff at all.⁵¹ The limited acceptance of men as healthcare providers for women means that the lack of female midwives, nurses and doctors poses a clear obstacle for many women and their children. Less than half of deliveries take place in health facilities and just 28% of women in rural areas receive a post-natal check-up within two days after delivery.⁵²

Despite the decades of conflict afflicting the country, Afghanistan's health system has no corresponding provision to ensure adequate trauma care capacity or mass casualty management. Major trauma responders in Afghanistan report consistent year on year increases in the number of war wounded patients being received

at emergency health facilities. A total of 57,346 war wounded cases have already been recorded from January to September 2016, compared to only 51,770 in 2015 and 19,749 in 2011.⁵³ Overall surgical capacity in Afghanistan is inadequate, with very few facilities able to provide surgical services. Limited certified surgeons result in surgeries being performed by general doctors and a lack of skill or absence of anaesthesiologists often forces the referral of patients for significant distances to the few available advanced surgical facilities - these distances can be more than 200 km, frequently on unpaved roads, and at times impassable, especially during the winter.

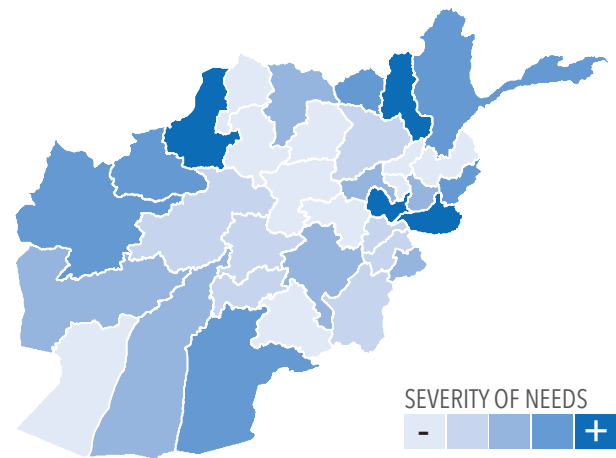
Large scale population movement exacerbates gaps in existing services with significant numbers of IDPs, returnees and refugees migrating to urban centres and periphery where basic service provision and infrastructure is unlikely to withstand the additional burden.

Resilience Shattered

The number of households experiencing shocks in Afghanistan is among the highest in the world.⁵⁴ The country experiences a perpetual cycle of crises and many affected people suffer repeatedly or for prolonged periods as a result. Recurrent shocks together with economic downturn has had significant impact on community resilience and coping capacities. Although risk is pervasive, the poorest households are exposed to more shocks due to exhausted coping capacities and cumulative vulnerability compounding their future susceptibility.

In the immediate aftermath of displacement, a system of emergency humanitarian support and protection for vulnerable IDPs is in place across much of the country. This response provides lifesaving basic support in the short term. Displacement however, is becoming more protracted for more people. As the on-going conflict and changing control of territory prevents people from returning home, the number of families enduring prolonged periods of displacement is increasing.⁵⁵ A cumulative estimate of the total number of people displaced since 2009 and still unable to return home is anticipated to reach 1.5 million by the end of 2016.⁵⁶ Assessments continue to highlight the particular needs of protracted IDP communities, and increased

SHOCK-INDUCED ACUTE VULNERABILITY



competition for meagre resources with host communities.⁵⁷ IDPs have limited access to labour opportunities – being unable to find employment, due to their rural skillset and low literacy rate – and are mostly reliant on casual labour. Women in particular find it very difficult or are not permitted to work to supplement their household income or support their families in the case of female headed households. Rates of severe food insecurity have been found to be extremely high among these groups.⁵⁸ The 2016 Seasonal Food Security Assessment also highlighted a much higher share (60%) of food insecure households among recent migrants than permanent residents.⁵⁹ The high risk of vulnerable displaced families engaging in harmful coping strategies, such as selling their productive assets or taking children out of school further inhibits the household's potential to escape poverty.

The Afghan government's Unified Action Plan intends to ensure the durable solution needs of refugee and undocumented returnees, as well as protracted IDPs are integrated within national development frameworks, programmes and sectoral strategies. However, greater synergy is needed between humanitarian assistance and longer term development efforts to ensure an extremely vulnerable population with acute humanitarian needs is not falling through the gap.

REACH Prolonged IDP Assessment

As part of the HRP 2016 strategic objective to enhance context analysis and coordinated needs assessments, REACH has been commissioned to conduct an assessment to better understand the humanitarian needs and vulnerability of prolonged IDPs in Afghanistan. As displacement becomes more widespread and people are unable to return home, the number of families enduring prolonged displacement is increasing, yet minimal monitoring or follow up of this group has been systematically undertaken to date. An improved understanding of the humanitarian needs of this group will inform a more tailored response following initial emergency assistance. The REACH assessment will produce the locations and estimated numbers of prolonged IDPs, as well as key demographic and socio-economic characteristics, future prospects, humanitarian and comparative needs of prolonged IDPs and host communities living in the same area. With preliminary findings expected in early December, the results are expected to inform primary needs data for both Category B and Category C; following joint analysis, the HNO will be updated to reflect any significant findings, while a review of the response plan will also be undertaken to account for critical needs identified and required interventions.

Unequal Coverage of Needs

Years of growing insecurity in Afghanistan has had a debilitating impact on the ability and the willingness of humanitarian agencies to ensure reactive, flexible presence, which is responsive to meet the needs of people most impacted by the crisis. Insecurity dictates where agencies operate, resulting in unequal coverage of needs.⁶⁰

The challenges posed by an increasingly insecure environment have inevitably prompted agencies to adopt coping strategies that seek to preserve the safety and security of their staff and assets. Establishing community acceptance and securing and sustaining approval and consent of the presence of humanitarian activities requires considerable time spent in communities to build relationships and develop trust.⁶¹ Once that acceptance and relative security is established, an inevitable inertia sets in contributing to grave disparities in terms of assistance provision relative to severity of need. This 'localisation' of operations not only impacts the provision of response but also severely limits understanding of humanitarian needs in the more insecure and harder to access areas - inevitably where needs would be comparatively higher.

Through the Common Humanitarian Fund, OCHA supported NRC/ATR to conduct a field study sampling more than 10,000 households across five provinces identified as having limited humanitarian presence. The principal objective was to better understand the difference in humanitarian needs between easy-to-access and hard-to-access areas and stimulate more rigorous prioritisation of assistance to the most pressing needs, wherever they might be.

The study confirmed that, comparatively, people in hard-to-access areas received less humanitarian assistance, and that while there were slightly fewer IDPs in need, their needs were often greater. Displaced households in harder-to-access areas are more likely to be poorer, larger, to house pregnant or lactating women and persons with disabilities, miss meals (18% had two or less meals per day, as opposed to 12% in easier-to-access areas), be accommodated in 'mostly destroyed' buildings (44%, as opposed to 21% in easy-to-access areas), and have a higher proportion of children out-of-school. In general, they had worse access to markets, largely due to insecurity and travel distances (around three times as distant), report increased demands for food assistance, and also had more limited conditions for women's access to healthcare (67% reported limited access in hard-to-access areas, in comparison to 24% of IDPs in easy-to-access areas), mostly due to insecurity and cultural restrictions. In particular, survey findings suggest that there were substantial numbers of unassisted IDPs in hard-to-access areas, even if those in harder-to-access areas are displaced for shorter periods.

Access to healthcare was also poorer in hard-to-access areas, where over a third had either no access to healthcare facilities or no facility within one hour of their home (over twice the number in easy-to-access areas). Moreover, maternal healthcare was far worse in hard-to-access areas - 12% reported no access (8% in easy) and 30% appeared to be dependent upon untrained midwives (17% in easy). More people in hard-to-access areas die from being war-wounded, birth trauma, and coronary heart disease, and fewer of these deaths are reported to public institutions. However, the main difference to note was that five times more families in harder-to-access areas reported deaths from diarrhoeal diseases than in easy-to-access areas. This is further expounded as hygiene practices are significantly poorer in hard-to-access areas, and water supplies were generally less safe; over a third of households in hard-to-access areas depended upon water from rivers or canals, in comparison to less than 10% in easy-to-access areas.

The humanitarian community in Afghanistan struggles to understand the levels of needs and suffering in opposition controlled areas of the country, particularly in less-secure provinces of the country. Data strongly shows key differences that imply hundreds of thousands of IDPs are unassessed and unassisted, and that there is an increased rate of preventable deaths suffered in areas under served by humanitarian agencies.

BREAKDOWN OF

PEOPLE IN NEED

The number of people in humanitarian need has increased by 13% over the past year, reaching a total of 9.3 million. Fundamentally, the conflict remains the key driver for the majority of known and anticipated needs.

In addition to the projected 450,000 new conflict IDPs expected in 2017, acute needs are identified among at least 385,000 people that remain in a situation of prolonged displacement. Chronic food insecurity in Afghanistan affects some 40% of the population - over 11 million people. Only the most critical among this group are included in the humanitarian needs identified. For this 1.57 million, extreme vulnerability often resulting from repetitive shocks, including repeated displacement, has resulted in the most severe levels of food insecurity.






Overwhelmingly the largest concentration of needs result from constrained or complete lack of access to essential basic

NUMBER OF PEOPLE IN NEED

9.3M

and emergency services, including health care, nutrition treatment, protective support and water and sanitation. Almost 6.5 million people, predominantly women and children, face significantly increased vulnerability to infection, disease and death due to the immediate and cumulative impact of the conflict on public service provision.

NUMBER OF PEOPLE IN NEED BY SECTOR

	BY STATUS							BY SEX & AGE*		TOTAL
	Conflict displaced	Natural Disaster Affected	Doc. & Undoc. Returnees	Pakistani Refugees	Host Communities	Access to Essential Services	Severely Food Insecure	% female	% children, adult, elderly*	People in need
 Emergency Shelter and NFI	0.51M	0.21M	1.17M	0.10M	0.07M	-	-	49%	57 39 5%	2.1M
 Food Security and Agriculture	0.84M	0.20M	0.47M	0.13M	-	-	1.57M	49%	56 39 5%	3.2M
 Health	0.45M	0.20M	0.99M	0.13M	-	4.55M	-	49%	55 40 4%	6.3M
 Nutrition	-	-	0.16M	0.01M	-	4.16M	-	64%	71 29 0%	4.3M
 Protection	0.75M	0.14M	1.34M	0.13M	0.17M	1.17M	-	49%	56 39 5%	3.7M
 Water Sanitation Hygiene	0.35M	0.16M	1.05M	0.08M	0.28M	0.41M	-	49%	56 40 5%	2.3M

*Children (<18 years old), adult (18-59 years), elderly (>59 years)

SEVERITY OF

NEED












The complexity of recurring small scale acute emergencies in the context of a deeper, more protracted crisis, means that the nature and severity of needs manifests in varied ways for different people, across all sectors, and according to different drivers.

The 2017 Afghanistan HNO places people at the centre of the humanitarian situation analysis. Rather than simply presenting people's needs across the whole of Afghanistan on the basis of sectors alone (food, wash, shelter, health, nutrition, protection) this analysis provides a more representative overview of how different people in different situations experience the humanitarian crisis.

A joint approach to inter-sectoral analysis of needs identified the following three most critical conditions that drive the humanitarian crises experienced by different elements of the Afghan population. Needs are most severe in categories A and B, that include civilians injured by the conflict, women

and children who without health interventions would die and displaced families without adequate food and shelter in locations suffering harsh winter climate. Needs are amplified where these situations overlap, and are more pronounced in non-government controlled territory, where typically, service delivery and humanitarian presence is minimal.

CATEGORY A: EMERGENCY RELIEF NEEDS

	BY STATUS							BY SEX & AGE*		TOTAL
	Conflict displaced	Natural Disaster Affected	Doc. & Undoc. Returnees	Pakistani Refugees	Host Communities	Access to Essential Services	Severely Food Insecure	% female	% children, adult, elderly*	People in need
 Emergency Shelter and NFI	0.45M	0.20M	0.82M	-	0.07M	-	-	49%	56 39 4%	1.5M 
 Food Security and Agriculture	0.45M	0.20M	0.47M	-	-	-	-	49%	56 39 5%	1.1M 
 Health	0.45M	0.20M	1.00M	-	-	-	-	49%	56 40 5%	1.6M 
 Nutrition	-	-	-	-	-	-	-	-	-	-
 Protection	0.45M	0.14M	1.00M	-	0.17M	-	-	49%	56 40 4%	1.7M 
 Water Sanitation Hygiene	0.27M	0.15M	0.75M	-	0.28M	-	-	49%	56 40 4%	1.4M 

*Children (<18 years old), adult (18-59 years), elderly (>59 years)

Category A - Emergency Relief

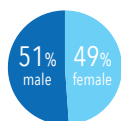
A state of continual emergency has become the norm for Afghanistan. Driven by constant conflict displacement, the influx of a huge number of refugee returns and the continual threat of natural disasters, it is anticipated that almost 2 million people will have emergency life threatening needs in 2017.

Immediate relief needs span all sectors; affected population groups include conflict affected and displaced, natural disaster affected and displaced, refugee and returnee families newly arriving from Pakistan and Iran in addition to a proportion of hosting families for all of the above. This 1.92 million people in need anticipated caseload has been projected based on trend data and forecasts agreed through the September 2016 national and regional IASC Emergency Response Preparedness (ERP) exercise.

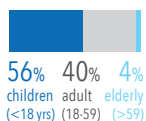
NO. OF PEOPLE IN NEED

1.9M

BY SEX



BY AGE



Category B - Excess Morbidity and Mortality

As the security situation continues to deteriorate, the impact of the conflict on access to basic services and population health is growing increasingly critical with just over 7 million people identified in need, approximately 1 million of which are also directly at risk of injury or death due to mine/ERW contaminations.

Coverage and quality of basic services, access to water and sanitation and functioning protection services have been extremely compromised by decades of conflict and under development. The continued violent conflict, attacks on health facilities and extensive population movements only serve to exacerbate these circumstances with significant numbers of IDPs, returnees and refugees congregating in urban centres where basic service provision is insufficient.

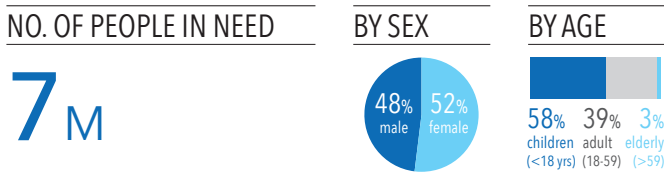
The challenge of accessing urgent health and nutrition care, accessing protection services, or meeting basic water and sanitation needs to prevent infection and disease is a reality for families in various circumstances across the country.

CATEGORY B: EXCESS MORBIDITY AND MORTALITY

	BY STATUS							BY SEX & AGE*		TOTAL
	Conflict displaced	Natural Disaster Affected	Doc. & Undoc. Returnees	Pakistani Refugees	Host Communities	Access to Essential Services	Severely Food Insecure	% female	% children, adult, elderly*	People in need
Emergency Shelter and NFI	-	-	-	-	-	-	-	-	-	-
Food Security and Agriculture	-	-	-	-	-	-	-	-	-	-
Health	-	-	-	0.13M	-	4.55M	-	49%	55 41 4%	4.7M
Nutrition	-	-	0.16M	0.01M	-	4.16M	-	64%	71 29 0%	4.3M
Protection	-	-	-	-	-	1.17M	-	48%	55 41 4%	1.2M
Water Sanitation Hygiene	0.08M	0.01M	0.31M	0.08M	-	0.41M	-	49%	56 39 5%	0.9M

*Children (<18 years old), adult (18-59 years), elderly (>59 years)

The excess morbidity and mortality category below therefore encompasses all population groups across multiple categories who are unable to access these critical services.

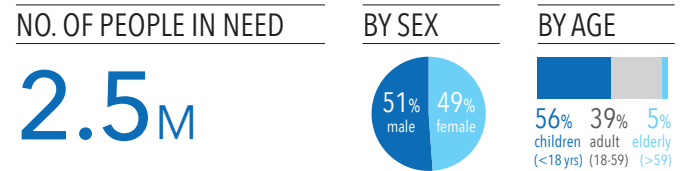


Category C - Humanitarian-Development Gap

The changing nature of the conflict, increasingly causing prolonged periods of displacement, and exposure to repetitive shocks, has resulted in increased numbers of people with residual acute humanitarian needs, long after the initial disaster or displacement. Just under 2.5 million people are identified with such needs linked to heightened shock induced

vulnerability and distinct from the large numbers of Afghans in a situation of chronic poverty.

Emergency one-off assistance is inadequate for IDPs and returnees still unable or reluctant to return home or unable to integrate to an adequate level; for people who experience repetitive shocks or who are already extremely vulnerable when impacted by a disaster or crisis. For families experiencing repetitive shocks and facing prolonged displacement, acute vulnerability, food, shelter and protection are particularly critical as they try to establish secure living arrangements and viable means to support their household. (The specific health, nutrition and wash needs of people falling into this category would be captured under category B).



CATEGORY C: HUMANITARIAN-DEVELOPMENT GAP

	BY STATUS							BY SEX & AGE*		TOTAL
	Conflict displaced	Natural Disaster Affected	Doc. & Undoc. Returnees	Pakistani Refugees	Host Communities	Access to Essential Services	Severely Food Insecure	% female	% children, adult, elderly*	People in need
Emergency Shelter and NFI	0.06M	0.01M	0.35M	0.10M	-	-	-	50%	57 38 5%	0.5M
Food Security and Agriculture	0.39M	-	-	0.13M	-	-	1.57M	49%	56 39 5%	2.1M
Health	-	-	-	-	-	-	-	-	-	-
Nutrition	-	-	-	-	-	-	-	-	-	-
Protection	0.30M	0.00M	0.34M	0.13M	-	-	-	50%	57 37 5%	0.8M
Water Sanitation Hygiene	-	-	-	-	-	-	-	-	-	-

*Children (<18 years old), adult (18-59 years), elderly (>59 years)

GEOGRAPHIC

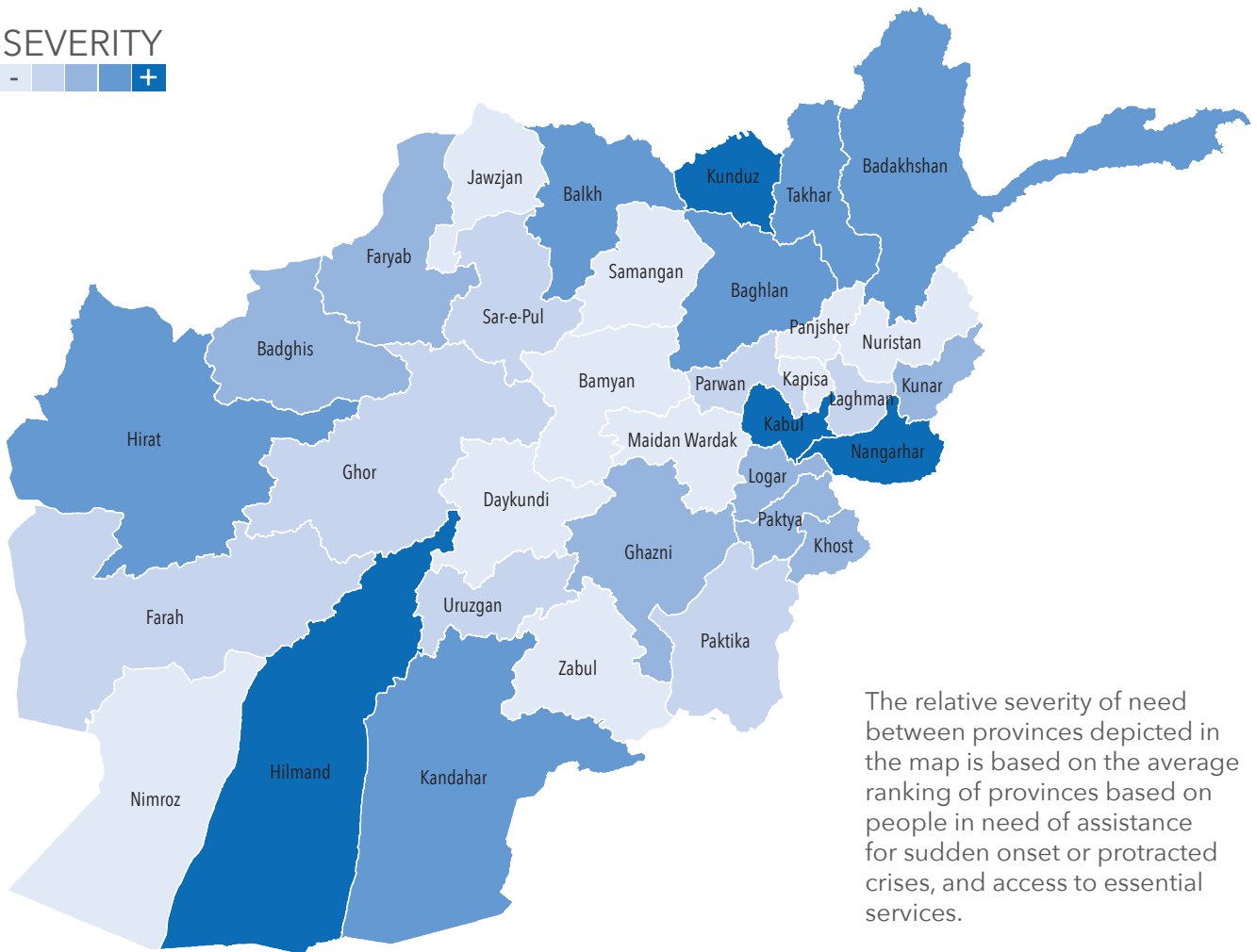
DISTRIBUTION OF NEED

Commensurate with the expanding nature of the conflict, humanitarian needs have been identified across all regions. The highest severity is seen in areas experiencing the greatest levels of violence as well as the adjacent provinces hosting the hundreds of thousands of displaced.

Provinces in the North, South, East and West of the country are equally experiencing extreme severity in terms of identified needs. Six out of eight regions of Afghanistan have between 1 and 2 million people in need of humanitarian









assistance. Only the mountainous and sparsely populated region of the central highlands is notable for its comparatively lower severity.

SEVERITY



The relative severity of need between provinces depicted in the map is based on the average ranking of provinces based on people in need of assistance for sudden onset or protracted crises, and access to essential services.

PEOPLE IN NEED (SEPT. 2016, IN MILLIONS)

	BY STATUS							BY AGE		TOTAL
	Conflict displaced	Natural Disaster Affected	Doc. & Undoc. Returnees	Pakistani Refugees	Host Communities	Access to Services	Severely Food Insecure	% female	% children, adult, elderly*	People in need
 CAPITAL	0.10	0.02	0.36	-	0.05	1.36	0.33	50%	54 42 4%	1.88
 CENTRAL HIGHLAND	-	-	-	-	-	0.15	0.07	55%	59 37 4%	0.16
 EASTERN	0.10	0.04	0.72	-	0.10	0.52	0.20	52%	59 38 3%	1.47
 NORTH EASTERN	0.25	0.05	0.18	-	0.05	1.08	0.21	50%	56 40 4%	1.61
 NORTHERN	0.07	0.05	0.07	-	0.02	0.78	0.13	53%	56 40 5%	1.01
 SOUTH EASTERN	0.06	0.01	0.07	0.13	0.01	0.48	0.04	54%	64 33 3%	0.75
 SOUTHERN	0.16	0.02	0.02	-	0.02	0.86	0.22	50%	58 39 3%	1.07
 WESTERN	0.10	0.02	0.02	0.01	0.01	1.17	0.38	49%	57 39 4%	1.33
	0.84M	0.21M	0.36M	0.13M	0.28M	6.41M	1.57M			

*Children (<18 years old), adult (18-59 years), elderly (>59 years)



PART TWO: NEEDS OVERVIEWS BY SECTOR

INFORMATION BY SECTOR

-  Emergency Shelter and NFI
-  Food Security and Agriculture
-  Health
-  Nutrition
-  Protection
-  Water, Sanitation and Hygiene

INFORMATION GAPS AND ASSESSMENT PLANNING

EMERGENCY SHELTER AND NFI

OVERVIEW



In 2016 every province of Afghanistan was affected by either a natural disaster or armed conflict, with 19 affected by both. Given the overall poverty level in Afghanistan – more than a third of the population live below the national poverty line – the level of resilience towards a shock remains very low. Consequently, even small scale disasters such as heavy rainfall can have a devastating impact on shelter and non-food items (NFIs), and with little or no spare income most families do not have the capacity to replace their lost items without resorting to negative coping mechanisms.

Displacement, both conflict induced and forced returns, has also generated significant shelter and NFI needs in 2016. As of November, more than 498,080 people have fled their homes due to violence,⁶² while 215,927 undocumented Afghans have returned from Pakistan,⁶³ many of whom have been either compelled to abandon their personal items and property or subjected to opportunistic asset stripping. Conflict-affected families, while often displaced in temporary accommodation with family or friends, require NFIs in order to cook, eat and to protect against harsh weather in high altitude areas, and natural disaster affected families, who are often able to evacuate to a safe location nearby, lose NFIs due to floods, landslides and earthquakes, which must be replaced.

Although flooding and large-magnitude earthquakes have the capacity to destroy whole homes, and is a certainty for which the humanitarian community must continue to be prepared, it is the absorption capacity of host communities to keep providing accommodation to conflict and returnee populations that is of most pressing concern. Indeed, without durable solutions in place, including access to land and tenure, it is likely that a significant proportion of these population groups will continue to require ES-NFI support in the future.

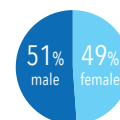
AFFECTED POPULATION

Conflict and natural disaster affected families with a vulnerable profile (including those with large numbers of children, a low income and few breadwinners) are more likely to present the need for ES-NFI support than other groups. Between January and September 2016, ES-NFI assistance was provided to approximately 64,500 families, of which 30% were girls, 30% boys, 21% women and 19% men.⁶⁴ With intensifying conflict and unprecedented waves of returnees, however, ES-NFI support may increasingly be required for host communities, many of whom share a similar economic profile to displaced populations but who themselves do not qualify for external humanitarian support, and whose capacity to continue accommodating relatives and friends is

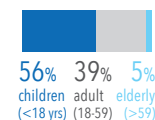
NO. OF PEOPLE IN NEED

2.1M

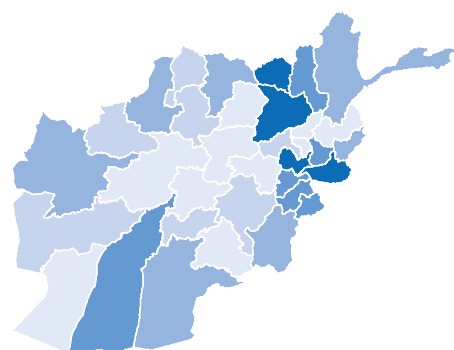
BY SEX



BY AGE



SEVERITY MAP



slowly being diminished by the repetitive and elastic nature of displacement. The inability of host communities to continue providing displaced and returnee families with safe sanctuary coincides with the rapidly encroaching winter, increasing the risk that these groups will be exposed to sub-standard living conditions – from over-crowding, to possible eviction and even sleeping out in the open – at a time they can ill afford, and further exposing them to protection, privacy and dignity violations.

HUMANITARIAN NEEDS AND DRIVERS

With the conflict showing no sign of abating and as one of Asia's most disaster-prone countries, populations in Afghanistan will continue to require both short and long-term emergency shelter support—ranging from temporary shelter solutions (such as tents), to shelter reconstruction/repairs (more common after natural disasters), rent support, winterisation and the reestablishment of a safe shelter in places of origin. While some families have the possibility of returning to a home that has suffered limited damage following armed conflict, at least 4 provinces experienced aerial shelling and heavy use of rockets which left cities with a much higher number of damaged or destroyed houses in 2016 compared to 2015. With the proliferation of intensified clashes and ground engagements in civilian inhabited areas, it is fair to assume that this trend will continue in 2017.

Simple household utensils and winter items to provide protection from the cold (such as blankets and warm clothes) are prioritised by populations displaced by both conflict and

natural disaster. With the majority of food support being distributed in-kind and as separate commodities, cooking utensils are required to enable families to subsist following a disaster. Personal effects, including blankets and warm clothes are often too heavy to carry in a situation where a family is forced to flee in a hurry, but are often the difference between life and death for individuals living at high altitude and exposed to freezing conditions during the winter, especially women and children.

Natural disasters continue to be the single-largest cause of shelter requirements in Afghanistan. Despite year-long efforts to incorporate disaster mitigation measures in new shelter construction projects the general standard of housing remains low. In 2017, as many as 200,000 families living in areas prone to floods, landslides, avalanches and earthquakes are considered to be at risk of being hit by a natural hazard and losing their shelter.⁶⁵

ASSESSMENTS AND METHODOLOGY

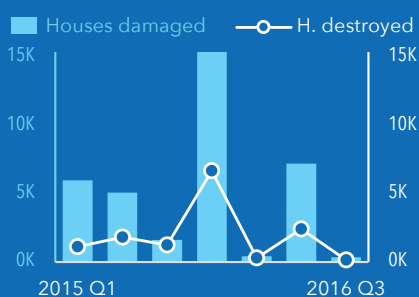
The ES-NFI cluster has based its sector specific needs on partner reporting of activities thus reflecting the ES and NFI needs that the humanitarian community currently has access to address. For the new groups included in the HNO for 2017, the cluster has based specific needs on inter-cluster assumptions and initial projected figures which will be adjusted with the outcomes of two currently ongoing

assessments. The first is a study into the residual ES-NFI needs of natural-disaster affected households (both assisted and non-assisted) who may still be living in damaged and potentially dangerous shelters and in need of post-emergency support, and the second is a study of the ES-NFI needs of prolonged IDP caseloads.

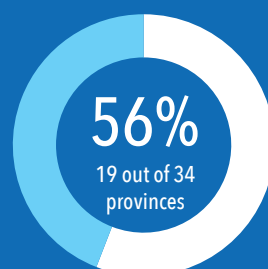
Limited post distribution monitoring following the provision of initial ES-NFI support means that the cluster knows little about the shelter and material requirements of prolonged IDPs and natural disaster-affected populations who may require supplementary assistance to rebuild their livelihoods. Currently, the ES-NFI cluster is in the process of developing a nationwide post distribution monitoring (PDM) tool for all partners to use, which will also raise the level of accountability to affected populations as their opinions and recommendations for improvements will be used to inform future standards and programme design. The ES-NFI PDM tool will be launched in early 2017. For cash based interventions the need for PDMs is evident to capture the actual expenditure of each family.

For each of the interventions listed a needs assessment (almost exclusively joint in nature) has been undertaken. The needs assessments conducted prior to the release of the HEAT tool varied in form and level of detail, but with the release and implementation of the latter, the majority of the ES-NFI partners are using this format to inform what assistance should be provided.

NATURAL DISASTERS



CONFLICT & NAT. DIS. AFFECTED



VULNERABLE RETURNEES



FOOD SECURITY AND AGRICULTURE

OVERVIEW



Food insecurity in Afghanistan is on the rise, with almost 6% of Afghans severely food insecure and another 34% moderately food insecure at the national level.⁶⁶ In 2016 the crop harvest remained below the 2015 and 5-year average production rate with a confirmed total deficit of almost 1.2 million metric tons.⁶⁷ Continued conflict, exposure to natural hazards and economic slowdown are affecting everyone particularly the vulnerable. Labour migration, conflict-induced displacement, and the sudden increase of returnees from Pakistan is taking place against a backdrop of the continued high level of conflict-induced displacement; these forced migrations in turn are increasing the rates of and burden on the urban and rural poor population and are increasing pressure on recessed labour markets, resulting in reduced income, price hikes, asset depletion and depressed wages. Natural disasters and conflict induced migrations further deteriorate income and production, increasing vulnerability both at household and community levels. In 2016 farmers were also affected by pest attack locust infestation and wheat rust, particularly in Ghor and Bamyan provinces along with localised floods and dry spells, damaging large swaths of crops and severely impacting on food stocks and income.

AFFECTED POPULATION

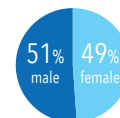
Severe food insecurity is on the rise with 1.6 million people severely food insecure.⁶⁸ In rural areas, the landless are the most food insecure, while smallholder farmers are the most vulnerable to shocks and largely unable to rebound following displacement or impact from natural disasters. The urban poor, particularly petty traders and daily labourers (engaged in agricultural or off-farm labour) are most vulnerable as their income decreased by 17% according to the 2016 Seasonal Food Security Assessment (SFSA). Additionally, the most vulnerable groups have been identified as: female headed households (59% food insecure); disabled headed households (39%, 25% severely so); households living in tents (74%); those occupying rooms at relatives (62%); those living in mountains and deserts (48%); and those with a higher dependency ratio.

While food insecurity is chronic in Afghanistan, those affected by recent/sudden shocks are considered to be most in need of immediate food assistance including recent returnees, refugees, newly displaced IDPs, prolonged IDPs with limited or no livelihoods options and natural disaster affected people.

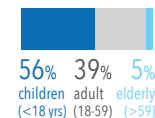
NO. OF PEOPLE IN NEED

3.2M

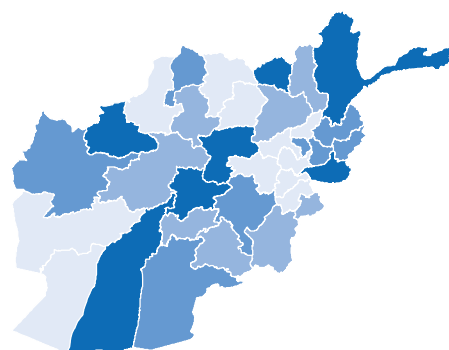
BY SEX



BY AGE



SEVERITY MAP



HUMANITARIAN NEEDS AND DRIVERS

Against a national backdrop of low income and vulnerability to natural disasters, continued conflict resulting in high numbers of IDPs, refugees and returnees, poor infrastructure, low levels of female participation in the labour force, high levels of unemployment especially under-employment, high fertility and dependency ratio are the bases for the Afghan population's vulnerability to food insecurity. The recent SFSA found that market prices for basic commodities in areas affected by increased returns have increased whereas labour wage rates has gone down significantly. The initial rapid assessment of returnees indicated that families had less than a week's worth of food stocks.⁶⁹ As a result, new conflict IDPs, returnees, host communities and refugees remain in need of critical humanitarian assistance; based on preliminary findings, food, livelihood support, shelter and protection are identified as major humanitarian needs.

In addition to the above, there are 1.6 million severely food insecure and 9.7 million moderately food insecure people in need of immediate assistance across the country.⁷⁰ The majority of the rural population depends on agriculture, livestock and daily wage labour and is extremely vulnerable to shocks and natural disasters. The poorest are the worst hit by conflict, natural disasters such as floods, localised dry spells,

pest attacks and the economic slowdown, and are affected by the decreased availability of unskilled work which is pushing wage rates down. The inevitable resorting to negative coping strategies, such as the withdrawal of children from school, distress sales of livestock or even the sale of land, directly affects their immediate and future food security.

ASSESSMENTS AND METHODOLOGY

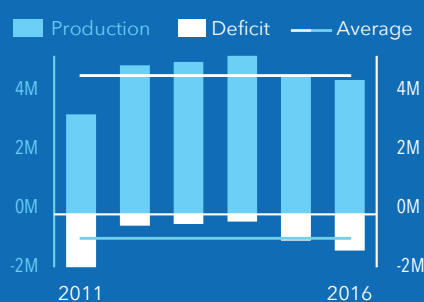
FSAC with the support of its partners carried out the SFSA, pre-harvest appraisal and Integrated Food Security Phase Classification (IPC) in 2016 to inform its programme design

in humanitarian, recovery and development targeting food and livelihoods needs. For the SFSA, FSAC uses different tools like detailed household food security and livelihoods questionnaires, community level questionnaires and market assessments. In 2016, 320 districts of 34 provinces were targeted for SFSA data collection. The pre-harvest appraisal is a qualitative approach to see crop area and production in different regions to estimate crop and livestock production. The IPC is comprised of analysis of all available assessment data through a detailed review process led by technical food security professionals in the country to provide phase classification of the food security situation at the provincial level.

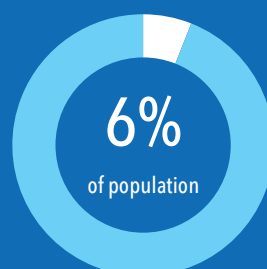


Photo: Jim Huylebroek/NRC

WHEAT PRODUCTION (MILLION MT)



SEVERELY FOOD INSECURE



RETURNEE FOOD ASSISTANCE

3 out of 4
returnees in need of food
assistance



HEALTH

OVERVIEW



Ongoing conflict and frequent disasters is causing increased displacement, mass casualty incidents and outbreaks of communicable diseases in the country, which disrupt health care services that are already overburdened by under-resourcing and the protracted complex emergency situation in the country. The situation has been further complicated by frequent exchange of territorial control and fighting between the government and non-state armed actors in wider geographical areas of the country, which has put health facilities under fire as many have been damaged or looted, loss of health care staff and disruption in the supply chain of essential medicines and vaccines.

The extensive population movements in the country exacerbate the circumstances with significant numbers of IDPs, returnees and refugees congregating in urban centres and the outskirts where basic service provision and infrastructure is unable to absorb the additional burden, and services are overwhelmed or simply not available to address mounting needs. The situation is expected to be further compounded with the return of 600,000 returnees, which also raises concerns related to disease outbreaks due to the influx of population with inadequate or no immunity against polio and other vaccine preventable diseases.

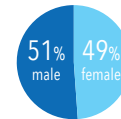
The expanding and worsening conflict continues to cause greater numbers of civilian casualties, with 22,986 cases of war-wounded having been reported in the first half of 2016, with almost half all these cases having been referred to and treated at major hospitals in Lashkargah and Kabul due to lack of capacity or presence of adequate trauma facilities in conflict areas.⁷¹

The consecutive emergency episodes have put tremendous strain particularly on the health system exhibited in high infant (73/1000 live births) and maternal mortality rates (327/100,000 live births), low immunisation coverage (less than 75% coverage for measles in one quarter of districts), and compromised access to quality health and nutrition care.⁷² Only 32.9% of deliveries take place in health facilities and 27.7% of post-natal care is provided by trained health staff.⁷³ Recent estimates reveal that over 9 million people have limited or no access to essential health care services, and around 920,000 women at reproductive age (15-49 years) are in need of reproductive health services including emergency obstetric care in the most affected areas. There is sub-optimal immunisation coverage in one quarter of the districts which results in widespread outbreaks of measles and pertussis among <5 years old children and almost all the major outbreaks are reported from the conflict affected locations.⁷⁴ Further incidents of diarrhoea and pneumonia which raises concern about the adequacy of health care service delivery in the white (not covered by EPHS/BPHS) and conflict affected areas.

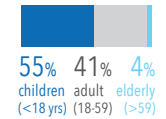
NO. OF PEOPLE IN NEED

6.3M

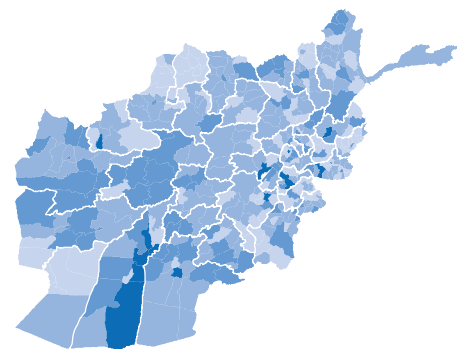
BY SEX



BY AGE



SEVERITY MAP



AFFECTED POPULATION

Continued displacement, inadequate safe water, poor hygiene and sanitation conditions in health facilities and overcrowded communities, limited access to food and quality nutrition services, and disruption of basic services in most vulnerable areas expose the affected population to higher public health risks including outbreak of diarrheal and respiratory diseases.

- An estimated 6.25 million people – over 20% of the total population are in need of essential health care services. Up to 53% of these are estimated to be women and an estimated 18% are under the age of five.
- Health service capacities in areas hosting IDPs and those with expected high concentrations of refugee returnees, particularly Kabul and Nangarhar, will be heavily overburdened by rapidly rising demands. The current waves of returnee Afghans from Pakistan (600,000), along with over 500,000 IDPs are key drivers of need for this sector, as existing services are not adequate to meet the basic life-saving health care needs of the affected populations.
- So called areas of white and conflict affected, either under the control of armed opposition groups or affected directly by the conflict, have experienced severe disruption of health services due to damage to facilities, staff displacement and disruption of supply chain of medicines and vaccines. Throughout the 95 high risk priority districts, over 4.5 million people are estimated to have limited or no access to basic health care services with high impact on survival needs of women and children under

five as the most vulnerable.

- Women and children are disproportionately affected by the severe reduction in health services. With a total fertility rate of 4.9%, compromised access to antenatal care, postnatal care, safe deliveries, and disrupted access to vaccinations for children particularly affect pregnant and lactating women (PLWs) and children under five warrants critical need for reproductive health and neonatal/child healthcare (RMNCH) services.
- Expanding geography and severity of conflicts and increasing number of weapon wounded inflict a high toll of morbidity and mortality in conflict affected areas. In the first half of 2016, a total of 22,986 weapon wounded or conflict related injuries were reported, among them 65% were male adults, 25% females and 10% were children.

HUMANITARIAN NEEDS AND DRIVERS

- While 70% of health expenditure by Afghans is out of pocket, displaced populations especially women in reproductive age are unable to cope with such expenditures and rely on health services provided by humanitarian actors. In view of the high maternal mortality rate of 327/100,000 live births, the delivery of maternal health care is a priority.

In view of the current distribution of the immunisation coverage, access to health care services and the prevalence of war trauma throughout the country, 95 districts with a total population of over 4.5 million are ranked as very high and high priority districts.

As per the Health Management Information System (HMIS) and Disease Early Warning System (DEWS) incidence based data every person in the country is experience at least one episode of common communicable diseases. Among them > 60% are attributed to acute respiratory infection, pneumonia and diarrhoeal diseases and <1% are attributed to the major outbreaks.

The critical need for emergency health services includes effective trauma care for weapon wounded of community based first aid as well as specialised trauma care delivery

at the referral hospitals, life-saving primary health care (PHC) services for the IDPs and returnees as well as the host communities in white conflict affected areas. Similarly, with special focus to health needs of women and children under five, the cluster needs includes selective RMNCH including access to emergency obstetric and family planning as well as blanket vaccination for unimmunised vulnerable children.

Key drivers of the need in the health sector:

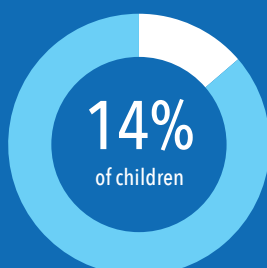
- Conflict, geographic, climatic factors and natural disasters including floods and earthquakes
- Internal displacement of over 500,000 and expected influx of 600,000 returnees from Pakistan by end of 2016 have overstretched already inadequate health care services.
- Disruption and dysfunction of basic health services due to direct damage by conflict and natural disasters to health facilities, lack of supplies and the fleeing of health personnel from conflict affected areas.
- Inadequate water, sanitation and shelter and reduced food security together expose the affected population to higher risk of outbreak of diseases
- Cultural barriers; and lack of female health personnel particularly in remote areas minimises women's access to basic health services.
- Health structures especially in urban areas are overburdened as had been planned for pre-war populations (i.e. Kabul was planned for 2 million not 5 million).

ASSESSMENTS AND METHODOLOGY

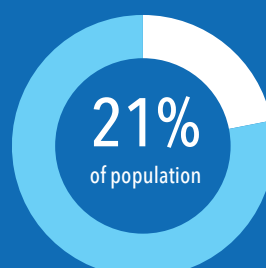
Health cluster identified people in need based on below 3 key indicators:

- Percentage of measles vaccination coverage based on the number of children who received the measles vaccination (January – June 2016), MoPH/EPI
- Number of war wounded registered at hospital level (January – June 2016), HMIS database (percentage of war wounded per 1,000 population)
- Percentage of population in white areas, MoPH/GCMU

PENTA 3 COVERAGE DEFICIT



POP. NOT SERVED BY OPD SERVICES



DISTRICTS WITHOUT FATP



NUTRITION

OVERVIEW



Afghanistan's nutrition situation continues to be negatively impacted by the conflict and decades of underdevelopment, despite enhanced efforts by Government and partners. More than a quarter of all provinces have acute malnutrition rates above 15%, thus classifying them as emergency, with 1.8 million people who will require treatment for acute malnutrition in 2017, including 1.3 million children under 5.⁷⁵ Community mobilisation, critical for the effective identification of malnutrition at an early stage and follow up at household level on the uptake of adequate infant and young child feeding (IYCF) practices, remains woefully inadequate with extremely low coverage of Integrated Management of Acute Malnutrition (IMAM), limited screening and active case finding and a lack of routine follow up. Health services currently reach only 60% of the population, and only 54% of these provide any nutrition services whatsoever (only 25% provide treatment for both severe and moderate acute malnutrition).⁷⁶ The impact of conflict and influx of returnees further exacerbates existing underlying conditions causing malnutrition including sub-optimal feeding and care practices (with exclusive breastfeeding rate at only 58.4%),⁷⁷ inadequate food security (12 provinces in Phase 3 – crisis situation, while three provinces [Badhakshan, Kunduz and Paktika] have 10 to 15% of the population in Phase 4 Emergency situation),⁷⁸ limited access to health services, limited access to safe drinking water and poor sanitation, as well as poor hygiene practices. This, combined with micronutrient deficiencies, another form of malnutrition having a deleterious impact on children under 5 and PLWs survival (anaemia prevalence in children aged 6-59 months is 44.9% and vitamin A deficiency is 50.4%) all contributes to increased rates of malnutrition.⁷⁹

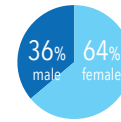
AFFECTED POPULATION

Children under the age of five and pregnant and lactating women continue to bear the brunt of Afghanistan's nutrition crisis. Despite the attempts to intensify the nutrition response by partners on the ground, the provinces affected by conflict and/or high acute malnutrition prevalence still record the highest malnutrition caseload and are therefore an immediate priority for the nutrition cluster (18 provinces out of 34). SMART surveys conducted in 2016 shows GAM prevalence ranging from 10.9 to 20.7% and SAM prevalence ranging from 3.2 to 8.4% (Badghis, Ghor, Herat, Panjsher and others). About 1.3 million children suffer acute malnutrition annually; including 600,000 that suffer from severe acute malnutrition and need immediate admission into therapeutic nutrition programs. Maternal nutrition is of particular concern, with some 400,000 pregnant and lactating women (PLW) being acutely malnourished every year.⁸⁰

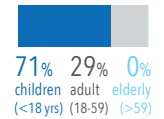
NO. OF PEOPLE IN NEED

4.3M

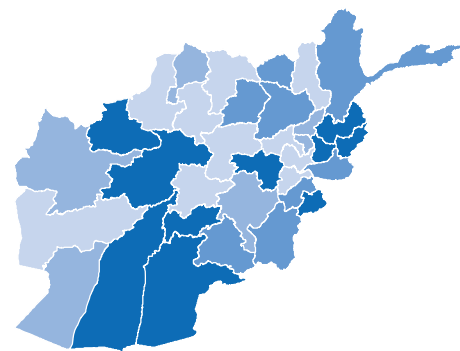
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BY AGE



SEVERITY MAP



Inappropriate infant and young child feeding practices (58.4% of infants are exclusively breastfed, 41.3% of infants 6-8 months are being introduced solid, semi-solid or soft foods,) significantly increase the risk of acute malnutrition and micronutrient deficiencies,⁸¹ and mean that 3.4 million PLW and caregivers of children 0-23 months are in need of IYCF counselling.⁸²

HUMANITARIAN NEEDS AND DRIVERS

The overall nutrition situation remains critical, with GAM prevalence >15% above the emergency threshold in nine provinces (Kunar, Uruzgan, Wardak, Laghman, Panjsher, Kandahar, Ghazni, Ghor and Nuristan) and SAM prevalence >3% above emergency threshold in 20 provinces.⁸³ Acute malnutrition is a life-threatening condition that requires urgent treatment: children suffering from SAM are nine times more likely to die than their healthy peers while children with MAM are three times more likely to die. Undernourished children who survive may become locked in a cycle of recurring illness and faltering growth, with irreversible damage to their development and cognitive abilities.

Currently, out of 1,922 health facilities across the country only 948 (49%) provide services for the management of SAM and 582 (30%) MAM, thus resulting in a significant gap between the extent of the needs of the affected population and their possibility to access both preventive and curative services.⁸⁴ In addition, the continuous influx of IDPs, refugees and returnees into urban areas increases the burden of malnutrition by stretching the capacity of the health system

to respond to and prevent different forms of malnutrition. PLWs have increased/specific nutritional requirements that cannot be met when optimal feeding practices and access to nutritious food have been impaired and more so in provinces where most households are highly food insecure. If not tackled, malnutrition in pregnant women can have adverse birth outcomes that might include low birth weight babies, miscarriages and pre-mature deliveries. Aggravating factors, such as water-borne illnesses and other infections, limited access to safe water, lack of adequate sanitation facilities and inappropriate hygiene practices, reduced food access and psychological stress also pose major threats to the survival and wellbeing of the affected population. Limited access to health care and difficulty to adequately promote, protect and support optimal IYCF practices significantly deteriorate the nutritional status of young children and PLW among IDPs, returnees, refugees and host populations leaving them exposed to increased morbidity and mortality, and impaired physical growth and cognitive development.

ASSESSMENTS AND METHODOLOGY

a) SMART Survey

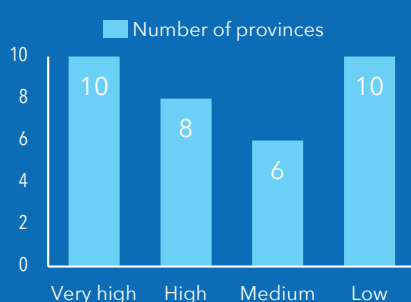
The interagency Standardised Monitoring and Assessment of Relief and Transitions (SMART) Initiative seeks to ensure that reliable and consistent data, starting with four critical data points on mortality, nutritional status, WASH and food security, are rapidly accessible for policy and resource decision making. For data consistency, the SMART in Afghanistan is conducted using a standardised set of tools, indicators and questionnaires that were developed in March 2016 in the cluster workshop. The methodology and package includes a software program that integrates the survey planning, collection and analysis of nutritional status and mortality rate

of surveyed population. Data reliability is facilitated by the software program (ENA) that simplifies the time-consuming process of survey planning, data entry and analysis with built-in statistical manipulations that generate sampling size, design effect, cluster groupings, and automatic standard tables and graphs. SMART is a simple, user-friendly tool to enable frequent, good quality surveys needed for monitoring fragile situations. Its built-in data quality assurance (plausibility check) programme eliminates data entry errors. In the context of Afghanistan, the main challenge to conducting SMART assessments is access to the districts due to increased levels of insecurity. It is therefore important to note that although some of the SMART assessments conducted managed to access the entire province (5 SMARTs) the remaining had partial coverage of the provinces (accessible areas for BPHS partners) with a population representation ranging from 40 – 80%.

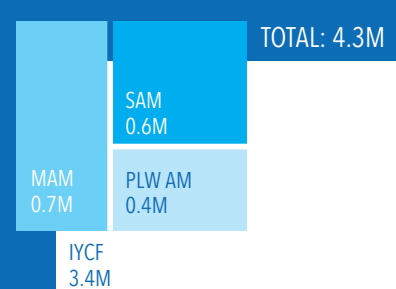
b) Rapid SMART Assessment

Rapid SMART assessment estimates the GAM and SAM prevalence of based on Mid-Upper Arm Circumference (MUAC) with the option of having Weight-for-Height in Z score (WHZ) results. This information gives an overview of the nutritional status of a certain population group at a certain period of time. This data can be collected using Rapid SMART only over a supposedly affected population living in a clearly delimited zone. The objectives of Rapid SMART are reached as far as the results are valid and therefore suitable for emergency programming. Their validity is confirmed only after the representativeness, accuracy and precision of the results are evaluated. If this assessment cannot be rapidly conducted (within a week) then the decision has to be oriented towards conducting a comprehensive multi-stage SMART nutrition survey.

MALNUTRITION VULNERABILITY



PEOPLE IN NEED



ACUTE MALNUTRITION CASELOAD

1 out of **4**
children under 5 will be
acutely malnourished in 2017



PROTECTION

OVERVIEW



The multi-faceted protection crisis continues to negatively impact upon the civilian population. Intensifying conflict throughout 2016 has resulted in increased civilian casualties and unprecedented levels of displacement. Newly displaced frequently settle in areas already hosting large numbers of prolonged displaced. Absorption capacity is limited and essential protective services, including health and education, are overstretched. This situation has been further aggravated by the swell in the number of returnees (both documented and undocumented), the majority of whom have had little time to prepare for return and are settling in the same areas. Vulnerabilities are aggravated and resilience impacted, especially for groups with specific protection needs such as women, children, older people and persons with disabilities. Limited accountability, insufficient humanitarian access, and uneven coverage of national protection frameworks and institutions – especially outside of urban centres – further affects the protection environment, while chronic poverty and underdevelopment renders large segments of the population susceptible to shocks. The protection impact of the existing crisis is often aggravated due to limited options for positive coping strategies, low awareness of basic rights and existing (gender) discriminatory socio-cultural practices.

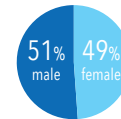
AFFECTED POPULATION

Protection related needs in Afghanistan are prevalent across the entire life-cycle of response, with some individuals and families exhibiting specific needs during emergency and post-emergency phases. HEAT data from May to October 2016 shows that half of the surveyed conflict induced displaced population is female, many pregnant or lactating (respectively 8% and 37% of surveyed households) and 62% are children – it is recognised that these large groups face particular and evolving concerns. High levels of extra-vulnerable households are present amongst those assessed: 8% is headed by an older person; 9.5% is female-headed; 0.7% is child-headed; 2.8% has a person with disability, and 2.8% a chronically ill family member.⁸⁵ Such households are at heightened risk in adverse circumstances – including threats of physical harm due to the conflict – and might require specialised life-saving assistance, as well as interventions to mitigate further exposure to protection violations. Similar vulnerability profiles and protection risks are present across refugee and (secondarily displaced) returnee populations, with a convergence of large numbers on urban centres also impacting upon the situation of hosting populations.

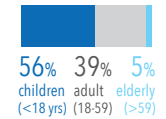
NO. OF PEOPLE IN NEED

3.7M

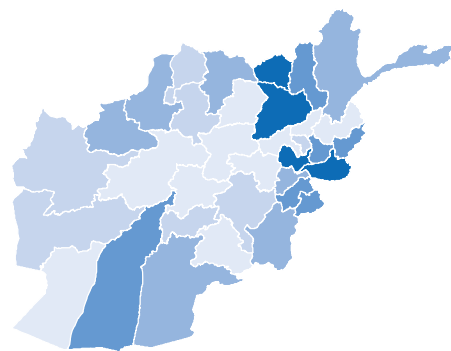
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BY AGE



SEVERITY MAP



HUMANITARIAN NEEDS AND DRIVERS

Protection needs in the complex emergency in Afghanistan are mainly related to the deteriorating security situation, involuntary population movements and the weakness of mechanisms, institutions and services to protect and fulfil basic rights. Violations of International Humanitarian Law (IHL) and Human Rights Law (HRL) occur regularly—including, targeted killings, forced recruitment⁸⁶ and attacks on health and education facilities.⁸⁷ In 2016, increasingly frequent ground engagements continued to be the main cause of civilian casualties,⁸⁸ while also limiting freedom of movement for civilians and contaminating areas with explosive remnants of war (ERW) which disproportionately affect children.⁸⁹

Forced displacement reduces the self-protection capacities of affected populations, including the loss of social support networks, and causes severe distress which can have long-term consequences for the entire household if not adequately addressed.⁹⁰ As displacement becomes prolonged protection risks evolve, particularly for those living in informal settlements – characterised by undignified and sub-standard conditions – with negative coping mechanisms proliferating due to an absence of livelihood opportunities, social protection⁹¹ and food security.⁹² Lack of civil documentation⁹³ and lack of access to land with tenure security hinders displaced and returnee populations' access to services and justice and increases the risk of forced eviction.⁹⁴

Children are at particular risk of abuse,⁹⁵ neglect, marginalisation, and exploitation,⁹⁶ as well as interrupted

school attendance,⁹⁷ harmful child labour,⁹⁸ drug abuse⁹⁹ and trafficking.¹⁰⁰ Multiple forms of GBV, particularly early and forced marriage,¹⁰¹ domestic,¹⁰² psychological,¹⁰³ and sexual abuse¹⁰⁴ are reported, affecting individuals in hosting and displaced communities alike.¹⁰⁵ Women, who are frequently already unable to participate fully in civil life,¹⁰⁶ face heightened risks of discrimination and abuse if divorced, separated or widowed,¹⁰⁷ including expulsion, forced remarriage and hampered property ownership.¹⁰⁸

Continuing instability, conflict, and increased ERW contamination inhibits return, while local integration of returnees and IDPs among host communities in urban contexts remains complicated due to lack of land/property ownership, as well as discriminatory attitudes, fuelled by competition for livelihood opportunities and overburdening of existing services.¹⁰⁹ Holistic approaches, aimed at improving the resilience and self-reliance of affected families, as well as enhancing positive engagement of governance structures are needed to reduce vulnerabilities and to mitigate short and longer term protection risks.

ASSESSMENTS AND METHODOLOGY

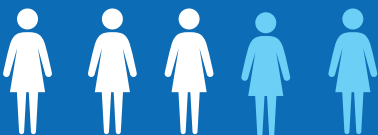
The Protection Cluster needs analysis is based on a large variety of sources, using both quantitative and qualitative information. Cluster members have undertaken several thematic protection assessments (civil documentation, durable solutions, protection of civilians, education, child-protection, etc.) and conduct regular protection monitoring (through focus group discussions and key informant interviews)

which informs needs analysis and response on a rolling basis.¹¹⁰ Many of the thematic assessments focus on a limited geographical area or isolated population and therefore do not allow confident generalisation due to the absence of statistical sampling which inhibits a reliable extrapolation of assessment results to the wider affected population. However, protection risks and needs can be inferred from analysis of existing countrywide datasets, combined with an understanding of dynamics within affected populations who are routinely assessed through consultations by protection monitoring actors. Inter-agency household assessments of new IDPs using the HEAT are providing minimal data on a limited number of specific vulnerabilities. This information would benefit from further contextualisation, although by virtue of an overall adequate sample size the data is able to supplement the overall cluster needs analysis (as well as inform programmatic targeting). It should be noted that numerous protection concerns, notably GBV, child recruitment, harmful child labour, etc., remain un- or underreported due to cultural sensitivities, thus preventing a successful systematic assessment of these phenomena and associated needs. To further expand and harmonise the sparsely available quantitative (and spatially comparable) information, in October 2016 the Protection Cluster conducted a protection risk analysis at both national and sub-national level involving approximately 100 humanitarian practitioners from all regions and pooling their understanding of protection risks, needs, and situational analysis of various population groups. The outcomes of this exercise were comparable with the results from protection monitoring and other localised studies.

CIVIL DOCUMENTATION

3 out of 5

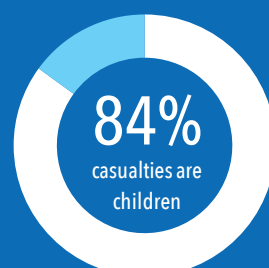
women do not possess a Tazkera



10% of men also do not have a Tazkera

Source: NRC, 2016

ERW CIVILIAN CASUALTIES IN 2016



Source: UNAMA, October 2016

VULNERABLE FAMILIES

1 out of 4

families have an extremely vulnerable family member



* Includes families with elderly, female or child head of households, and households with more than 3 children under age of 5, disabled or chronically ill person. Source: ERM (August 2016)

WATER, SANITATION AND HYGIENE

OVERVIEW



According to a UNICEF-WHO joint monitoring report from 2015, 68% of Afghans don't have access to improved sanitation and nearly 15 million, or 45%, use unimproved water sources.

There is huge urban-rural and inter-provincial disparity. The provinces with higher intensity of conflicts are also the ones with poorer WASH indicators (ALCS 2014). Safe hygiene behaviours like handwashing with soap at critical times is practiced by less than 30% of people in 24 out of 34 provinces (ALSS). As a result, water-borne disease like diarrhoea with strong association to chronic malnutrition among children is a matter of concern. The situation is being further exacerbated by increasing IDP caseloads and influx of returnees from Pakistan, further accumulating the number of people that may need humanitarian WASH support. Persistent natural disasters is also a huge burden on WASH infrastructure that is rather poorly maintained. These conditions are expected to put even higher pressure on urban-fringes where most of the returnees are settling. In such circumstances, the affected population (including host communities) often end up using unimproved water sources and practice risky behaviours like open defecation. Furthermore, nearly 25% of all basic health facilities lack basic WASH services. Lack of WASH facilities reduces the impact of health and nutrition intervention, especially during emergency when the facilities are overcrowded.

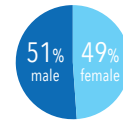
AFFECTED POPULATION

Those fleeing the conflicts as well as returnees often live in makeshift shelters in marginal lands with no WASH facilities. At times, these families are also sheltered in temporary camps without safe water and sanitation including latrines and bathing facilities, and as a result people often use unprotected and distant water sources and practice open defecation. These conditions compromise the dignity of women and girls, put them at risk of harassment, and expose people to life-threatening disease including outbreaks of acute diarrhoea, cholera, ARI and measles, especially young children and sick and elderly people. Diarrhoeal disease, if not treated, traps young children in a vicious circle of malnutrition and diarrhoea leading to chronic malnutrition and potential death. Natural disasters force communities to abandon their homes and damage or contaminate water and sanitation facilities, making them unsafe to use. Health facilities that provide essential life-saving health and nutrition interventions

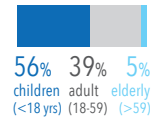
NO. OF PEOPLE IN NEED

2.3M

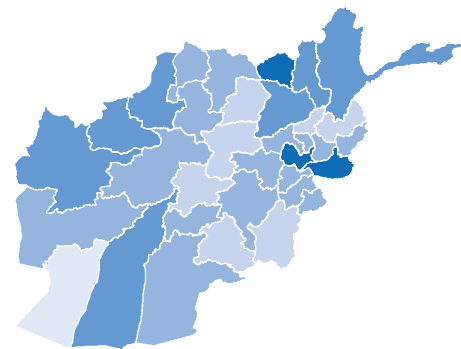
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BY AGE



SEVERITY MAP



to disaster and conflict affected people are often also without adequate and safe water supply thus seriously compromising the efficacy of the services.

HUMANITARIAN NEEDS AND DRIVERS

The key protective measures from water-borne diseases such as use of toilets (avoiding open defecation) and hand-washing with soap at critical times are further compromised during emergency due to lack of facilities and poor awareness among the affected population about the associated risks. Low levels of education and certain cultural practices often act as barriers for promoting good sanitation and hygiene, especially among the women. A limited number of female workers hinders the capacity of humanitarian agencies in reaching out the vulnerable population (women and children) with quality hygiene promotion interventions. The risk of diarrhoeal diseases gets escalated in communities with already alarming levels of malnutrition, as weaker children are more susceptible to repeated bouts of diarrhoea leading to poor absorption of nutrients and thus forcing the child into a cycle of malnutrition and diarrhoea. A number of nutrition surveys in Afghanistan have shown strong association with access to safe water, sanitation and good hygiene practices with child malnutrition. Limited access to water and sanitation and poor hygiene practice is responsible for more than 80% of

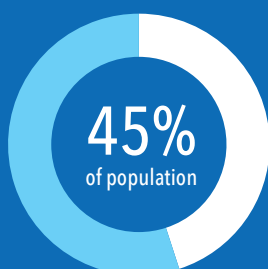
diarrheal cases (WHO 2004). Safe drinking water coupled with basic sanitation (latrine, bathing facility and safe disposal of wastewater and solid wastes) and improved hygiene can prevent the spread of water-borne diseases including diarrhoea in emergencies.

Rapid onset emergencies (especially those resulting displacement) double the burden in urban-fringes and informal settlements where houses are stacked close to each other without proper sanitation and drainage systems. Such conditions are common in Jalalabad, Kabul and other provincial centres where IDPs and returnees are finding their shelters. Unless sufficient measures are taken, such conditions are favourable places for vector breeding and spread of water-borne diseases.

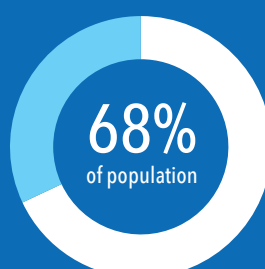
ASSESSMENTS AND METHODOLOGY

WASH Cluster has used the figures from 'Afghanistan National Living Standard Survey 2013 – 2014' to find out the coverage status of provinces with access to water, sanitation and hygiene. The national level coverage has been taken from the UNICEF-WHO joint monitoring report 2015 which provides estimated figures through triangulation of multi-year data from all national surveys. The prevalence of diarrhoea and SAM cases at provincial level was abstracted from Nutrition Survey 2014. Likewise, historical data from the past 5 years (2012-2016) has been analyzed to anticipate the People in Need (PIN) for humanitarian support in the WASH sector. Appropriate weightage was assigned to each of the indicators (water, sanitation, SAM cases and diarrhoea prevalence) to identify the severity ranking of the provinces.

LACK OF ACCESS TO CLEAN WATER



% WITHOUT IMPROVED SANITATION



POOR HYGIENE PRACTICES

Over 7 out of 10 people
do not wash hands with soap



in 24 out of 34 provinces

INFORMATION GAPS AND ASSESSMENT PLANNING

Since the start of 2016, 63 humanitarian partners have carried out 461 needs assessments, more than tripling the number reported last year. The vast majority of this increase is the result of the nationwide roll-out of the multi-sector Household Emergency Assessment Tool (HEAT), endorsed

by the HCT in June, which comprises 60% of all assessments completed.

While substantial progress has been made in determining emergency needs at the household-level, insufficient follow-up and in-depth assessments of caseloads receiving one-off

NUMBER OF ASSESSMENTS

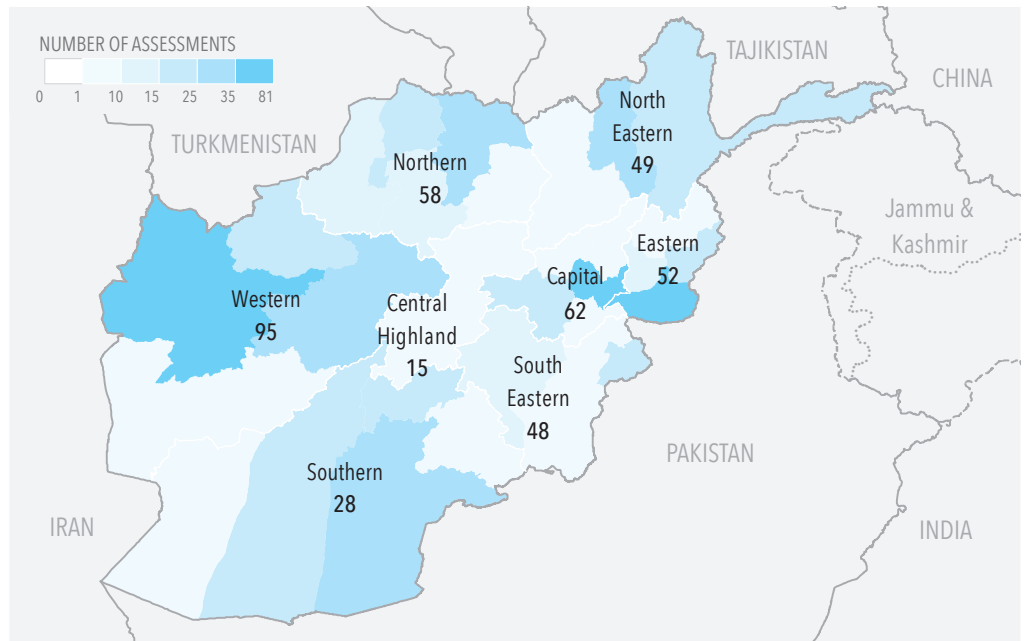
461

NUMBER OF PARTNERS

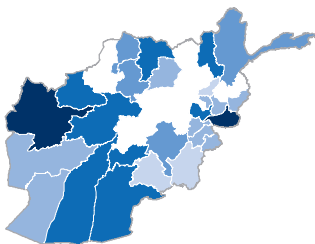
63

PLANNED NEEDS ASSESSMENTS

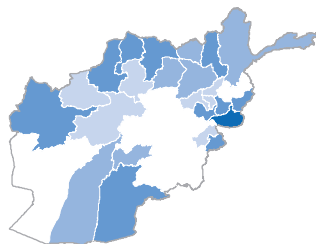
49



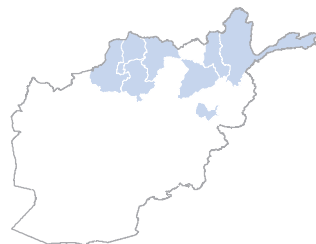
HEAT



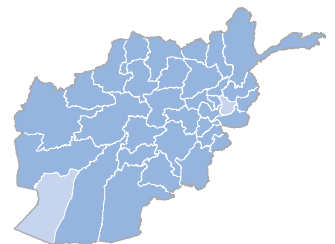
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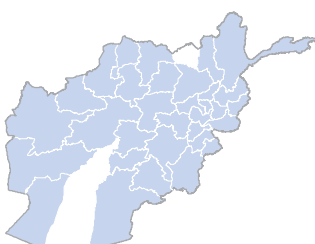
EM. SHELTER & NFI



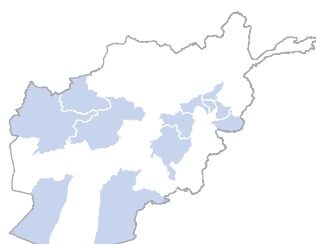
FOOD SECURITY



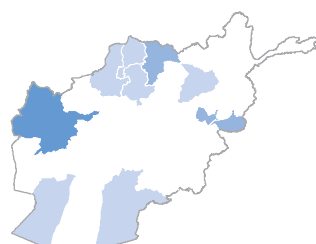
HEALTH*



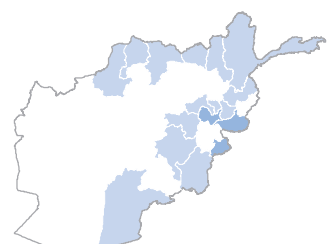
NUTRITION



PROTECTION



WASH











* Coverage: 3 targeted districts per province.



assistance packages has limited our understanding of the potential medium-term needs of affected populations and their susceptibility to prolonged, acute vulnerability. An over-reliance by the Health Cluster on data gathered by the HMIS and DEWS, which only provides information on populations with access to BPHS services, also tells us little about the extent or prevalence of needs among the approximate 9

million living in areas not covered by the BPHS, where they are arguably the greatest. Due to socio-cultural sensitivities and limited numbers of female staff in field teams, GBV concerns remain underreported, hindering provision of timely assistance.

NUMBER OF ASSESSMENTS BY LOCATIONS AND BY SECTOR

	Emergency Shelter	Food Security	Health	Nutrition	Protection	WASH	CBT	HEAT	TOTAL
 CAPITAL	1	3	1	4	4	4	17	30	64
 CENTRAL HIGHLAND		3	1						4
 EASTERN		3	2	3	4	4	33	32	81
 NORTH EASTERN	2	3	1		1	3	17	25	52
 NORTHERN	1	3	1		3	3	25	25	61
 SOUTH EASTERN		3	1	1		7	6	15	33
 SOUTHERN		3	1	2	2	1	14	59	82
 WESTERN		4	1	4	5		12	105	131
TOTAL	2	4	2	14	10	14	124	291	

PLANNED NEEDS ASSESSMENTS

CLUSTER/SECTOR	LOCATION	TARGETED PEOPLE	LEAD AGENCY	PLANNED DATE	SUBJECT
Multi-Cluster	Nationwide	IDPs, natural disaster affected, returnees		January to December 2017	Household level assessment of emergency needs
Emergency Shelter & Non-Food Items	Badakhshan, Baghlan, Takhar, Balkh, Jawzjan, Sar-e-Pul, Faryab	Families affected by floods in 2014	REACH		Shelter cluster flood response evaluation in the north
Emergency Shelter & Non-Food Items	Badakhshan, Baghlan, Kabul	Families assisted with unconditional cash grants after 2015 earthquake	REACH		Shelter cluster earthquake response evaluation
Food Security & Agriculture	Nationwide	All population	WFP, FAO	March 2017	Pre-harvest Seasonal Food Security Assessment (SFSA)
Food Security & Agriculture	Nationwide	Host community, farmers, provincial authorities and NGOs	WFP, FAO, FEWSNET and MAIL	March 2017	Pre-harvest Appraisal
Food Security & Agriculture	Nationwide		MAIL	August 2017	IPC (integrated phase classification)
Food Security & Agriculture	Nangarhar	Prolonged IDPs and Returnees	FSAC (FAO/WFP)	March 2017	Detailed need assessment
Health	Nationwide	Population with limited access to health care services	MoPG and WHO	November 2016 to January 2017	Review of white areas and the population with limited access to health care services
Health	Nationwide	Total population of un-assessed districts remaining districts (303) districts will be targeted, including Hilmand and Kunduz, which were missed in the first phase of assessment	WHO	Depends on availability of fund	Health Emergency Risk assessment
Nutrition	Badakhshan, Baghlan, Balkh, Bamyan, Daykundi, Farah, Faryab, Ghazni, Hilmand, Jawzjan, Kabul, Kandahar, Khost, Kunar, Kunduz, Laghman, Logar, Nuristan, Paktika, Paktya, Samangan, Sar-e-Pul, Takhar, Uruzgan, Wardak, Zabul	All population	ACF, TBD	2017	SMART
Nutrition	TBC	All population	ACF	2017	SQUEAC
Protection	Nationwide	IDPs	UNHCR	Throughout 2017	IDP protection monitoring
Protection	Takhar, Baghlan	IDPs, host communities	DRC	January-February 2017	Protection assessment
Protection	Nationwide	IDPs, host communities, returnees	UNICEF	April-July 2017	Protection assessment
Protection	Nationwide	All population	UNMAS	Throughout 2017	Mine/ERW survey
Protection	Nationwide (focus on regional centers)	IDPs, returnees, host communities	HLP TF	Throughout 2017	Assessment of land allocation sites where required
Protection	Nationwide	All population	UNFPA	January-June 2017	GBV benchmarking

CLUSTER/SECTOR	LOCATION	TARGETED PEOPLE	LEAD AGENCY	PLANNED DATE	SUBJECT
Water, Sanitation & Hygiene	Nangarhar	Returnees and host communities	DACAAR	Jan – Feb	WASH Situation of Returnees and host communities in Nangarhar
Water, Sanitation & Hygiene	Nangarhar	Returnees and host communities	IMC	Feb – March	WASH Situation of Returnees and host communities in Nangarhar
Water, Sanitation & Hygiene	Takhar	IDPs, host community	ADEO	Feb – March	WASH Situation of IDPs and host communities in Takhar
Water, Sanitation & Hygiene	Khost, Paktika	Host communities, returnees, IDPs	COAR	Feb – March	WASH Situation of Host communities and Returnees in Khost and Paktika
Water, Sanitation & Hygiene	Balkh	IDPs, host communities	DACAAR,	Jan – March	WASH Situation of IDPs and Host communities in Balkh
Water, Sanitation & Hygiene	Takhar	IDPs, host communities	DACAAR,	Feb – April	WASH Situation of IDPs and Host communities in Balkh
Water, Sanitation & Hygiene	Hilmand	IDPs, host communities	DACAAR	Jan – March	WASH Situation IDP and host communities in Hilmand
Refugee & Returnees	Nationwide (focus on areas of high displacement)	Returnees	UNHCR	Throughout 2017	Returnee monitoring

ACRONYMS

ALCS	Afghanistan Living Conditions Survey
ANDSF	Afghan National Defense and Security Forces
ANSF	Afghan National Security Forces
BPHS	Basic Package of Health Services
CSO	Central Statistics Organisation
DAC	District Administrative Centres
DEWS	Disease Early Warning System
ENA	Emergency Nutrition Assessment Software
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunisation
ERW	Explosive Remnants of War
ES	Emergency Shelter
FSAC	Food Security and Agriculture Cluster
GAM	Global Acute Malnutrition
GBV	Gender Based Violence
GCMU	Grant and Contract Management Unit
HEAT	Household Emergency Assessment Tool
HMIS	Health Management Information System
HNO	Humanitarian Needs Overview
HRL	Human Rights Law
IDP	Internally Displaced Person
IHL	International Humanitarian Law
IPC	Integrated Food Security Phase Classification
ISK	Islamic State's Khorasan
IYCF	Infant and Young Child Feeding
MAM	Moderate Acute Malnutrition
MMR	Maternal Mortality Ratio
MoPH	Ministry of Public Health
MUAC	Mid-Upper Arm Circumference
NFIs	Non-food Items
NSAG	Non-State Armed Group
PDM	Post Distribution Monitoring
PHC	Primary Health Care
PIN	People in Need
PLW	Pregnant and Lactating Women
RMNCH	Reproductive Health and Neonatal/Child Health Care
RNA	Rapid Nutrition Assessment
SADD	Sex and Age Disaggregated Data
SAM	Severe Acute Malnutrition
SFSA	Seasonal Food Security Assessment
SMART	Standardised Monitoring and Assessment of Relief and Transitions
UNAMA	United Nations Assistance Mission in Afghanistan
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
WHZ	Weight-for-Height in Z score

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6. See endnote 5. "The intensification of ground fighting is directly related to the increase in civilian casualties from ERW, or unexploded ordnance. UNAMA documented 510 civilian casualties (160 deaths and 350 injured), a 67 per cent increase from the same period in 2015." According to UNAMA Human Rights, 84% of civilian casualties are below 18 years of age.
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10. 51.8% of children throughout Afghanistan are reported to be involved in labour, 45% of them are forced to work due to chronic poverty. See: AIHRC, Children's Situation Summary Report, September 2013. UNICEF reports a percentage of 30% of children involved in child labour with higher frequency in rural areas. See: endnote 8. For an example of hazardous child labour in brick kilns and the risks children are exposed to - including violence - see: Samuel Hall/UNICEF/LO, Breaking the mould: Occupational safety hazards faced by children working in brick kilns in Afghanistan, 2015
11. Research suggests violence against women and early/forced marriage increases in situations of protracted displacement. See: NRC and Samuel Hall, Challenges of IDP protection in Afghanistan, November 2012; NRC and TLO, Listening to women and girls displaced to urban Afghanistan, January 2015, and MoWA, Violence against women primary database, 3rd edition, 2014. Reportedly 46% of Afghan girls get married before they are 18 years old and 15% get married before they are 16 years old. See: AIHRC, Children's Situation Summary Report, September 2013. UNAMA HR quotes a figure of 57% of all Afghan marriages being child marriages. See: UNAMA HR, Harmful Traditional Practices and Implementation of the Law on Elimination of Violence against Women in Afghanistan, December 2010; for the link between poverty and loss of livelihoods and early/forced marriage see below in the same report and MoWA, Violence against women primary database, 3rd edition, 2014. These findings are corroborated by the trends detected by the CPIE/GBV Rapid Assessment conducted mid-2015 amongst IDP communities. Early sexual activity and child bearing are associated with significant health risks for young girls. See: UNICEF, Children and Women in Afghanistan: A Situation Analysis, November 2014.
12. Afghans see domestic violence as an increasingly worrying problem, with 13% of all female Afghans polled mentioning the phenomenon as the biggest problem faced by women. See: Asia Foundation, A survey of the Afghan People, October 2014. A study by Global Rights from 2008 gives a figure of 62% of all Afghan women experience multiple forms of domestic violence. See: Global Rights Report, Living with Violence: A National Report on Domestic Abuse in Afghanistan, March 2008. For anecdotal corroboration and illustration of the situation in IDP communities, see *inter alia*: NRC and TLO, Listening to women and girls displaced to urban Afghanistan, January 2015.
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87. See endnote 3
88. See endnote 5
89. *ibid*
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92. "With few resources and even fewer opportunities, the protection needs and vulnerabilities of IDPs affect all facets of their lives. They are generally worse off than the rest of the national population: *The illiteracy rate for both IDP men and women is above national averages (for men: 74 per cent vs. 61 per cent; for women 98 per cent vs. 88 per cent). *Women's vulnerabilities increased further after displacement, particularly for widowed women who composed 19 per cent of our total female respondents. *On average, IDPs live in larger households (9.5 people) than other Afghans (7.3 people according to national statistics). With higher average household sizes and lower incomes, IDPs struggle to meet their family's most basic needs." See: NRC and Samuel Hall, *Challenges of IDP protection in Afghanistan*, November 2012. Also: "Despite similar vulnerability to price shocks, the food security of IDPs is much worse than that of urban poor households from the NRVA sample. Focusing only on extreme outcomes, only 7 percent of IDPs report to have never had problems in satisfying household's food needs compared to 37 percent of urban poor. In addition, 14 percent of IDPs are mostly food insecure i.e. cannot satisfy food needs several times every month versus three percent of urban poor." UNHCR & World Bank, *Research study on IDPs in urban settings - Afghanistan*, May 2011
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98. See endnote 10
99. Research from UNODC from 2009 is quoted by UNICEF. "The drugs commonly used by children aged 10-15 years were cannabis, opium and heroin; opium, tranquilizers and cannabis are commonly used by children under 10 years." Street children and children working on the streets are predominantly exposed to the risk of drug abuse. UNICEF, *Children and Women in Afghanistan: A Situation Analysis*, November 2014
100. "'Domestic' trafficking in Afghanistan is more prevalent than transnational trafficking, though the latter is not uncommon. The majority of trafficking victims are children, and increasing numbers of boys and girls are reported to have been subjected to forced labour in carpet-making factories and domestic servitude, as well as to commercial sexual exploitation, forced begging and drug smuggling." See: UNICEF, *Children and Women in Afghanistan: A Situation Analysis* (2014). "Who is at risk? Children and youth in large, impoverished families are particularly at risk, especially when the family is in debt. While demand for particular activities is gendered, both male and female individuals are targeted for different forms of exploitation." See: Samuel Hall & IOM, *Old practice, new chains: modern slavery in Afghanistan*, 2015; based on 2013 study.
101. See endnote 11
102. See endnote 12
103. MoWA, *Violence against women primary database*, 3rd edition, 2014
104. See endnote 14
105. See endnote 15
106. "Afghan internally displaced persons do not live in camps, but in informal settlements on the outskirts of major cities. The overcrowded living situation increases the risks of violence for women. Many of them are subjected to domestic violence and forced marriages. Furthermore, the switch in traditional housing conditions, including the move from rural to urban environments, have an effect on women's freedom of movement, as they cannot benefit from the protection of their courtyards, gardens and villages." See: UN Human Rights Council, *Report of the Special Rapporteur on violence against women, its causes and consequences, Rashida Manjoo; Addendum; Mission to Afghanistan*, 12 May 2015. See also: NRC and TLO, *Listening to women and girls displaced to urban Afghanistan*, January 2015
107. "The average age of Afghan widows is just 35 years, says [the organisation] Beyond 9/11. About 94 per cent cannot read and write. About 90 per cent have children, four on average. Widowed women are also at greater risk of developing "emotional problems and impaired psychosocial functioning than either married women or men, typically because of social exclusion, forced marriages, gender-based violence and lack of economic and educational opportunities," says the organisation." See: *Afghanistan Analysts Network, Covering for Each Other in Zanabad: The defiant widows of the hill*, May 2015
108. "Identity documents or tazkeras are particularly important, as in order to initiate a procedure before the statutory justice system a person must present an identity document. Yet, they are very often not available to displaced widows, female-headed households or displaced women estranged from their husbands, as women are included in the personal documentation of their male relatives or husband. The lack of documentation is a particularly acute issue for displaced women - for example 81.8 per cent of IDP women do not have a tazkera as opposed to 16.6 per cent of IDP men in the same situation. Without the documentation, there is no possibility for them to claim their rights independently." See: Samuel Hall & NRC, *Strengthening Displaced Women's Housing, Land and Property Rights in Afghanistan*, November 2014
109. "One third of the IDPs surveyed reported living in unsatisfactory and precarious accommodations. This, in turn, is susceptible to lead to land disputes and social fragmentation. The issue of the right to land in informal settlements has led to situations of heightened tensions and confrontation. The pressures on land and services result in a competition over resources and in discriminations between longer-term residents (or host community) and IDPs." See: MEI-FRS, *Urban Returnees and Internally Displaced Persons in Afghanistan*, January 2011. "Large numbers of IDPs risk falling into permanent displacement with no immediate prospect of durable solutions. IDPs suffer from the risk of being 'stuck in displacement', being unable to find or stalling in their search for durable solutions, with its related vulnerability risks." See: NRC and Samuel Hall, *Challenges of IDP protection in Afghanistan*, November 2012. See also: UNHCR & World Bank, *Vulnerability of Internally Displaced Persons in Urban Settings*, 2011. "The pace of urbanisation calls for new systems of land governance, particularly the regulation of informal settlements. However, the authorities have been reluctant to acknowledge informal settlements. The situation is compounded for the displaced whose right to choose their place of settlement has not been recognised. IDPs rarely wish to leave towns and cities where they are living, yet policy-makers fail to acknowledge the mobility of the Afghan population and continue to link long-term solutions to returning 'home.'" See: IDMC & NRC, *Still at Risk: Security of tenure and the forced eviction of IDPs and refugee returnees in urban Afghanistan*, February 2014.
110. From January to September 2016, UNHCR and partners have carried out focus group consultations with ca. 130,000 affected individuals (SADD data: 35,690 girls, 30,840 boys, 35,552 women, and 27,660 men) in 30 provinces.



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