ANNUAL REPORT
ON THE USE OF CERF GRANTS
AFGHANISTAN

Country	**Afghanistan**
Resident/Humanitarian Coordinator	**Peter Crowley - OiC**
Reporting Period	**1 January 2010 – 31 December 2010**

I. Summary of Funding and Beneficiaries

Funding	Total amount required for the humanitarian response:		US$ 40,571,983
	Total amount received for the humanitarian response:		US$ 31,515,034
	Breakdown of total country funding received by source:	CERF:	US$ 11,019,952
		ERF COUNTRY LEVEL FUNDS:	US$ 6,282,314
		OTHER (Bilateral/Multilateral):	US$ 20,359,990
	Total amount of CERF funding received from the Rapid Response window:		US$
	Total amount of CERF funding received from the Underfunded window:		US$ 11,019,952
	Please provide the breakdown of CERF funds by type of partner:	a. Direct UN agencies/IOM implementation:	US$ 5,591,991
		b. Funds forwarded to NGOs for implementation (in Annex, please provide a list of each NGO and amount of CERF funding forwarded):	US$ 4,353,856
		c. Funds for Government implementation:	US$ 1,074,105
		d. TOTAL:	**US$ 11,019,952**
Beneficiaries	Total number of individuals affected by the crisis:		2,822,220 individuals
	Total number of individuals reached with CERF funding:		1,795,018 total individuals
			428,788 children under 5
			470,408 females
Geographical areas of implementation:		Kohistan, Qaiser, Maimanan, Dawlat Abda, Almar,Shrin Tagab,Badakhshan, Warduji and Argu,Balkh, Bamyan, Daikundi, Asheterlay, Faryab, Ghor, Jawzjan, Kandahar, Ghor, Shahrak, Kunar, Narang, Noorgal, Chawkai,Assadabad, Sarkani Kunduz, Laghman, Nangarhar, Rodat,Kot,Bati Kot,Samangan Saripul	

II. Analysis

Brief overview of the humanitarian situation

Afghanistan benefited from one CERF allocation in 2010. In April, the country team received US$11,019,952 from the Underfunded Window for the response to emergency need gaps related to Health, Nutrition, Water, Health and Sanitation (WASH) and Agriculture. The funds received were crucial in upgrading the level of response in terms of both number of beneficiaries and the timeliness of support to several emergency programmes including distribution of food, cleanliness, and vaccines.

A large proportion of Afghanis remain highly vulnerable to the effects of both the recurrent armed conflicts and natural calamites - such as avalanches, floods, earthquakes and the outbreak of diseases. These all carry negative consequences, including an extra negative influence on food and nutritional security, access to health services, and the control of infectious diseases.

The total humanitarian need for Afghanistan in 2010 in the Humanitarian Action Plan was $870,561, 261.

Summary of selected sectors from HAP in 2010 in Afghanistan	Total Requirement (US$)	Revised Requirement (US$)	Total Received/available (US$)	Per cent Covered (US$)
Food/ Agriculture	372,539,155	368,691,762	294,569,328	79.9
Nutrition	8,434,443	8,669,571	6,263,336	72.3
Health	10,673,254	12,702,186	6,236,306	49.1
WASH	36,581,681	39,444,136	6,760,816	17.4
Total	428,228,533	429,507,655	313,829,786	73.3

Later, the Humanitarian Action Plan was revised by reducing the requirements from other sectors to US$ 774,508,310.

CERF's Underfunded Emergency Window allocated US$11,019,952 to Afghanistan to address the most critical need gaps as a life- saving intervention in four areas: Health, Nutrition, Agriculture (Seed and fertilizer) and Water and Sanitation.

Each of the humanitarian cluster/sector leads (NGOs and UN agencies), and the humanitarian country team have discussed the prioritization of needs for legitimate allocation of the funds, with the focus being on sectors with critical resource gaps. All the clusters agreed unanimously on the selected priority sectors and the funds were allocated accordingly. Top priority was given to the needs of children and pregnant and lactating women, access to health care and drinking water among internally displaced and vulnerable populations in remote areas in different parts of the country, as well as seed and fertilizer support to the most vulnerable farmers.

The Humanitarian Coordinator approved the CERF projects, aiming to improve food security, nutrition, health service access, and to create an important environment for sustainability of livelihood thorough early recovery support within the life-saving criteria of CERF.

The allocation as per the prioritized cluster lead UN agencies was as follow:

Sector	Agency	Received (US$)	Total by Cluster (US$)
Emergency Health	UNFPA	274, 262	3,028,793
	WHO	2,754, 531	
Agriculture and livestock: Seed and fertilizer	FAO		3,000,000
Nutrition	UNICEF	1,851,782	1,990,882
	FAO	139,100	
WASH	UNICEF	3,000,277	
Total			11,019,952

Nutrition

There is widespread household food insecurity in Afghanistan caused by recurrent floods, droughts, political instability, insecurity and poor health service. In 2010, floods affected some 200,000 people, washed away crops, food stocks and thousands of livestock. Hundreds of houses were destroyed, worsening an already difficult situation.

Afghanistan also faced severe malnutrition in 2010. An estimated 422,000 Afghan children are acutely malnourished of which 172,000 are severely acutely malnourished. Some 2,910,000 children suffer from chronic malnutrition[1]. Chronic malnutrition is irreversible, meaning those children remain physically as well as mentally retarded throughout their life. Additionally, 48 per cent of children and women suffer from different kinds of micronutrient deficiencies, including iron deficiency anaemia (NNS 2004), mainly due to a poor dietary diversity among adults or inadequate child feeding practices.

CERF's Underfunded grant to Afghanistan supported emergency nutrition interventions. In view of the serious nutrition concerns in the country, United Nations Children's Fund (UNICEF) together with sector competent NGOs enhanced the nutrition support. The improved programme was able to support 4,413 women, boys and girls residing in Kunar Province, while meeting SPHERE standards. In addition, as a result of CERF-funded efforts, the cure rates of 19,976 women, boys and girls increased by over 90 per cent in Kunduz, Badakhashan, and Ghor provinces. While the Outpatient Programme (OTP) has become fully functional, the MAM programme for moderately malnourished and pregnant and lactating women continues to be under development. Thus far, the outcomes of the OTPs and Therapeutic Feeding Unit (TFU) programmes are excellent.

Finally, a regular nutritional supplies system was established with technical assistance on a periodical monitoring of nutritional status. Funding from CERF significantly boosted the Nutrition Cluster's target beneficiaries that were reached in 2010. It allowed basic primary health services implementers and other partners to scale up emergency nutrition interventions. The number of provinces providing community-based management of acute malnutrition services more than tripled (from 54 to 273 sites of which 175 are mobile). The community-based OTP was scaled up to 12 provinces. The number of severely malnourished children and their families who directly benefited from the programme is more than 25 per cent of the original Humanitarian Action Plan target. Moderately malnourished children and their families benefited from the programme as the screening activities set to identify severely malnourished children also helped the moderately malnourished children. Health workers were trained on how to detect and diagnose acute malnutrition, how to determine the admission and discharge criteria for malnourished children, how to organize complementary feeding and demonstrations and how to provide support for the community gardens for families with severely malnourished children. This has significantly increased the reach of nutrition programmes. The funding provided opportunities to further enhance cluster

1. Source: a. Secondary UNICEF: Child-Info monitoring the situation of women and children b. Primary: 2004 National Nutrition Survey.

coordination, joint action and synergy between prevention and treatment of malnutrition. For instance, Women Extension Services promoted healthy nutrition clinics, and gardens for families with malnourished children. Nevertheless, joint planning and implementation capacity at province and lower levels are still low and there is need to continue strengthening it.

Water and Sanitation Responses

The complex combination of violent conflict and natural disasters have left more than one million people in Afghanistan in need of short and long term solutions to accessing safe drinking water, adequate sanitation and better hygiene practices. In addition, an estimated 440,647 internally displaced people, 60 per cent of whom fled because of the conflict are in dire need of basic social services, including water and sanitation. Diarrhoea contributes to 33 per cent of disease burden among children under-five years of age and 30 per cent of under-five mortality in Afghanistan because of poor hygiene practices at institutions like schools and among families.

The CERF-supported water, sanitation and hygiene mitigation interventions benefited up to 800,000 people affected by the 2010 flash floods, drought, conflict, returnees, students and teachers in urgent need of the services. This is about 53 per cent of the total estimated target beneficiaries for humanitarian response for 2010. Implementation was accompanied by intensive hygiene education, household water treatment using Biosand filter technology and training of masons, technicians, hygiene promoters and water management committee members. Each water point was handed over to a caretaker from the communities who also received practical training during the construction and installation process. CERF support provided the opportunity for the WASH cluster partners to gain experience on how to prepare proper proposals for emergency interventions and enhanced cluster coordination. This is expected to lead to stronger cooperation in the future for similar projects and activities. There was still need to enhance implementation and coordination capacity at local and community levels. Insecurity in parts of the project areas affected prompt implementation and monitoring of the project.

The Water, Sanitation and hygiene response in 14 high-risk provinces, where drought and conflict played a major role, enabled over 1.2 million children, women and other vulnerable population group access to life-saving interventions.

Health Response

During 2009, the health sector was drastically underfunded: only 4 per cent of the requested funds were secured; consequently, the resulting emergency responses were largely insufficient. The CERF allocation of $ 3 million to the health sector in 2010 enabled the strengthening of the humanitarian response to address the immediate health needs of more than 1 million people affected by natural and manmade disasters. In particular, CERF funds allowed for the establishment of rapidly evolving stock in high-risk areas, which proved vital in addressing the health emergencies created by the significant increase in kinetic military operations after mid 2010, which displaced large segments of the population and increased the number of new casualties in the region.

The UNFPA project implemented by AADA targeted remote and isolated rural communities in Qaisar, Maimana, Shirin Tagab, Almar, Dawlat Abad and Kohistan districts of Faryab Province, covering approximately 142,220 people living in villages with previously no access to healthcare.

The project covered two Mobile Health Teams (MHT) and two sub-centres (SC), the latter in Malghi and Lafrai communities of Kohistan district, with the aim to serve marginalized and vulnerable people including IDPs and people living in insecure and remote areas. These MHT and SC operated from April to December 2010 with CERF funding.

The provincial Ministry of Public Health (MoPH) officials initially planned to establish Basic Health Centres in Malghi and Lafrai. However, lack of funding within the Basic Package of Health Care Services has so far prevented this. UNFPA with CERF funding established a health sub-centre (SC) at each of these communities, which is operating in buildings provided by the community. The two MHT covered 98,220 people living at 28 Service Delivery Points (SDP). The SCs and MHTs provided services in accordance with MoPH BPHS standards for SC and MHT.

UNFPA in close collaboration with MoPH, sought other sources of funding to sustain the project activities after CERF funding ceased, including integration into the BPHS. In the interim, UNFPA hoped to utilise its Regular Resources to sustain the SC and most MHT SDP. The project enhanced community participation by mobilizing local community resources by giving them a greater sense of responsibilities for their own health. Beneficiary communities provided in-kind contributions for supporting this action such as: providing a venue for MHT service delivery, offering accommodation and securing venues for the MHT staff and sub health centres.

Seed and Fertilizer Response

Agriculture is a time bound activity. Timely planting of quality inputs is essential for better yields. Certified wheat seed production in the country is very limited and cannot cover the national seed requirement. CERF funds enabled FAO for timely planning of inputs procurement, quality control; delivery and distribution of essential inputs (seed and fertilizer) to most vulnerable farming families who had no purchasing power whatsoever, or could not find quality inputs if they had some purchase capacity. Despite some logistical constraints, this intervention could meet the time critical needs of most of targeted vulnerable farming families in remote and insecure locations of Nangarhar, Kuner, Badakhshan, Ghor and Daikundi provinces.

CERF funding approved in March 2010, enabled FAO to procure the inputs prior to the planting period (September - October 2010). The inputs were procured, quality controlled, delivered and distributed on time to most of the targeted beneficiaries.

The CERF was the first contributor to the response but not the largest. Following CERF funding, FAO received additional funds ($12,723.162) from the governments of Japan and Belgium. These funds were used to target vulnerable households in different communities. CERF funds made around 19 per cent of total funds received by FAO from different donors supporting vulnerable farming families through the provision of certified wheat seed and fertilizer for the autumn 2010 planting season.

Accessibility to quality fertilizer is another big challenge for the vulnerable farming families in remote and insecure areas. In conclusion, on the one hand the vulnerable farming families have no purchasing power and on the other, the quality inputs are not available in their local markets.

This intervention has enabled the targeted vulnerable farmer to have access to quality inputs, and on time. This should also have an effect on their income, their health, their access to services. CERF funds also mobilized other donors to assist the vulnerable farming families through distribution of certified wheat seed and fertilizer.

III. Results

Sector/ Cluster	CERF project number and title (If applicable, please provide CAP/Flash Project Code)	Amount disbursed from CERF (US$)	Total Project Budget (US$)	Number of Beneficiaries targeted with CERF funding	Expected Results/ Outcomes	Results and improvements for the target beneficiaries	CERF's added value to the project	Monitoring and Evaluation Mechanisms	Gender Equity
Water and Sanitation	10-CEF-012A Provision of safe and sustainable drinking water, sanitation and hygiene education and promotion	3,000,277	9,951,000	117,000 IDPs, returnees and hazard affected population	▪ Provide sustainable water supply, sanitation and hygiene in ten provinces mostly affected by drought, floods and conflict, and have returnees and IDPs	▪ 304,000 drought and conflict-affected community members and 15,600 students and teachers have access to sustainable WASH services through construction of 15 piped schemes, 479 water wells with hand pumps, 3 strategic water points, 24 water storage reservoirs, and 331 demonstration latrines. ▪ Another 480,000 people displaced by floods received water delivered using water tankers, sanitation and hygiene services for a period of 4 months. ▪ 32,321 people trained and able to deliver WASH service. The WASH cluster IACP developed in four regions.	Prompt provision of funding enabled life-saving interventions, including additional emergencies occasioned by the floods and drought.	▪ Joint WASH Cluster team conducted regular monitoring, received and reviewed monthly reports from implementing partners and shared findings. Tools developed by the joint WASH Cluster and Ministry of Rural Rehabilitation and Development were used for monitoring and reporting.	▪ Women and girls were primary beneficiaries as the burden to ensure availability of potable water in households lie with them. Women were included as members of the water committees and in hygiene promotion training.

Nutrition	10-CEF-012B Response intervention to nutrition emergency in Afghanistan	1,851,782	3,690,304	17,000 severely and acutely malnourished children treated; 41,655 moderately malnourished children; and 29,159 pregnant and lactating women.	▪ Prevent and treat malnutrition in under-five children, pregnant and lactating women through community-based management of malnutrition approach in high-risk provinces resulting from drought, high food prices and conflict.	▪ 22,723 severely and acutely malnourished children of whom 5,753 had complications were treated with cure rate of over 90 per cent. ▪ 241,000 children, 151,259 pregnant and lactating women received micro-nutrient supplementation. ▪ 2,000 health workers trained in community-based management of malnutrition, identified and treated 50,000 moderately malnourished children and their mothers. ▪ 50 medical doctors and nutritionists trained in community-based management of acute malnutrition and 22 retained as trainers. This is part of organisational and national contingency in case of emergency.	▪ CERF funding enabled implementation of life-saving nutrition interventions and strengthened nutrition programme, which is now an entry point of other nutrition and food security programme in the country.	▪ Nutrition Cluster team monitored implementation of the project. Implementing partners provided monthly reports to the cluster while monthly field visits were conducted by the joint cluster team coordinated by UNICEF.	▪ The project focused on most vulnerable groups - children under five, pregnant and lactating women.

Nutrition	10-FAO-021 Response intervention to nutrition emergency in Afghanistan	139,100	Total budget: of Nutrition Cluster US$1,990,882 of which UNICEF implemented: US$ 1,851,782	Acutely malnourished children: 354,764 Pregnant and lactating women: 180,418	▪ Nutrition promotion and support to food production complements community based management of acute malnutrition (CMAM).	▪ Women trained in adequate complementary feeding using local products (10,887 caretakers of malnourished children and pregnant and lactating women, 152 health workers as intermediaries). ▪ Families with malnourished children received vegetable seeds (440 families). ▪ TFUs and CMAM sites that established clinic and home gardens (39 TFUs/clinics, 22 women demonstration gardens, 440 individual gardens established).	Facilitated joint actions linking treatment of malnutrition to nutrition promotion and food production. Allowed to formulate/advocate for joint nutrition cluster response (integrated CMAM). Increased awareness/knowledge for using local food products to address malnutrition. Build vulnerable people's self help capacity, production of nutritious foods, building women's capacity). Monitoring and evaluation, including the assessment of behaviour change and linkages to other clusters should be strengthened in future.	▪ Monitoring form developed, officer hired during second half, random monitoring visits conducted, reports shared. ▪ Review workshop with cluster members, exchange of joint experience.	▪ Special attention to support women. ▪ Women received agriculture support (inputs and extension). ▪ MAIL's Women Extension Department involved to allow working with women. ▪ Women are the priority users of the women demonstration gardens.

Health	10-WHO-011 Emergency health intervention and outbreak response and control for the extremely vulnerable: IDPs, people living in conflict and remote areas without access to essential health care	Total: $3,048,053 divided between two recipient agencies: UNFP: $ 293,522 WHO: $ 2,754,531	12,588,271	500,000 people (240,000 female, and 100,000 children < 5years of age) IDPs, returnees/refugees and extremely vulnerable people in need of humanitarian aid	500,000 targeted beneficiaries are provided with emergency health services through mobile and temporary static clinics.	▪ Some 530,000 people had improved access to essential emergency health services. Of this number, 312,000 people affected by chronic compounded vulnerabilities (conflict, ethnic discrimination, un-covered by BPHS, extreme remoteness and harsh weather) had improved access to health services through establishment of six mobile teams and 12 temporary static clinics in five provinces of Afghanistan (Kabul, Kandahar, Zabul, Badakshan, Faryab). Additionally, medical supplies were provided to respond to the immediate health needs of around 200,000 people affected by floods, epidemics, and earthquake that bypassed the local response capacities in 16 provinces of Afghanistan: Bamyan, Ghazni, Kabul, Kapisa, Khost, Maidan Wardak, Paktia, Parwan, Nangahar, Kunar, Langman, Nuristan, Zabul, Sari Pul, Daikunki and Samangan. ▪ A total of 258,189 curative consultations were conducted by the established static and mobile HFs; Utilisation rate was 1.2 consultations/person/year.	CERF funding enabled health partners to timely respond to the emergency situations resulting from growing insecurity and its consequences, and natural disasters that bypassed local response capacity.	▪ Regular monitoring through field visits in accessible areas by UNFPA and WHO staff jointly with implementing partners ▪ Discussions with beneficiaries through Shuras meetings ▪ Field visits in insecure areas conducted by Polio district focal points (APW contract with WHO). ▪ Monitoring tools: Quality assurance standard checklists,	▪ To promote and facilitate women access, acceptability and utilisation of health reproductive services, all supported HFs (static and mobile) had at least one qualified female staff (midwife or doctor) ▪ Necessary supplies for conducting basic reproductive health service (folic acid, ferrum, birth control available with all supported teams

					▪ The stocks of medicines for the priority health facilities and mobile clinics procured and distributed for the project period. ▪ Effective response to life threatening outbreaks implemented. ▪ At least 80 per cent of epidemic alerts/rumours are timely investigated and responded (within 48 hours from reporting).	▪ WHO purchased and distributed most of the necessary medicines /medical supplies to all implementing partners. Interagency Emergency Health Kit (IEHK) for general curative care, Diarrhoeal Diseases Kit (DDK) for response to cholera outbreaks, miscellaneous for other type of outbreaks, and trauma kits to support the treatment of increased number of casualties in insecure areas. ▪ UNFPA supplemented health supplies specific for reproductive health (clean delivery and basic reproductive kits). ▪ Supplies covered essential health needs of 280,000 people for nine months and another 440,000 for three months. DDK were used for treatment of 28,000 cases of AWD, and trauma kits were delivered for conducting 600 major surgeries. ▪ 186 epidemic alerts reported and investigated during the nine months implementation period through DEWS system. 158 confirmed and 95 per cent of them were responded to within 48 hours from notification. WHO support included provision of laboratory reagents for case confirmation, provision of additional medicines/medical supplies for response, vaccination campaigns, and health awareness campaign through media (radio). Largest outbreaks caused by cholera occurred during the floods in Ghazni, Nangarhar, and Kabul provinces. However, vast majority (70 per cent) were caused by measles, which reflects low population coverage in high risk areas and further increases population vulnerability. ▪		▪ DEWS initial assessment reports. ▪ National monitoring check list. ▪ Supervision form .	▪ In Kabul, IDPs camps/Informal settlements where the living conditions are precarious hygiene and new borne kits were distributed to all women (ante and post partum) who attended at least two ANC. ▪ Involvement of women in local health committees had facilitated health awareness on reproductive and child health issues. ▪ Referral mechanism focusing on evacuation of pregnant women and children with complication was established especially for very remote communities.

Items	QTY	Total Amount $
IDDK	38	331,972
Trauma kit A	9	110,178
Trauma kit B	9	128,619
IEHK basic	690	386,531
IEHK sup	59	401,078
		1,358,378

					▪ 80 per cent of targeted population receive health information messages on ARI, scabies, diarrhoea and malaria. ▪ 80 per cent of targeted facilities detect, refer, and manage cases of acute and severe malnutrition in children and carry out nutrition education through growth monitoring.	▪ All temporary static clinics supported the communities to establish health Shuras and conducted health education sessions for patients, caretakers and local population. ▪ All supported health facilities offered growth monitoring services and referral of severe cases to TFUs. A rapid survey of nutritional status amongst children less than five was conducted in Kabul IDP/Informal settlements that showed the global acute malnutrition at 10 per cent. Through coordination and collaboration with nutrition cluster (UNICEF), CMAM component was included into services provided by the mobile teams in Badakshan (implementing partner Merlin			

HEALTH	10-FPA-008 Emergency health intervention and outbreak response and control for the extremely vulnerable: IDPs, people living in conflict and remote areas without access to essential health care	274,262	274,262	142,220	▪ Increased access to essential primary health care services, specially maternal and child health care, to selected un-served populations in Faryab province, living in excess of 10km or 2 hours walk from the nearest health facility.	▪ In total, 69,734 clients were served by MHT and SC from April 2010 to December 2010 through CERF project, this including repeat visits. 14 per cent of clients were pregnant women who received antenatal care and TT2 immunization before delivery. Deliveries attended by qualified staff made 5 per cent of the total consultations, while 2 per cent of complicated cases were referred to emergency obstetric care centres. The postnatal care was 7 per cent of the total clients. 13 per cent of clients were children under one and received PENTA 3 immunization.	With CERF funding, UNFPA established two Mobile Health Teams (MHT) and two Sub-Centres (SC), serving highly vulnerable population including IDPs and people living in insecure and remote areas in the six districts of Faryab province.	▪ Regular monitoring of the performance of MHT and SC against set targets and quality assurance standards to improve quality of health services carried out through joint field visits and discussions with project beneficiaries. The most critical supervisory tool used, was the quality assurance standard checklists, National Monitoring Checklist and analysis of HMIS data.	▪ Involvement of women in local health committees, staffing MHT and SC with qualified female staff, raising women awareness through health education sessions and availability of quality reproductive health services for vulnerable groups through MHT and SC have contributed to achieve this objective and women's well-being in general.

Food Security and Agriculture Cluster (FSAC)	10-FAO-010 Emergency support to vulnerable, food insecure farming families in Nangarhar, Kuner, Ghor, Badakhshan and Daikundi provinces	3 million	3 million	100,702 persons, 55 per cent of targeted population is women	▪ Immediate resumption of wheat planting by 14 400 vulnerable, high food prices and drought affected farming families. ▪ Increased crop production, resulting in enhanced food security and reduced dependence on food aid. ▪ Awareness-rising about the benefit of using high-yielding wheat seed varieties and dissemination of improved wheat seed among farmers in the target areas for subsequent cropping seasons.	▪ Each of 14,386 farming families received a package of 50 kg certified wheat seed, 50 kg DAP and 100 kg DAP for cultivation for cultivation of 0.4 ha irrigated land with technical assistance. Total 5 755 ha irrigated land cultivated with 720 tonnes of certified wheat seed with 720 tonnes DAP and 1 440 tonnes urea fertilizer. 12 packages will be distributed for next first coming up planting season.	On time allocation of CERF funds for procurement, quality control, delivery and distribution of inputs to needy farming families, identified through Food Security and Agriculture Cluster.	▪ The project is being implemented under direct supervision of MAIL 2010 National Seed Distribution Program. The project is being monitored and evaluated by the MAIL and partners (FAO) joint monitoring evaluation mechanism.	▪ The project has addressed the vulnerable (returnees, IDPs, flood affected, drought affected, women headed, orphan headed, aged people headed) farming families who had access to land and water. 55 per cent of targeted population were female.

Annex 1: NGOS and CERF Funds Forwarded to Each Implementing NGO Partner

NGO Partner	Sector	Project Number	Amount Forwarded (US$)	Date Funds Forwarded
Merlin	Health	AFG-10/H/27065	286,353	
Ibn Sina	Health	AFG-10/H/28927	123,200	
SHRDO	Health	AFG-10/H/28923 AFG-10/H/28944	167,885	
AHDS	Health	AFG-10/H/28927	61,161	
AADA	Health	AFG-10/H/27065	274,262	
AADA	Health	AFG3R22A	274,262	May 2010
Swedish Committee for Afghanistan (SCA) with Community Development Councils and close cooperation of Provincial Rural Rehabilitation Department	WASH	Project Cooperation Agreement with Swedish Committee for Afghanistan ,	602,864	1 June 2010
Afghan Aid with Community Development Councils and close cooperation of Provincial Rural Rehabilitation Department (P-RRD)	WASH	Project Cooperation agreement with Afghanaid:	249,999	27April 2010
Tear Fund with PRRDs and CDCs	WASH	Project Cooperation Agreement with Tearfund	320,100	20 May 2010
Save the Children UK (SC-UK) with PRRDs and CDCs	WASH	Project cooperation Agreement with Save the Children – UK (SC-UK)	249,617	27 May 2010
Helvetas with PRRDs and CDCs	WASH	Project Cooperation Agreement with Helvetas	163,225	20 May 2010
AMI	NUTRITION	Project Cooperation Agreement with AMI	87,619	5 May 2010
MERLIN-KUNDUZ	NUTRITION	Project Cooperation Agreement with MERLIN-KUNDUZ	65,493	6 May 2010
MERLIN-BADAKHASHAN	NUTRITION	Project Cooperation Agreement with MERLIN-BADAKHASH	242,703	6 May 2010
OXFAM NOVIB, CHA	NUTRITION	Project Cooperation Agreement with OXFAM NOVIB	343,724	24 June 2010
SAVE THE CHILDREN	NUTRITION	Project Cooperation Agreement with SAVE THE CHILDREN	444,607	3 June 2010

Afghan Aid	Food Security and Agriculture	10-FAO-010	199,468	June 2010 and January 2011
OXFAM GB	Food Security and Agriculture	10-FAO-010	106,133	June 2010 and January 2011
SOFAR	Food Security and Agriculture	10-FAO-010	60,000	June 2010 and February 2011
AREA	Food Security and Agriculture	10-FAO-010	60,000	June 2010 and February 2011

Annex 2: Acronyms and Abbreviations

ARI	Acute respiratory Infections
AWD	Acute Watery Diarrhoea
BPHS	Basic Package of Health Services
CHW	Community Health workers
CERF	Central Emergency Response Fund
CMAM	Community Management of Acute Malnutrition
DDK	Diarrhoeal Diseases Kit
DEWS	Disease Early warning System
HAP	Humanitarian Action Plan
HC	Humanitarian Coordinator
HF	Health Facility
IDP	Internally displaced People
IEHK	Interagency Emergency health Kit
MHT	Mobile Health Team
NGO	None government organisation
OTP	Outpatient Program
SC	Sub Centres
SDP	Service Delivery Points
TFU	Therapeutic Feeding Unit
WASH	Water, Health and Sanitation