United Nations CERF Central Emergency Response Fund

AFGHANISTAN
RAPID RESPONSE
POST-CONFLICT NEEDS
2021

21-RR-AFG-49422

Ramiz Alakbarov

Resident/Humanitarian Coordinator

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

PART I – ALLOCATION OVERVIEW

Reporting Process and Consultation Summary:	
Please indicate when the After-Action Review (AAR) was conducted and who participated.	17 May 2022

The After-Action Review took place on 17 May 2022 and was convened by the Health Cluster Coordinator. It featured the participation of UNICEF and WHO and drew on the inputs provided by implementing partners.

Please confirm that the report on the use of CERF funds was discussed with the Humanitarian and/or UN Country Team (HCT/UNCT).	Yes ☒ No ☐

N/A

Please confirm that the final version of this report was shared for review with in-country stakeholders (i.e. the CERF recipient agencies and their implementing partners, cluster/sector coordinators and members and relevant government counterparts)?	Yes ☒ No ☐

N/A

1. STRATEGIC PRIORITIZATION

Statement by the Resident/Humanitarian Coordinator

Central Emergency Response Fund Rapid Response (CERF RR) support under this allocation came at a critical time for the health sector in Afghanistan. Following the takeover of the country by the Taliban in August 2021, Afghanistan's health system faced the real risk of collapse given that it had been largely dependent on international funding channelled through mechanisms of the previous Government. In the absence of a re-establishment of funding mechanisms and donors' counter-terrorism measures, a freeze on the development funding which had largely propelled basic service delivery forced the health system to a halt. Almost all the life-saving humanitarian health and nutrition response had been delivered based on these basic health service structures. This timely CERF RR allocation enabled the Health Cluster through United Nations Children's Fund (UNICEF), World Health Organisation (WHO) and their implementing partners to maintain and sustain the continuity of the *Sehatmandi* public health service – the backbone of the Afghan national health system – for three months while longer term funding channels were identified. The efforts were successful, in that follow-on funding was initially secured for the April – June 2022 period which, in turn, enabled the preparation of an 18-month funding request for the programme from the World Bank-managed Afghanistan Reconstruction Trust Fund (ARTF).

CERF's Added Value

Through this CERF RR allocation of US$45 million, UNICEF, WHO and their implementing partners could sustain the provision of critical, life-saving medical services in 31 of 34 provinces of Afghanistan.

1. The allocation reduced the multiple negative effects resulting from the sudden pause in development funding to Afghanistan and allowed continuity of health services. Approximately 75 per cent of population indirectly benefited from this allocation through continuity of health services across the country, thereby preventing a humanitarian catastrophe while alternative, longer term solutions were found.
2. The allocation prevented worsening of morbidity and mortality by keeping 2,233 health facilities functioning.
3. The allocation strengthened localization in Afghanistan. Recognizing that Afghan entities are the primary health sector responders, UNICEF and WHO channelled about 64 per cent ($27,866,443) of response funds through Afghan non-government organizations (NNGO) and 22 per cent ($10,040,477) through international non-government organizations (INGOs).
4. The allocation strengthened health coordination mechanisms not only between the funding recipients and their implementing partners, but also between all health cluster members and other humanitarian actors.

Did CERF funds lead to a <u>fast delivery of assistance</u> to people in need?

Yes ☒ Partially ☐ No ☐

The proposal was quickly approved, and implementation started immediately. Timely CERF assistance allowed Health Cluster partners to rapidly provide healthcare and referral services to patients in 31 of 34 provinces of Afghanistan. Strong coordination and the established presence and acceptance of participating NNGOs facilitated the fast roll-out of the programme.

Did CERF funds help respond to <u>time-critical needs</u>?

Yes ☒ Partially ☐ No ☐

CERF assistance allowed Health Cluster partners to respond to the rapidly deteriorating health care situation brought about by the suspension of the *Sehatmandi* programme and other funding to Afghanistan. This included the support for the salaries of health-care workers to continue working and provide critical health services.

Did CERF improve coordination amongst the humanitarian community?

Yes ☒ Partially ☐ No ☐

The CERF allocation was coordinated by the Health Cluster. Implementing partners actively participated in cluster coordination meetings and activities at national and sub-national levels. Coordination was reinforced between UNICEF and WHO and *Sehatmandi* service providers, implementing partners and donors. Exceeding the proposed 10 planned coordination meetings, roughly 50 coordination meetings were held at all levels.

Did CERF funds help improve resource mobilization from other sources?

Yes ☒ Partially ☐ No ☐

The CERF allocation, and the continuation of health services by humanitarian actors, demonstrated that humanitarian financing and humanitarian response capacity were fundamental to the overall welfare of the country through the transition period and beyond. These demonstrated resulted catalysed other donors to contribute funding to the humanitarian health response and to the Humanitarian Response Plan (HRP) and September's Flash Appeal. This included raising additional funding to cover a continuation of the programme from April to June 2022 which, in turn, allowed for the development of an 18-month proposal submitted to the ARTF set to commence in July 2022.

The CERF allocation also provided a critical window for alternative funding and funding mechanisms to be identified to support longer term needs in Afghanistan, considering counter-terrorism financing measures in place.

Additionally, in November 2021, the Humanitarian Coordinator, through the Afghanistan Humanitarian Fund (AHF) launched a standard allocation of $112 million to cover multisectoral urgent needs. Within this allocation, $17.5 million was provided for urgent and life-saving health activities in addition to the CERF RR grant.

Considerations of the ERC's Underfunded Priority Areas[1]:

Women and girls:

WHO and UNICEF put in place several measures to improve outcomes for women and girls, including:

i) Third party monitoring (TPM) and UN agency monitoring staff including men and women to facilitate the organization of the visits, interaction and exchange of feedback with female beneficiaries (medical/paramedical staff and patients);

ii) The verification checklist covered gender-responsive programmes (e.g., maternal and child health), enabling monitoring of access and utilization of services;

iii) Hiring and retaining female health-care workers in health facilities supported under this programme.

The funded projects provided health care to 2,951,691 women and 4,025,637 girls.

Persons with disabilities:

[1] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

Under this allocation, WHO, UNICEF and their implementing partners addressed the health needs of people living with disability by securing the continuity of services related to mental health and psychosocial support. The allocation assisted 281,641 people living with disability. During the AAR, WHO highlighted the need to better serve people living with disability and other vulnerable and often excluded people, to improve their inclusion and access to dignified care within the health-care sector. WHO emphasized the importance of improving data collection, reporting and information sharing related to disability access and inclusion.

Protection:

Protection principles were actualized through risk-sensitive project design and the continued emphasis on meaningful access, safety, and dignity with implementing partners, beneficiaries and de facto authorities. This included enhancing the prevention and mitigation of protection risks and responding to protection needs by ensuring protective environments in the project locations and intended beneficiaries.

Referral pathways for the medical treatment (physical and psychological) of victims of gender-based violence (GBV) in conflict-impacted and underserved areas were established to provide physical and psychological health care at referral facilities. However, sensitive and confidential data on GBV case management was managed by standalone information management systems of individual organizations (UN and non-UN). In this regard, during the AAR, WHO noted the critical need for health partners to draw additional expertise from OCHA and inter-cluster mechanisms to address issues in GBV data management and referral pathways, including an improved information management system and reporting within the Health Cluster.

Education:

Health education and hygiene promotion were core components of activities funded by this allocation. Health-care workers provided information and educated patients regarding their health, and information and advice was provided to pregnant and lactating women (PLW), along with vaccination promotion and family planning information.

Table 1: Allocation Overview (US$)

Total amount required for the humanitarian response	**152,900,000**
CERF	45,000,000
Country-Based Pooled Fund (if applicable)	105,000,000
Other (bilateral/multilateral)	0
Total funding received for the humanitarian response (by source above)	**150,000,000**

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
UNICEF	21-RR-CEF-044	Health	21,924,000
WHO	21-RR-WHO-031	Health	23,076,000
Total			**45,000,000**

Table 3: Breakdown of CERF Funds by Type of Implementation Modality (US$)

GUIDANCE (delete when completed): The information is to be prepared by the **CERF focal point** based on agencies' inputs**.**

Total funds implemented directly by UN agencies including procurement of relief goods	**7,093,080**
Funds sub-granted to government partners*	0
Funds sub-granted to international NGO partners*	10,040,477
Funds sub-granted to national NGO partners*	27,866,443
Funds sub-granted to Red Cross/Red Crescent partners*	0
Total funds transferred to implementing partners (IP)*	**37,906,920**
Total	**45,000,000**

* Figures reported in table 3 are based on the project reports (part II, sections 1) and should be consistent with the sub-grants overview in the annex

NB: There is a small difference of 1$ due to the reduction of the decimals on the amount channelled through implementing partners.

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OPERATIONAL PRIORITIZATION:

Overview of the Humanitarian Situation:

At the time of this CERF allocation, the humanitarian needs in Afghanistan were enormous and increasing. There were concurrent emergencies due to different types of hazard: a violent conflict, large-scale displacement, a pandemic that continues to spread, and a major drought. At the start of 2021, 18.4 million people needed humanitarian assistance, the fourth largest number globally and a 32 per cent increase from 2020. This increase in humanitarian need was being complicated by a suspension of development funding for the *Sehatmandi* project. This was the backbone of the Afghan health system that supported over 2,331 health facilities across all 34 provinces of the country. The health cluster indicated that 90 per cent of these facilities would close unless urgent action was taken. The Afghan health system would collapse, and 20 years of progress would be lost. This would have a rippling effect on the availability of basic and essential health care, nutrition services, and the livelihoods of thousands of health care workers including community midwives and nurses. The *Sehatmandi* project provided both primary (Basic Package of health Services – BPHS) and secondary (Essential Package of Health Services – EPHS) health service packages. Service delivery was implemented by NGOs in 2,168 health facilities in 31 provinces whereas the remaining 163 facilities in three provinces were directly implemented by the Ministry of Public Health.

Operational Use of the CERF Allocation and Results:

Through this CERF RR allocation, UNICEF, WHO and their implementing partners could sustain the provision of critical life-saving medical services in 31 of 34 provinces of Afghanistan.

The grant reached 14,226,890 people (2,951,691 women, 2,946,764 men, 4,025,637 girls and 4,302,798 boys) including 281,641 people living with disability (58,433 women, 58,335 men, 79,693 girls and 85,180 boys).

By population profile, this grant assisted 285,967 internally displaced persons (IDPs) (59,331 women, 59,231 men, 80,917 girls and 86,488 boys) and 13,940,923 vulnerable people with humanitarian needs and shock-affected non-displaced people, including members of host communities (2,892,361 women, 2,946,764 men, 4,025,637 girls and 4,302,798 boys).

The grant enabled the following outcomes:

- Provision of medicine and medical supplies and regular and continuous functioning of 2,233 targeted health facilities.
- Payment of salaries to about 25,046 medical and paramedical health-care workers.
- Ensuring theoretical access to primary and secondary health care, comprising fixed and mobile health facilities, both at primary and secondary level, for nearly 30.3 million people, awareness campaign and health education activities.
- Enabling treatment of 14.2 million patients who received both inpatient and outpatient consultations between November 2021 and January 2022.

UNICEF funding of $21.9 million allowed 1,031 health facilities to keep functioning and provided more than 7,304,019 health-care consultations, provided antenatal care (ANC) to 446,733 pregnant women and vaccinated 137,023 children under age 1 with the PENTA 3 vaccine, while 560,000 children benefited from Growth Monitoring and Promotion (GMP) and Infant and Young Child Feeding (IYCF).

WHO funding of $23 million allowed 1,202 health facilities to keep functioning and provided 6,922,871 health-care consultations, adequately assisted the live births of 108,141 children, enabled access to ANC for 441,376 pregnant women, vaccinated 157,085 children under age 1 with the PENTA 3 vaccine, while 862,256 children benefited from GMP and IYCF.

The project contributed to preventing worsening morbidity and mortality by ensuring provision of BPHS/EPHS in provinces under its operation.

People Directly Reached:

This allocation was implemented by WHO, UNICEF and their implementing partners. Its main aim was to avoid the collapse of the *Sehatmandi* health system in Afghanistan. The two agencies carried out their respective projects with similar activities, each in different parts of the country. The allocation directly reached 14.2 million people who accessed in- and outpatient services.

Implementation of the project took place based on a geographic division of responsibility whereby WHO and UNICEF each ensured the continued operation of health facilities under the *Sehatmandi* programme in approximately half of the country's provinces. This avoided duplication and double-counting of beneficiaries while ensuring the provision of comparable services.

People Indirectly Reached:

The project enabled the continued operation of health facilities in 31 provinces of Afghanistan. The indirect beneficiaries, therefore, are those living in the catchment of the health facilities and who benefited from the availability of health care and referral services.

Table 4: Number of People Directly Assisted with CERF Funding by Sector/Cluster*

	Planned					Reached				
Sector/ Cluster	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
HEALTH	10,203,408	7,412,732	5,726,699	5,729,107	**29,071,946**	2,951,691	2,946,764	4,025,637	4,302,798	14,226,890

Table 5: Total Number of People Directly Assisted with CERF Funding by Category*

Category	Planned	Reached
Refugees	0	0
Returnees	0	0
Internally displaced people	583,798	285,967
Host communities	28,488,148	13,940,923
Other affected people	0	0
Total	**29,071,946**	**14,226,890**

Table 6: Total Number of People Directly Assisted with CERF Funding*

			Number of people with disabilities (PwD) out of the total	
Sex & Age	Planned	Reached	Planned	Reached
Women	10,203,408	2,951,691	203,486	58,433
Men	7,412,732	2,946,764	145,348	58,335
Girls	5,726,699	4,025,637	116,278	79,693
Boys	5,729,107	4,302,798	116,278	85,180
Total	**29,071,946**	**14,226,890**	**581,390**	**281,641**

Note on methodological discrepancy in the targeting and reporting approach:

During the application stage, the total number of targeted people (29,071,946) was determined to be the number of people with theoretical access to primary and secondary health care services. Accordingly, the total number of people targeted by each agency was set as equal to the total population in each agency's respective catchment area (12,043,528 for UNICEF; 17,028,418 for WHO). However, independent of whether it is at the targeting or reporting stage, the totals and disaggregations for people targeted/reached in CERF documents are supposed to provide an overview of only those who directly benefitted from CERF-funded programming. People with theoretical access to services should, by the same logic, be counted as indirectly reached.

The error made by the CERF secretariat during the application stage to accept target figures that included both directly and indirectly targeted people was only discovered at the reporting stage, and, after consultations internally and with OCHA Afghanistan, the decision was made to not attempt to retroactively revise target figures and to instead include a clarifying note.

At the same time, for directly reached people, CERF reverted to only counting those who were directly reached through CERF-funded services. For this allocation, the total number of people reached is the sum of people reached by UNICEF and WHO through in- and outpatient consultations respectively, given that there was no geographic overlap in target areas.

Note on Age Disaggregation:

CERF requires all funds-receiving agencies to disaggregate people targeted/reached by sex and age. For age disaggregations, CERF considers people over the age of 18 as either women or men, and people under the age of 18 as either girls or boys. That

said, for this report, both UNICEF and WHO provided figures for directly reached people that disaggregate based on a different age separator by which all people over the age of 5 are considered adults and all people under the age of 5 children. As both agencies clarified, the source of information used for reporting – HMIS/ DHIS II – only provides break downs by under 5 and over 5 for relevant indicators and does not provide disaggregation by under and over 18.

To ensure consistency with other CERF data, the information provided by agencies was cross-referenced with demographic data from the National Statistics and Information Authority (NSIA) report titled “Estimated Population of Afghanistan 202-21” to calculate estimates for people reached under/over the age of 18 respectively.

PART II – PROJECT OVERVIEW

2. PROJECT REPORTS

2.1. Project Report 21-RR-CEF-044

1. Project Information					
Agency:	UNICEF		**Country:**	Afghanistan	
Sector/cluster:	Health		**CERF project code:**	21-RR-CEF-044	
Project title:	Health Emergency Response to ensure life-saving primary and secondary healthcare services				
Start date:	15/10/2021		**End date:**	14/04/2022	
Project revisions:	No-cost extension ☐		Redeployment of funds ☐	Reprogramming ☐	

Funding		
Funding	**Total requirement for agency's sector response to current emergency:**	**US$ 114,457,083**
	Total funding received for agency's sector response to current emergency:	**US$ 20,986,303**
	Amount received from CERF:	**US$ 21,924,000**
	Total CERF funds sub-granted to implementing partners:	**$18,327,611**
	Government Partners	$0
	International NGOs	$1,693,041
	National NGOs	$16,634,570
	Red Cross/Crescent Organisation	$0

2. Project Results Summary/Overall Performance

With financial support from CERF, UNICEF and its implementing partners provided life-saving primary and secondary health-care services to 7,304,019 people (2,944,030 women, 1,773,004 men, 1,281,655 girls and 1,305,330 boys) at 1,031 BPHS/EPHS in 15 provinces. A total 11,046 health-care workers were paid and supported, health supplies and equipment were procured and supplied, and the community benefited from health and nutrition education and hygiene promotion.

A total population of 12,043,528 people are estimated to have indirectly benefitted from the project, mainly through health promotion/awareness raising provided by health-care workers, community health-care workers, and social mobilizers.

Between November 2021 and January 2022, 446,733 pregnant women received ANC services, 97,196 women delivered babies at hospitals, 137,023 children received PENTA vaccines, and 130,370 women and children received IYCF and GMP.

3. Changes and Amendments

No major programmatic changes were recorded during the project period. Variances specific to the indicators are explained and reported later in the report.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
Category	Planned					Reached				
	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	96,329	120,411	12,041	14,449	**243,230**	30,604	30,553	41,739	44,613	**147,510**
Host communities	4,130,104	2,950,074	2,360,060	2,360,060	**11,800,298**	1,484,780	1,482,302	2,025,004	2,164,424	**7,156,509**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**4,226,433**	**3,070,485**	**2,372,101**	**2,374,509**	**12,043,528**	1,515,384	1,512,855	2,066,743	2,209,037	**7,304,019**
People with disabilities (PwD) out of the total										
	84,287	60,205	48,164	48,164	**240,820**	29,707	29,657	40,516	43,305	**143,185**

5. People Indirectly Targeted by the Project

The total eligible population estimated to live in the catchment area is set at 12,043,528 people. This population is estimated to have benefitted from the project, mainly through health promotion/awareness raising provided by 11,046 health-care workers (gender disaggregation not available through service providers), 13,465 (7,319 male and 6,146 female) community health workers, and social mobilizers (total number not available) supported.

6. CERF Results Framework

Project objective	To reduce excess morbidity and mortality by keeping health facilities financed by the Sehatmandi project operational
Output 1	Populations have access to curative and preventative BPHS and EPHS health care services

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☐

Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of provinces with signed NGO contracts	15	15	Signed humanitarian programme documents (i.e. agreements) between UNICEF and partners
Indicator 1.2	H.7 Number of functional health facilities supported	1,038	1,031	DHIS 2
Indicator 1.3	Number of healthcare consultations provided	12,043,528	7,304,019 **Note:** At the time of submission and approval of the CERF project proposal, the total number of populations residing in the target provinces (geographic coverage) was used as a proxy target to measure and monitor medical consultations (coverage). Given that the total population cannot be expected to directly receive health services within the project period, the target here does not necessarily present a useful baseline for comparison, and the comparatively lower achievement does not necessarily constitute an underachievement.	DHIS 2
Indicator 1.4	RH.1 Number of live births assisted by a skilled health personnel	95,000	97,196 (102 per cent achieved)	DHIS 2
Indicator 1.5	Number of pregnant women who receive ANC	295,000	446,733 (151 per cent achieved)	DHIS 2

Indicator 1.6	H.4 Number of people vaccinated (children under 1 who receive PENTA 3)	195,000	137,023 (70 per cent achieved)	DHIS 2
Indicator 1.7	Number of children who benefit from Growth Monitoring and Promotion (GMP) and Infant & Young Child Feeding (IYCF through Pregnant and Lactating Women (PLWs)	560,000	130,370 people (893,063 sessions) **Note:** The agency clarified that the indicator target (560,000) errantly refers to sessions, not targeted children. In this context, the agency overachieved as more sessions were held than initially planned.	DHIS 2
Indicator 1.8	Number of coordination meetings held	10 (revised 40)	50 (5 national, 3 X 15 = 45 provincial level)	Project reports
Explanation of output and indicators variance:		• Number of functional health facilities supported –1,038 vs 1,031 (Reason – some Mobile Health and Nutrition Teams (MHNT) included in the original figure of 1,038, resulted to not be active as they had previously been managed by the Ministry of Public Health (MoPH) and ceased operations, thus final target BPHS/EPHS facilities registered was 1,031 instead of 1,038) • Number of health-care consultations provided – see note in the Achieved section of Indicator 1.3 (indicator target = total population; not a realistic baseline for comparison) • Number of pregnant women who receive – 152 per cent achievement (Reason – overachieved mainly as those who would normally visit private clinics, could no longer afford to pay for ANC services and resorted to the use of public facilities) • Number of people vaccinated (children under 1 who receive PENTA 3) – 71 per cent achievement (Reason – Unoptimized outreach, low priority for preventable immunization service due to increased economic constraints for access to health facilities) • Number of children who benefit from GMP and IYCF 23 per cent achievement (Reason – The target of 560,000 was incorrectly set as it did not capture the number of children benefitting, as per the description, but rather the number of sessions provided).		

Activities	**Description**	**Implemented by**
Activity 1.1	Finalize the operational structure and financing mechanisms to support project management, contract management, implementation, monitoring, risk management and accountability to affected populations	UNICEF staff
Activity 1.2	Contract NGOs in target provinces to deliver BPHS and EPHS services	UNICEF staff
Activity 1.3	Deliver BPHS and EPHS services	Service providers (NGOs)
Activity 1.4	Monitor the services contracted-out at health facility level	UNICEF staff, UNICEF Health and Nutrition extenders
Activity 1.5	Conduct coordination and review meetings	UNICEF staff

7. Effective Programming

a. Accountability to Affected People (AAP) [2]:

Consultative inputs were provided by implementing partners, UNICEF field offices, Health Cluster partners and the MoPH on priority health needs of community members. The inputs reflected the urgent needs of people affected by political changes and increased economic constraints. The health facilities supported through CERF funding were closely monitored by the MoPH and Provincial Health Directorates, community health councils, civil society organizations and organizations of vulnerable groups to ensure quality and equitable access of health services to all. Access to health services for women and girls, and the presence of female health-care workers were closely monitored by all stakeholders involved in this project.

b. AAP Feedback and Complaint Mechanisms:

UNICEF received community feedback through Provincial Health Coordination Committees and the Health Cluster. UNICEF also used Awaaz, an inter-agency information and accountability center, which functions as a whole-of-response collective accountability and community engagement AAP tool (and which is a channel to provide complaints and feedback in a safe manner) as its feedback and complaints mechanism for this project. No critical complaints were reported, while all feedback was examined and jointly reflected for progress through consultations with partners.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

During the project implementation, UNICEF actively participated in the PSEA Inter-Agency Task Force and conducted capacity development sessions for implementing partners in line with its policy and guidelines. UNICEF ensured all implementing partners involved in this project were briefed and had a valid PSEA policy in their organization.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

In this project UNICEF closely monitored and ensured the presence of at least one female health-care worker in health facilities and monitored the ease access of the women and girls to health facilities. During the project period, while implementing partners reported challenges with the recruitment of female staff to fill many vacancies, female health-care workers could be present at work and generally available.

e. Persons with disabilities:

Under this project all target facilities facilitated mobility for people living with disability and promoted their access to services provided throughout the project implementation. Female health staff in the targeted health facilities facilitated access to services for women and girls with disabilities.

f. Protection:

In this project UNICEF strengthened the referral pathway for GBV survivors from communities to the nearest health facilities to access protection and necessary psychosocial support by linking UNICEF-supported MHNTs and community health workers, and through multisectoral programme platforms (e.g., child protection, nutrition, health, WASH).

g. Education:

As a component of the BPHS/EPHS, UNICEF closely monitored implementing partners to ensure health, nutrition and hygiene education and promotion at all BPHS/EPHS facilities were provided through group counselling and via outreach to encourage health-seeking

[2] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

behaviours. This included ANC and post-natal advice for PLW, immunization, family planning, nutrition, and mental health care. Hygiene promotion sessions were conducted at community level through community health workers that mitigated the spread of COVID-19.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?		
Planned	**Achieved**	**Total number of people receiving cash assistance:**
No	No	N/A
If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible. If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.		
N/A		

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Guidance (to be deleted): Please list weblinks to publicly available social media posts (Twitter, Facebook, Instagram, etc.), videos and/or success stories, evaluations or other kind of reports on the agency's websites covering CERF-funded activities under this project.

Title	**Weblink**
Press Release	https://www.unicef.org/afghanistan/press-releases/rising-health-risks-children-across-afghanistan-disruption-health-and-nutrition
Social Media Post	Twitter: https://t.co/HnKjsrXbMU FB: https://www.facebook.com/afghanistanunicef/posts/5408895255806314 Instagram: https://www.instagram.com/p/CYA1iv-IEVl/
Web Story (Nutrition)	https://www.unicef.org/afghanistan/stories/life-after-severe-acute-malnutrition https://www.unicef.org/afghanistan/stories/parwanas-journey-recovery-severe-acute-malnutrition

2.2. Project Report 21-RR-WHO-031

1. Project Information					
Agency:	WHO		**Country:**	Afghanistan	
Sector/cluster:	Health		**CERF project code:**	21-RR-WHO-031	
Project title:	Health Emergency Response to ensure life-saving primary and secondary healthcare services				
Start date:	22/10/2021		**End date:**	21/04/2022	
Project revisions:	No-cost extension ☐		Redeployment of funds ☐	Reprogramming ☐	

Funding		
	Total requirement for agency's sector response to current emergency:	**US$ 38,450,000**
	Total funding received for agency's sector response to current emergency:	**US$ 2,443,496**
	Amount received from CERF:	**US$ 23,076,000**
	Total CERF funds sub-granted to implementing partners:	**US$ 19,579,308**
	Government Partners	US$ 0
	International NGOs	US$ 8,347,435
	National NGOs	US$ 11,231,873
	Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through this project, WHO and its implementing partners contributed to maintain the continuity of the *Sehatmandi* public health service programme, the backbone of the Afghan national health system, following the political shift of August 2021.

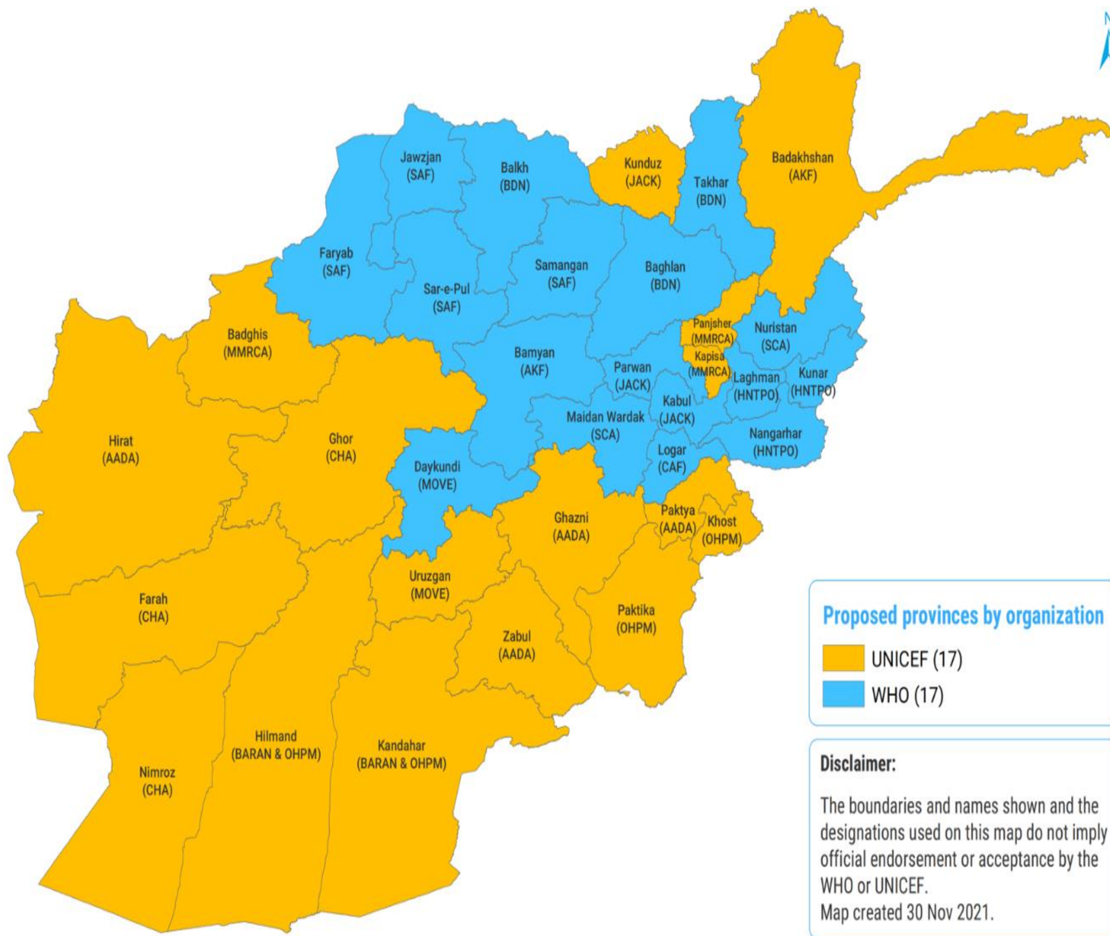
Within the CERF allocation, WHO and UNICEF coordinated their projects by splitting the geographic area, with UNICEF providing assistance in 15 provinces and WHO providing assistance in 16 provinces (+ an additional province with WHO-internal funding). Ergo, CERF-funds enabled the two agencies to provide assistance in 31 out of 34 total provinces in the country. The geographic focus was informed by context-related and capacity-related factors, including – but not limited to: (i) urgency to activate the response and avoid the risk of a major humanitarian downfall and further deterioration of the health system heavily impacted by the pandemic; (ii) newly emerging health and humanitarian needs; (iii) existing operational capacity of WHO and UNICEF to scale up, including availability of *Sehatmandi* partners in situ.

Combined, the 17 provinces receiving WHO's support (16 via CERF and 1 via WHO-internal funds) have the largest populations in the country (rural and urban), including Kabul and other major provinces. Linked to this, WHO extended its operational response not only to primary care units and facilities, but also to the largest hospitals defined by capacity (number of beds), coverage of outpatient and inpatient consultations, size of the facility, access and population coverage.

In the implementation period, WHO supported:

- 1,202 health facilities (52 per cent of *Sehatmandi* facilities) provided with medicines, medical supplies and salaries for about 14,000 health workers (medical and paramedical);
- 23 million people (55 per cent total Afghan population across the country) indirectly benefitting by gaining or sustaining access to primary and secondary health care, comprising fixed and mobile health facilities, both at primary and secondary level;
- 6.9 million people received medical services – both inpatient and outpatient consultations, between November 2021 and January 2022, exceeding the planned quarterly target under the CERF-funded project. Up to 74 per cent of patients accessing medical consultations were female, specifically: women (4.1 million) and girls (997,000);
- Prevented the closure of functional/semi-functional health facilities and avoided decrease in access and utilization of services, increasing positive trends registered under *Sehatmandi* prior to August 2021 (see charts on service coverage).

Note: While the below graphic shows an even split of all provinces between UNICEF and WHO, for the CERF allocation, it was ultimately agreed that UNICEF would cover 15 provinces and that WHO would cover 16 provinces.



No.	Provinces	Total population (UN data)
1	Baghlan	1,348,763
2	Balkh	2,006,175
3	Bamyan	658,750
4	Dykundi	686,593
5	Faryab	1,474,502
6	Jawzjan	800,355
7	Kabul	6,918,624
8	Kunar	663,847
9	Laghman	655,998
10	Logar	577,418
11	Nangarhar	2,262,084
12	Nooristan	217,760
13	Parwan	980,635
14	Samangan	572,253
15	Sar-e-Pul	825,504
16	Takhar	1,453,059
17	Wardak	877,687
	Total	22,980,008

Table 1: Detailed breakdown by province of the total population covered by WHO within the Sehatmandi programme during the reporting period. Source: UN Afghanistan (the table is a WHO re-elaboration)

Outpatient consultations- new cases					
Data / Period	Nov-21	Dec-21	Jan-22	Total (CERF Period)	<5 and >5 client/patient
Patients/Clients <5 yrs, Female	313,190	346,805	336,818	996,813	2,029,388
Patients/Clients <5 yrs, Male	329,266	356,085	347,224	1,032,575	
Patients/Clients >=5 yrs, Female	947,657	1,123,664	1,101,269	3,172,590	4,893,483
Patients/Clients >=5 yrs, Male	501,313	598,672	620,908	1,720,893	
Total Client/Patient	2,091,426	2,425,226	2,406,219		**6,922,871**

Outpatient consultations, re-attendance				
Data / Period	Nov-21	Dec-21	Jan-22	Total
Patients/Clients Re-attendance	341,782	391,348	430,662	**1,163,792**
Patients/Clients Referred-In	30,836	37,593	39,514	**107,943**
Patients/Clients Referred-Out	11,795	12,793	13,538	**1,271,735**

For further context on age and gender disaggregations, please see the **Note on Age Disaggregatio**n on p. 19

3. Changes and Amendments

The project was implemented as per the original approved plan.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
	Planned					**Reached**				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	136,227	170,285	17,028	17,028	**340,568**	28,726	28,678	39,178	41,875	**138,457**
Host communities	5,840,748	4,171,962	3,337,570	3,337,570	**16,687,850**	1,407,580	1,405,231	1,919,716	2,051,887	**6,784,414**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**5,976,975**	**4,342,247**	**3,354,598**	**3,354,598**	**17,028,418**	**1,436,307**	**1,433,909**	**1,958,894**	**2,093,762**	**6,922,871**
People with disabilities (PwD) out of the total										
	119,199	85,143	68,114	68,114	**340,570**	28,726	28,678	39,178	41,875	**138,457**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

Indirect beneficiaries include communities in 17 provinces with a population of 22.9 million people that were not targeted directly by this project. They benefited from available health-care services and referral services.

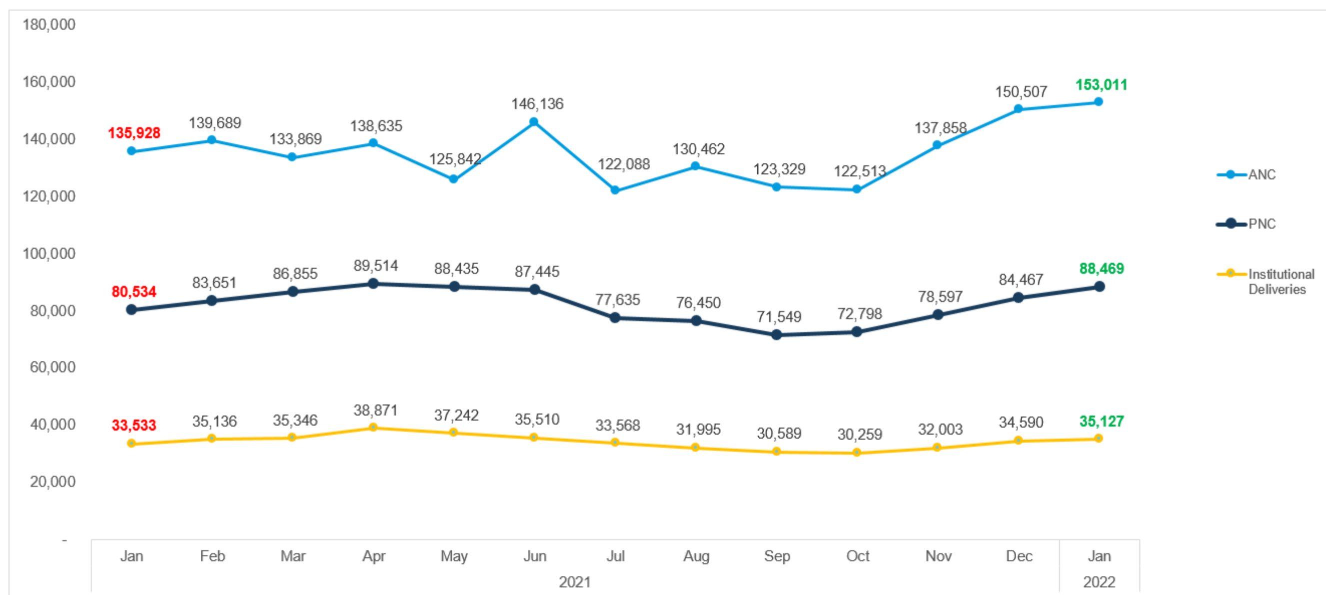
6. CERF Results Framework

Project objective	To reduce excess morbidity and mortality by keeping health facilities financed by the Sehatmandi project operational

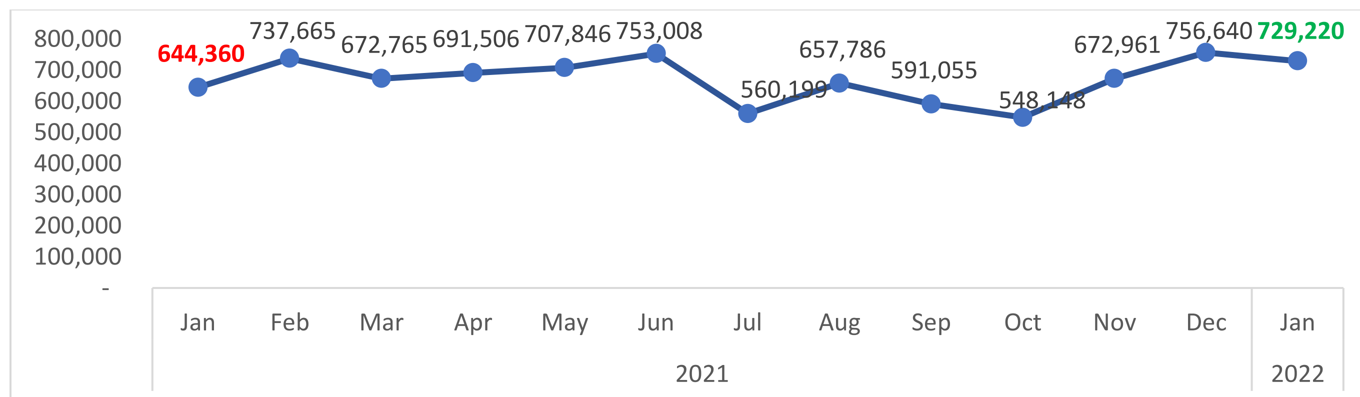
Output 1	Populations have access to curative and preventative BPHS and EPHS health care services			
Was the planned output changed through a reprogramming after the application stage? Yes ☒ No ☒				
Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of provinces with signed NGO contracts	16	16	Contractual documents, Health facility performance monitoring checklist, monitoring report, TPM report, field visits. **Note:** 16 provinces covered with CERF funding and 1 province (Parwan) supported by WHO with its own direct resources. The takeover of the *Sehatmandi* programme based on geographic focus coherent with this approach, and with the aim of providing the complete analysis of the impact generated within the *Sehatmandi* programme, WHO is presenting service coverage results from all 17 provinces.
Indicator 1.2	H.7 Number of functional health facilities supported	1,130	1,202	Health facility performance monitoring checklist, monitoring report, TPM report, field visits
Indicator 1.3	Number of healthcare consultations provided	17,028,418	6,922,871	Health Management Information System (HMIS), monthly reports, end of project reports **Note:** At the time of submission and approval of the CERF project proposal, the total number of populations residing in the target provinces (geographic coverage) was used as a proxy target to measure and monitor medical consultations (programme coverage). Given that the total population cannot be expected to directly receive health services within the project period, the target here does not necessarily present a useful baseline for comparison, and the comparatively lower achievement does not necessarily constitute an underachievement. In fact, in consideration of a) the trends of BPHS/EPHS recorded through DHIS2 in 2021 (prior to the events leading to the political shift in August of the same year); and b) the time period of delivery which CERF funds contributed to (November 2021 – January 2022), the total number of recorded consultations exceeds the projected average quarterly trends of service coverage.
Indicator 1.4	RH.1 Number of live births assisted by a skilled health personnel	105,000	108,141	HMIS, monthly reports, end of project reports.

				Note: The final cumulative result includes normal and assisted deliveries.
Indicator 1.5	Number of pregnant women who receive ANC	345.000	441,376	HMIS, monthly reports, end of project reports.
Indicator 1.6	H.4 Number of people vaccinated (children under 1 who receive PENTA 3)	171,000	157,085	HMIS, monthly reports, end of project reports.
Indicator 1.7	Number of children who benefit from Growth Monitoring and Promotion (GMP) and Infant & Young Child Feeding (IYCF) through Pregnant and Lactating Women (PLWs)	540,000	862,256	HMIS, monthly reports, end of project reports.
Indicator 1.8	Number of coordination meetings held	WHO: 10	+30	Meeting reports (WHO-UNICEF, WHO-Health Cluster, WHO and *Sehatmandi* service providers, WHO-donor partners).
Explanation of output and indicators variance:		In the light of increased vulnerability of the people especially in the areas of reproductive, maternal and child health, the activities were able to expand the services to more beneficiaries to address their emerging needs. Accordingly, the number of beneficiaries benefitted from health-care services (indicator 1.5, 1.6 and 1.7) has increased.		

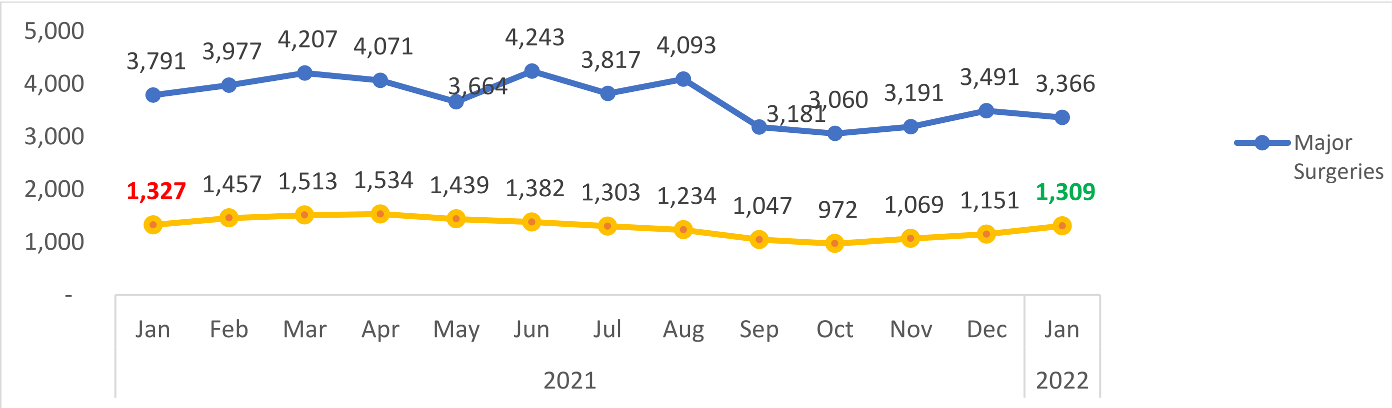
Activities	**Description**	**Implemented by**
Activity 1.1	Finalize the operational structure and financing mechanisms to support project management, contract management, implementation, monitoring, risk management and accountability to affected populations	WHO in partnership with UNICEF
Activity 1.2	Contract NGOs in target provinces to deliver BPHS and EPHS services	WHO in coordination with the NGO partners
Activity 1.3	Deliver BPHS and EPHS services	WHO NGOs in coordination with health authorities (local and central level) as well as Health Cluster.
Activity 1.4	Monitor the services contracted-out at health facility level	1. WHO (17 M&E field officers) with the operational support from Kabul office and 5 regional sub-offices; 2. WHO-contracted TPM.
Activity 1.5	Conduct coordination and review meetings	WHO in partnership with UNICEF



WHO Afghanistan, *Sehatmandi* programme, CERF-funded interventions. Trends overview of ANC, postnatal care consultations and institutional deliveries supported within the CERF-funded project [Nov 21-Jan 22], versus previous trends of programme coverage for the same type of services.



WHO Afghanistan, *Sehatmandi* programme, CERF-funded interventions. Trends overview of child morbidity-related services supported within the CERF-funded project [Nov 21-Jan 22], versus previous trends of programme coverage for the same type of health-care services.



5,000
4,000
3,000
2,000
1,000
-
3,791
3,977
4,207
4,071
3,664
4,243
3,817
4,093
3,181
3,060
3,191
3,491
3,366
1,327
1,457
1,513
1,534
1,439
1,382
1,303
1,234
1,047
972
1,069
1,151
1,309
Jan
Feb
Mar
Apr
May
Jun
Jul
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Nov
Dec
Jan
2021
2022
Major Surgeries

-

7. Effective Programming

a. Accountability to Affected People (AAP) [3]:

Design stage: The planned activities under the WHO project were based on gaps identified by the WHO team in situ, in close collaboration with *Sehatmandi* service providers, Health Cluster and the Humanitarian Country Team. It is important to note that WHO's partners contracted within the CERF project were *Sehatmandi* partners prior to August 2021, thus holding long-term experience and local knowledge where the health facilities operate.

Implementation and monitoring: WHO carried out regular and systematic monitoring of health facilities to ensure performance and quality of services and to remain accountable to people seeking health care, from district to provincial level. AAP was promoted and preserved through the following mechanisms which WHO has extended to the subsequent phase of the *Sehatmandi* programme in 2022 (with funding support from the ARTF):

1: Service provider monitoring and reporting

- Monthly technical and financial reports from NGOs
- End-of-project technical and financial report from NGOs
- Monitoring health facility functionality in each province
- NGO monthly reporting to HMIS/MoPH using existing tools (in place prior to August 2021)

2: WHO visit every health facility for performance monitoring against 63 indicators.

3: Third Party Monitoring report

Illustrative examples of how beneficiaries' participation is embedded in the project design include:

1. The needs and requirements of medicines, medical supplies, fuel, and other items are identified jointly with the health facilities staff, also factoring in the types of consultations and health needs, including specific winter-related needs.

2. The need to sustain the target hospitals and health facilities and information from the BPHS/EPHS service providers as well as the needs presented by the health staff (different cadres) was heavily conveyed. The project also factored in the feedback that medical and paramedical staff provided to WHO TPM during exit interviews regarding the most urgent needs of the health facilities, quality and stock of medicines needed, the need to improve pre-positioning, and contingency planning of essential items.

b. AAP Feedback and Complaint Mechanisms:

WHO has its own feedback and complaints mechanism to ensure feedback or complaints are dealt with full confidentiality. Regular meetings were held with BPHS/EPHS service provider NGOs to address issues arising in health-care facilities, to address community needs and health-care worker needs.

[3] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

The period of implementation financed by CERF provided the opportunity to gather evidence across different levels of care to address structural and operational needs in 2022. Building on the feedback and needs emerging between November 2021 and January 2022, WHO supported the rehabilitation of EPHS facilities within the second phase of the *Sehatmandi* support (from February to June 2022).

c. Prevention of Sexual Exploitation and Abuse (PSEA):

WHO is committed to creating and maintaining a safe environment free from physical harassment, sexual harassment, abuse, and discrimination for its staff and beneficiaries. WHO has a clear policy of zero-tolerance of sexual exploitation and abuse.

Considering the gender-based disparity in access to health services for women and girls, the project ensured that all services were available to all strata of population in the targeted communities. WHO is an active member of the PSEA Inter-Agency Task Force within the UN and has conducted capacity building sessions for WHO staff and health-care workers and all implementing partners (NGOs and suppliers) of this project to ensure that they clearly understand how PSEA policies are developed and used in their organizations.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

WHO remains committed to inclusivity, gender and rights mainstreaming, from the planning stage to the monitoring and evaluation of the results achieved through the provision of essential care. WHO operates according to the "do no harm" principle and has zero tolerance towards Sexual Exploitation, Abuse and Harassment.

Building on these pre-conditions, WHO put in place the following risk mitigation measures during the reporting period and thanks to the generous support from CERF: i) TPM and WHO monitoring staff comprise both men and women to facilitate the organization of the visits, interaction and exchange of feedback with female beneficiaries (medical/paramedical staff and patients); ii) the verification checklist covers gender-responsive programmes (e.g., maternal and child health), thus enabling WHO and its partners to monitor data related to access and utilization of services; iii) WHO has requested the TPM to include the indicator "BPHS and EPHS for facilities with at least one female health worker"-the evidence generated through this indicator remains a critical point of information to identify issues of retention and protection of the female healthcare workers.

The focus of the BPHS and EPHS was intended to provide services to the entire communities, with a specific focus on women and girls with a two-fold objective: 1) Addressing essential care needs of women and girls in areas where inequity to access and protection remain major barriers to health care seeking; 2) respond to child survival starting from the health of mothers and caregivers.

As indicated in the previous sections of this report, WHO – in collaboration with its partners – secured the job retention of over 4,700 female health workers at a critical time of organizational and institutional transition (up to 34 per cent of the total 14,000 health workers who received their salaries during the reporting period). The retention of female staff at the health facilities contributed to preserve safe space for women and girls to continue seeking for health care, both at primary and secondary level of care.

Medical supplies and medicines procured as part of the CERF-funded project comprise supplies equally addressed the needs of men and women. WHO ensured that supported health facilities would prioritize the privacy and dignity of different age and gender groups not only in terms of provision of P/SHC, but also in terms of access and use of the health facilities' spaces. In this regard, WHO ensured its *Sehatmandi* implementing partners would maintain in place waiting room areas for mothers and other caregivers and would take required action to have gender-responsive WASH services (e.g., separate toilets including locking doors).

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e. Persons with disabilities:

During the AAR, WHO highlighted the need to better serve people living with disability and other vulnerable and often excluded people, to improve their inclusion and access to dignified care within the health-care sector. WHO emphasized the importance of improving data collection, reporting and information sharing related to disability access and inclusion within the Health Cluster, building on existing mechanisms such as the ReportHub platform[4]

f. Protection:

WHO is committed and accountable to its beneficiaries to ensure that they are treated with dignity and respect by affording a safe environment free of harassment, abuse, and discrimination. This is being done by incorporating protection principles in all its activities and promoting meaningful access, safety, and dignity in humanitarian aid. This includes enhancing the prevention and mitigation of protection risks and responding to protection needs by ensuring protective environments in the project locations and targets.

Referral pathways for the medical treatment (physical and psychological) of victims of gender-based violence (GBV) in conflict-impacted and underserved areas were established to provide physical and psychological health care at referral facilities. However, sensitive and confidential data on GBV case management was managed by standalone information management systems of individual organizations (UN and non-UN). In this regard, during the AAR, WHO noted the critical need for health partners to draw additional expertise from OCHA and inter-cluster mechanisms to address issues in GBV data management and referral pathways, including an improved information management system and reporting within the Health Cluster.

Within the CERF-funded project, WHO addressed mental health needs by securing the continuity of services related to mental health and psychosocial support. The number of people seeking health support related to mental health disorders highlights how mental health care remains an urgent need in Afghanistan for men, women, boys and girls, including people living with disability and older people. The summary table below provides the cumulative number of outpatient consultations registered during the project reporting period (November 2021 to January 2022) across all WHO 17 target provinces. Women and girls remain the largest group seeking mental health support (60 per cent of total consultations). Most people seeking mental health support did so at the BPHS level (5.3 out of 6.9 million consultations, or 77 per cent).

Age and gender	<5 yrs, Female	<5 yrs, Male	>=5 yrs, Female	>=5 yrs, Male	**Total**
Total number	996,813	1,032,575	3,172,590	1,720,893	**6,922,871**
% against the total concerned population	14%	15%	46%	25%	

g. Education:

Health education and hygiene promotion were key components of the project. Health-care personnel educated patients regarding health seeking behaviour, as well and health and hygiene promotion, ANC for breastfeeding women, vaccination and family planning.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?		
Planned	**Achieved**	**Total number of people receiving cash assistance:**

[4] The ReportHub platform also collects information on services to beneficiaries that feature figures on people living with disability. When reporting, partners can select and identify beneficiaries with disability. Source: Afghanistan Humanitarian Response Plan (HRP) for 2022, section on Health Cluster (page 65).

No	Choose an item.	[Fill in]

If no, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

CVA was not assessed as a feasible modality given the allocation focus on sustaining provision of medical services in health facilities.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
WHO Afghanistan: Emergency Situation Report, 15 January 2022	http://www.emro.who.int/images/stories/afghanistan/WHO_AFG_EMERGENCY-SITUATION-REPORT__15_Jan._2022.pdf
WHO Afghanistan: Emergency Situation Report, 31 January 2022	http://www.emro.who.int/images/stories/afghanistan/AFG_WHO_EMERGENCY-SITUATION-REPORT_Jan-31-2022.pdf
WHO Afghanistan: Emergency Situation Report, 15 February 2022	http://www.emro.who.int/images/stories/afghanistan/AFG_WHO_EMERGENCY-SITUATION-REPORT_Fab-15-2022.pdf
WHO Afghanistan: Emergency Situation Report, 28 February 2022	http://www.emro.who.int/images/stories/afghanistan/AFG_WHO_EMERGENCY-SITUATION-REPORT-13-2022-February_28.pdf?ua=1
WHO Afghanistan: Emergency Situation Report, 15 March 2022	http://www.emro.who.int/images/stories/afghanistan/AFG_WHO_EMERGENCY_SITUATION_REPORT_14-March_2022.pdf
WHO Afghanistan Facebook Sehatmandi video	https://www.facebook.com/WHOAfghanistan/videos/511927060552915
WHO Afghanistan Facebook Sehatmandi	https://www.facebook.com/WHOAfghanistan/posts/4762502567201223

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Implementing Partner Name		Sub-grant made under pre-existing partnership agreement	Partner Type	Total CERF Funds Transferred to Partner US$
			Extended Name	Acronym			
21-RR-CEF-044	Health	UNICEF	Agency for Assistance and Development of Afghanistan	AADA	No	NNGO	$5,856,238
21-RR-CEF-044	Health	UNICEF	Aga Khan Foundation	AKF	No	INGO	$1,686,365
21-RR-CEF-044	Health	UNICEF	Bu Ali Rehabilitation and Aid Network	BARAN	No	NNGO	$2,829,522
21-RR-CEF-044	Health	UNICEF	Organization for Health Promotion & Management	OHPM	No	NNGO	$1,695,363
21-RR-CEF-044	Health	UNICEF	Just for Afghan Capacity and Knowledge	JACK	No	NNGO	$1,129,107
21-RR-CEF-044	Health	UNICEF	MOVE Organization	MOVE	No	NNGO	$1,105,823
21-RR-CEF-044	Health	UNICEF	Medical Management and Research Course for Afghanistan	MMRCA	No	NNGO	$966,703
21-RR-CEF-044	Health	UNICEF	Coordination of Humanitarian Assistance	CHA	No	NNGO	$2,958,952
21-RR-CEF-044	Health	UNICEF	Coordination of Humanitarian Assistance	BDN	No	NNGO	$92,862
21-RR-CEF-044	Health	UNICEF	Coordination of Humanitarian Assistance	HNTPO	No	INGO	$6,677
21-RR-WHO-031	Health	WHO	Aga Khan Foundation	AKF	Yes	INGO	$911,752
21-RR-WHO-031	Health	WHO	Bakh Development Network	BDN	Yes	NNGO	$4,366,458
21-RR-WHO-031	Health	WHO	Care of Afghan Families		Yes	NNGO	$1,679,552
21-RR-WHO-031	Health	WHO	Health Net TPO		Yes	INGO	$5,296,006
21-RR-WHO-031	Health	WHO	Just for Afghan Capacity and Knowledge		Yes	NNGO	$824,411
21-RR-WHO-031	Health	WHO	Move Welfare Organization	MOVE	Yes	NNGO	$1,023,028
21-RR-WHO-031	Health	WHO	Solidarity for Afghan Families		Yes	NNGO	$3,338,424
21-RR-WHO-031	Health	WHO	Swedish Committee for Afghan		Yes	INGO	$2,139,677

ACRONYMS

Abbreviation	Name
AAP	Accountability to Affected Populations
ANC	Antenatal Care
ARTF	Afghanistan Reconstruction Trust Fund
BPHS	Basic Package of Health Services
CERF RR	Central Emergency Response Fund Rapid Response
EPHS	Essential Package of Health Services
GBV	Gender-based Violence
GMP	Growth Monitoring and Promotion
HMIS	Health Management Information System
I/NNGO	International /National Non-Government Organizations
IDP	Internal Displaced Person
IYCF	Infant and Young Child Feeding
MHNT	Mobile Health and Nutrition Teams
MoPH	Ministry of Public Health
PLW	Pregnant and Lactating Women
PSEA	Prevention of Sexual Exploitation and Abuse
P/SHC	Primary/Secondary Health Care
UN	United Nations
UNICEF	United Nations Children’s Fund
Sehatmandi	System Enhancement for Health Actions in Transition
TPM	Third Party Monitoring
WHO	World Health Organisation