

COVID-19 Multi-Sector Humanitarian Country Plan

AFGHANISTAN

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INTRODUCTION

Situation Overview

Due to the scale and spread of transmission, the novel coronavirus (COVID-19) outbreak was declared a global pandemic on 11 March 2020. Current medical evidence shows that the main symptoms of COVID-19 include coughing, fever and, in severe cases, shortness of breath, although some people may carry the virus without being symptomatic. While 80 per cent of the COVID cases globally are considered to be mild, the elderly, as well as people with compromised immune systems and pre-existing health conditions, such as diabetes or heart disease, are considered to be at higher risk. As it is a new virus, the lack of immunity in the population (and the absence as yet of an effective vaccine) means that COVID-19 is spreading quickly around the globe.

Afghanistan is likely to be significantly affected due to its weak health system and limited capacity to deal with major disease outbreaks. Afghanistan's close proximity to the Islamic Republic of Iran – a global hotspot for the virus – puts the country at heightened risk, with tens of thousands of people and commercial movements across the border from Iran each day. High internal displacement, low coverage of vaccination required for stronger immune systems and augmented ability to fight viral and bacterial infections), in combination with weak health, water and sanitation infrastructure, only worsen the situation.

As of 23 March, there were 42 confirmed COVID-19 cases in Afghanistan across 12 provinces, including Kabul. The first death from COVID-19 was confirmed on 22 March in Balkh Province involving a man with no travel history outside the country. Most of those confirmed with the virus so far do have a prior travel history, mostly to Iran. One person (the first diagnosed) has recovered and been released from hospital. To date, testing has been small scale which may account for the relatively low number of confirmed cases relative to the high number of border crossings from Iran.

No reliable COVID-19 modelling for a country with Afghanistan's unique characteristics and vulnerabilities currently exists but WHO is working with experts to predict the likely spread. It is considered almost certain that the virus will spread to other provinces, beyond those already affected with a significant impact on the country's estimated population of almost 38 million people (plus an additional two million Kuchi). Laboratory testing capacity is currently being expanded. While Afghanistan has recently received deliveries of diagnostic kits from UAE and China, diagnostic testing is still stretched given the increasing demand.

In response to the outbreak, the Government of Afghanistan has developed a master response plan for the health sector and has established a High-Level Emergency Coordination Committee in the area of health with various technical working groups (Surveillance and Early Detection; Coordination and Resource Mobilisation; Health Care Provision; Health Promotion and Risk communication; Infection prevention and protection); and efforts are ongoing to establish sub-national coordination structures particularly in Hirat province which has the highest number of confirmed cases to date. The Government has also decided to close all schools until 30 April and is considering a range of other restrictions on public gatherings, transportation and related actions.

As of 24-March, most major international border crossings are closed excepting the Iranian frontier which remains open. Pakistan's borders are closed to people crossing but sporadic openings have permitted a small number of commercial vehicles to cross. Sustained movements of commercial and humanitarian goods across the Pakistan border are essential to markets in Afghanistan and the humanitarian response. Point of Entry screening was initiated in late January and is presently ongoing in eight locations throughout the country.

To support Government efforts to contain the disease and prevent further spread, the ICCT has developed this COVID-19 Multi-Sector Country Plan that outlines the strategic response approach to the outbreak for the next three months (April-June 2020). This document is intended to complement wider plans by the Ministry of Public Health/ WHO and all elements of these plans are fully aligned.

Scope of the Plan

This Multi-Sector Humanitarian Country Plan outlines preparedness and response efforts that complement the health response to the COVID-19 outbreak. This Multi-Sector Plan extracts the emergency humanitarian elements of the WHO Phase 2 plan with regard to health, but also looks more widely to include activities by other clusters that support the response. Some are existing activities within the HRP that can be scaled-up or extended to new areas, others are entirely new activities that are necessary because of COVID-19. It is important to note that this plan is only for the initial three months of the response and is intended as a living document that will inevitably need to be revised or extended as the situation evolves.

The Plan estimates that \$108.1 is needed to mobilise activities that contribute to the containment of COVID-19 outbreak in affected and at-risk provinces, as well as minimise the humanitarian consequences of the outbreak and interruptions to existing humanitarian assistance. Of this, \$36.9m is for existing activities that support COVID-19 preparedness and \$71.2m is for new and extra activities, not previously costed. It includes the cost of maintaining the UN Humanitarian Air Service in country for domestic travel and the cost on an international airbridge for six months. An estimated 6.1m people (0.8m existing and 5.3m new) will be reached through the multi-sectoral activities outlined in this plan. The plan also includes mitigation measures clusters are adopting to minimise interruptions to existing non-COVID-19 activities as a result of resource, logistics and personnel constraints.

Total Requirements: \$108.1m

- Requirement for activities already costed but not funded in the HRP: \$36.9m
- New requirements: \$71.2m

People To Be Reached: 6.1m

In line with WHO's Global COVID-19 Strategic Preparedness and Response Planning guidance, this Country Plan outlines activities under the multi-sector 'coordination and response planning' and 'risk communication and community engagement' pillars, while highlighting the core health components of response to COVID-19 under 'surveillance, rapid response teams, and case investigation'; 'points of entry'; 'national laboratories'; 'infection prevention and control'; 'case management'; and 'operational support and logistics' pillars.

The implementation of this Plan will be carried out in support of efforts by the Government of Afghanistan (especially the Ministry of Public Health), with coordination from OCHA and under expert guidance from WHO. This Plan will serve as the overarching guide for preparedness and response to all agency/organisation-specific plans. This is not intended as a technical health/medical response plan. For technical health details, please refer to the MOPH and WHO Phase 2 plans.

It is important to recognise that while this plan is primarily focused on emergency humanitarian efforts, there are many things development actors can also contribute to build the country's resilience to disease and strengthen response systems. The wider health response plan developed by MOPH outlines some of these measures and requests additional funds to support them. Development assistance is also relevant to other sectors such as education where the majority of schools do not have running water or hand washing facilities for students if they re-open, as just one example. Development donors and implementers are urged to consider how they can complement this initial humanitarian emergency response, particularly in high-risk locations with more resilience-building activities. Coordination is critical. The scale of economic disruption may also require a scaled-up social-safety net response from development donors that is beyond the scope of this emergency humanitarian planning. The impact on livelihoods is likely to be high if economic activities are disrupted, especially for a protracted period. People living in urban and peri-urban areas could lose employment and this would directly impact their financial position and already eroded capacity to cope.

Planning Assumptions and Risks

Possibility of movement restrictions or changed isolation advice

The introduction of movement restrictions or quarantine zones could fundamentally change the humanitarian community's capacity to continue delivering assistance. Negotiations would be required with the authorities to ensure humanitarian corridors are established for the continuation of life-saving activities. In the event that the situation deteriorates, or testing is dramatically increased, cases may exceed hospital capacity and affected areas may need to implement in-home isolation at the village/community level. Distribution of food and other assistance packages to service these quarantine zones will need to be considered if there is a spike in confirmed cases and fatalities. Lockdowns, quarantines and other such measures to contain and combat the spread of COVID-19 should always be carried out in strict accordance with human rights standards and in a way that is necessary and proportionate to the evaluated risk. Restrictions on movement, including health checkpoints and quarantine can create opportunities for abuse of power and/or (sexual) exploitation and abuse. In such circumstances, in order to reduce exploitation, it is critical that assistance continues to be distributed impartially, according to need and in line with people's specific vulnerabilities. Specific protections must be consistently provided to female-, elderly-, child-headed households and women, girls, men and boys living with physical and psychosocial disabilities.

Establishment of quarantine camps

There has been discussion about the possible establishment of camps, encashment centres or quarantine locations for returnees, especially in the country's West. The humanitarian community does not support the establishment of camps for people returning from either Iran or Pakistan. This is not in line with global best practice and has proven an ineffective tool in other contexts such as Pakistan which established a quarantine camp at Taftan on its border with Iran.¹ The concentration of individuals in such confined environments increases the risk of disease spread. Containment in hospitals where people can receive medical care and can be isolated from each other is the approach recommended by WHO, where such facilities exist. Should such camps be established, there is likely to be pressure for the humanitarian community to provide food and other support.

Ongoing conflict and political tensions

The COVID-19 outbreak comes at a time of political uncertainty following the results of the 2019 Presidential election and developments towards a reduction in hostilities. Despite a joint agreement between the US and the Taliban to reduce fighting, this has not yet translated into sustained reduction in violence on the ground. In light of the COVID-19 outbreak, continued violence is now seen as a threat to not only the immediate safety and well-being of citizens of Afghanistan but also to overall public health as it may hinder detection and the delivery of life-saving medical care. Conflict-related movement among armed groups, as well as displacement of civilians, creates further risk of intensifying the scale and spread of the virus. Humanitarian access is being negotiated to non-Government controlled areas for COVID-19 activities. The plan assumes that humanitarian assistance will be exempt from illegal levies. In line with global standards the imposition of taxes by government (beyond income tax of national aid workers) and levies by the Non-State Armed Groups is illegal.

Floods

The COVID-19 outbreak comes against the backdrop of the Spring flood season. Each year, floods affect large swathes of the country as heavy snow melts and rivers swell, inundating communities. Heavy rainfall also contributes to flash flooding. The typical flood season runs from March to June each year. In 2020, some 200,000 people are expected to be affected by floods and humanitarian partners plan to provide multi-sector life-saving assistance to 170,000 people. (See Flood plan in Annex 2) While flood-related displacement is usually temporary, it creates conditions that are ripe for the spread of various diseases, in turn weakening people's immune systems, and creating risks of higher transmission of COVID-19 due to higher population concentrations. This is particularly concerning for the country's west and south – projected to be affected by both floods and also bordering Iran and Pakistan respectively (the former being one of the largest global

¹ <https://www.aljazeera.com/news/2020/03/pakistan-spike-coronavirus-cases-raises-quarantine-concerns-200316090946936.html>

hotspots for COVID-19 pandemic). Humanitarian partners plan annually for this flood response but there is a risk that life-saving relief supplies may be stretched if a widescale COVID-19 response is required simultaneously and pipelines are interrupted.

Registration of people with new needs

In some locations, humanitarian partners are reporting that Government officials have stopped accepting petitions from newly displaced people as a result of other non-COVID-19 drivers such as conflict and floods. Conflict and floods are likely to generate new needs and new beneficiaries who are not on existing assistance lists. Advocacy is required to ensure that humanitarian partners are able to identify and address new non-COVID-19 related needs. The humanitarian community is working to ensure sufficient capacity remains in place to continue assessments of and assistance for people who are newly displaced, although this may be affected by movement restrictions and the availability of personnel and response supplies.

Locusts

Due to the current favorable breeding season in the region there could be three times higher than normal breeding rates of desert locust swarms in Iran. Another potential source of desert locusts could be from the Horn of Africa that could spread as far as India. Technically the chances of desert locusts invading Afghanistan are fairly low, however this situation can easily change. The most likely timeframe for any such invasion in Afghanistan would be between April-July. This would occur at the same time as the primary harvest season which will be vital at a time of potential food and financial insecurity caused by COVID-19. Locust attacks affect the region's standing crops - mostly wheat, vegetable and fodder crops. The locust attack reduces the yield of wheat crops and causes a shortage of fodder for animals, seriously affecting the farmer's income and impacting on food insecurity across the country.

Pipeline replenishment

The capacity of humanitarian agencies to import relief items depends on funding, import restrictions, border closures and the stability of local and international suppliers. Even before COVID-19, supplies of food were at risk of a partial pipeline break by May 2020 unless additional funds were made available. Supplies of hygiene kits, school bags, and nutrition treatment supplements are all at risk of imminent pipeline breaks. Health is also concerned about the availability of core medical supplies. Critical medicines and hospital supplies (beds, thermometers, etc.) as well as Personal Protective Equipment (PPE), masks and other consumables are urgently required on scale that is appropriate for this outbreak. Continued sourcing and delivery of additional testing kits is also critical.

Supply constraints and relief pipelines

The global COVID-19 outbreak is limiting the movement of people and, critical relief commodities (including food and medicines); and basic consumer goods. On 13 March, Pakistan announced it was sealing its western border with Afghanistan and Iran for an initial period of 14 days related to protective measures against COVID-19. This closure took effect on 16 March. This has affected the main supply routes for critical relief items – notably food. While there have been sporadic openings to allow commercial vehicles to pass into Afghanistan, this has not been sustained and humanitarians are gravely concerned about the impact this might have on markets inside Afghanistan and on the delivery of humanitarian supplies. Except for a brief break over the Nowruz New Year holiday, the Iranian border currently remains open. Global shortages of key medical supplies are already a concern with a number of countries withholding exports in order to build domestic stockpiles.

Consumer goods and financial pressure on households

The outbreak is likely to have an impact on the market for basic consumer goods in Afghanistan, particularly those that are imported. It is likely that there will be a surge in prices for some key goods and transport costs. In some cases, these will be opportunistic and not justified by actual shortages. COVID-19-related price rises will be on top of steadily accelerating year-on-year inflation (including food and energy commodities) seen in 2019, as well as rapidly escalating rates of household debt. Humanitarian partners are closely monitoring market prices for key food commodities. If realised, price rises this will have a disproportionate effect on the finances of impoverished households, as well as the country's economy as a whole. Some 14.3m people are projected

to be in crisis and emergency levels of food insecurity through until the end of March 2020. The current price situation may further threaten food security and the health and well-being of individuals, in turn raising the chances of a more severe impact if people are exposed to COVID-19.

Preliminary results from FSAC's assessments show that there are national shortages in wheat flour and that rice may reduce in availability along with slight reductions in vegetable oil, while pulses are still making their way through northern crossings. A full border closure preventing any movement of commercial goods would impact on availability and variety of fruits and vegetables given limited national production, while minimal price increases are possible in other staple goods such as salt and meat. The FSAC Hazard's Working Group will conduct informal price monitoring in all the major urban areas to assess price spikes and potential impact on affected people's coping strategies.

There will most likely be an additional impact on labour markets, purchasing power and lost productivity – all of which are significant factors for Afghanistan, not least because few Afghans have access to productive or sustainable remunerative employment. A quarter of the labour force is unemployed, and 80 per cent of employment is 'vulnerable' and insecure, comprising self-employment, day labour, or unpaid work. There are also growing concerns that due to price increases and future movement restrictions, farmers' and herders' access to farming inputs may be hampered, reducing their ability to successfully grow summer crops (mostly vegetables and pulses), sell produce and vaccinate/treat their livestock. There may also be implications for the export of Afghan high value products such as saffron and dry fruits.

It is also important to note that Afghanistan's economy and millions of families have grown reliant on remittances from Iran. Currency devaluations over the past year have resulted in a drop in the value of such remittances but the surge in returns and COVID-19 interruptions to work opportunities in Iran will further diminish the purchasing power of many communities who have been heavily reliant on remittance payments over recent years. This may have a severe impact on vulnerable families.

Operational response capacity

Humanitarian partners' capacity to stay and deliver on the priorities outlined within the 2020 revision of the multi-year Humanitarian Response Plan is threatened by the COVID-19 outbreak. The additional needs and complications created by the virus will require a further revision to the HRP, in line with the priorities outlined in this plan. Partners' already stretched resource and response capacity will be put under further strain by the humanitarian consequences of the outbreak and will require re-prioritisation. This is already being seen with the re-deployment of polio workers to COVID-19 surveillance. Some NGOs have already started reducing their international footprint in country, while others are preparing to scale-up to respond to the COVID-19 outbreak and ensure continuity of existing services in the areas where they operate. Frontline aid workers are at-risk of transmission which may limit their capacity to respond and agencies are taking additional measures, such as the provision of appropriate personal Protective Equipment (PPE) and additional training, to protect staff.

FSAC has temporarily paused seasonal support activities and trainings that were planned to start in April, while existing livelihood support such as distribution of seeds are planned to continue. While the impact of this temporary suspension is viewed to be minimal in the immediate term, given the extended lead times ahead for delivery of planned activities, FSAC is concerned about losses of value in supply and agricultural value chains if the temporary pause extends for more than a month.

Movement of humanitarian personnel within, as well as in and out of the country may become increasingly restricted, reducing the ability of staff to rotate in and out of the response. The UN is working to ensure it can stay and deliver life-saving humanitarian services to people in need and coordinate the response, but this will require additional robust measures to keep staff and beneficiaries healthy, as well as safe in a country where violence persists. UN operational agencies that are supporting the COVID-19 response in Afghanistan will be keeping their offices open although the need for social distancing will mean some organisations may reduce the density of the staff in their offices each day. The UN will be taking additional precautions and extra care to minimise risks from staff who are out of the country and returning. Arrangements are being constantly reviewed based on the global advice.

The response demands that we do everything to ensure critical meetings can still go ahead but are tailored to ensure social distancing in meeting rooms (at least 1 metre between participants). Remote dial-in options will also be provided as much as possible. All training and non-critical face-to-face meetings will be postponed. People should not attend meetings if they are unwell, have a fever, cough or respiratory symptoms.

The humanitarian community's ability to travel to affected areas partially depends on the ability to access flight from the UN Humanitarian Air Service (UNHAS). Disruptions to these services will further limit the ability of humanitarian organisations to move staff to hot spots and to monitor the response. UNHAS is exploring options for an international airbridge to maintain a transport link for humanitarian staff in and out of the country.

The Government's response capacity is also likely to diminish if the virus takes hold and affects staff or movement restrictions are introduced. Government administrative regulations issued on 16 March 2020 allow older staff (aged 58-65) to work from home for three weeks; pregnant women to work from home for two weeks; obligates staff returning from outside the country to use two weeks annual leave to isolate. High levels of fear are being reported among health staff in the field and need to be effectively countered with facts.

Donor flexibility

Movement restrictions, flight cancellations, reduction in partner footprint, staff health concerns, and inability to conduct focus group discussions and convene assessment teams may affect the humanitarian community's ability to conduct normal monitoring and evaluation of their programming. Aid agencies might need to re-programme or extend existing funds and therefore donors are asked for maximum flexibility.

National vulnerabilities and pressure points

Porous borders

In 2019, more than 540,700 returnees and refugees came to Afghanistan from Iran (487,035), Pakistan (25,493), Turkey (25,715) and other countries (2,034). Following the COVID-19 outbreak, IOM reports that the flow of spontaneous returnees (citizens of Afghanistan) from Iran increased compared to previous months, primarily due to concerns about the spread of COVID-19 in Iran. During the week starting 8 March, IOM reported that between 5,000 and 8,000 returnees came into Afghanistan each day through the Islam Qala border crossing alone. Between 14 and 15 March, more than 20,000 returnees arrived into Afghanistan from Iran through this crossing – the largest two-day return ever recorded. This excludes commercial movements. Overall numbers for the first three months of the year are similar to 2018 when there was a previous spike in returns. This is placing great strain on processing at the border crossing points and raises concerns about the spread of the virus given the scale of arrivals in a few weeks. Returns have slowed over the Nowruz (Persian New Year) holiday but are expected to pick-up again. As many returnees are going home to chronically under-developed areas with limited-to-no-health service provision the risk of undetected transmission is significant.

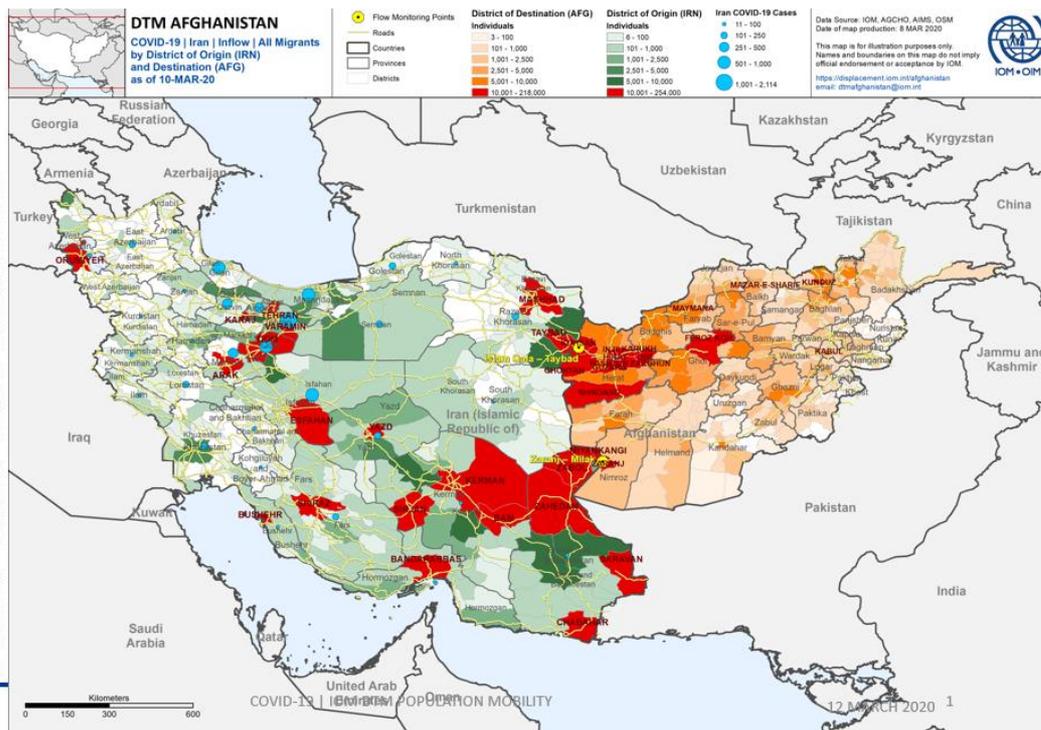
'At-Risk' Areas

Given the prevalence of COVID-19 in Iran, prevention and preparedness activities in Afghanistan will initially focus on provinces and districts that are considered to be at highest risk due to the volume of cross-border movement. Based on past years' data on population flows (from IOM's Displacement Tracking Matrix), this initial three-month plan is primarily focused on the 25 districts that are the primary destinations for returnees from Iran (including from COVID-19 hotspots) – are at high risk of spread. According to IOM, Hirat, Nimroz, Kabul, Balkh, Faryab are the top five provinces that are at the highest risk due to their greater connectivity to outbreak provinces in Iran. Some clusters have included additional locations based on their own risk analysis but the 25 high-risk districts were used as a common base for multi-sectoral planning.

CLUSTER	PRIORITY DISTRICTS (DTM)	ADDITIONAL DISTRICTS
EiEWG	25	-
ESNFI	25	2
FSAC	25	4
Health	25	National
Nutrition	23	15
Protection	25	100
WASH	25	16

Top 25 districts in Afghanistan at risk of spread of COVID-19, through human mobility

Rank	Province	District	Total Inflow from Iran	% of Total Inflow
1	Herat	Hirat	217,439	18.40%
2	Nimroz	Zaranj	124,058	10.50%
3	Herat	Kohsan	61,141	5.17%
4	Kabul	Kabul	51,950	4.40%
5	Herat	Injil	41,727	3.53%
6	Herat	Guzara	35,789	3.03%
7	Herat	Shindand	19,669	1.66%
8	Balkh	Mazar-e-Sharif	18,360	1.55%
9	Herat	Ghoryan	16,395	1.39%
10	Faryab	Maymana	12,613	1.07%
11	Kunduz	Kunduz	10,867	0.92%
12	Ghor	Feroz Koh	10,478	0.89%
13	Herat	Pashtun Zarghun	10,416	0.88%
14	Herat	Obe	10,226	0.87%
15	Herat	Karukh	10,176	0.86%
16	Farah	Farah	9,829	0.83%
17	Herat	Kushk	9,739	0.82%
18	Ghor	Tolak	9,717	0.82%
19	Kunduz	Imam Sahib	8,783	0.74%
20	Takhar	Taloqan	8,258	0.70%
21	Takhar	Rostaq	8,226	0.70%
22	Ghor	Shahrak	7,920	0.67%
23	Herat	Gulran	7,506	0.64%
24	Badghis	Qala-e-Naw	7,162	0.61%
25	Ghor	Taywarah	6,974	0.59%



While the border with Pakistan was officially closed to people movements on 16 March, it is likely that there is also some continued informal movement of people across the border. This is difficult to quantify but does present a risk as registration of such arrivals and subsequent contact tracing is not possible. IOM's DTM team is working on a similar risk analysis to the above, looking at Pakistan returnees and internal population flows, that can supplement future planning. DTM is actively scaling-up Flow Monitoring on major border crossing points to supplement available information on returnee demographics and intentions.

Weak health system

Afghanistan's under-developed health system is thinly spread across the country, due to ongoing conflict and insecurity, as well as infrastructure challenges. Around 30 per cent of the population has limited access to basic health services within a two-hour travel radius and maternal mortality is among the highest in the world. Only 50 per cent of children under five have received the full suite of recommended vaccinations to keep them safe and healthy. The fragile health system is further overburdened by mass casualty incidents and recurrent outbreaks of communicable diseases, especially among internally displaced people.

Inadequate water and sanitation infrastructure

Owing to decades of conflict and under-development, the coverage of water and sanitation facilities, as well as hygiene access, remains low in Afghanistan. This is particularly the case for displaced households – 57 per cent of whom have insufficient or barely enough water. More than 65 per cent of returnees (majority of whom coming from Iran) live in settlements that do not have access to any WASH services, whilst others stay with host communities where services are already over-stretched. Women and people with disability have even lower access to WASH facilities. Disrupted livelihoods and reduced income, coupled with chronic underlying poverty, further challenge families' capacity to purchase essential hygiene supplies. As many as 68 per cent of displaced households report not having access to or being unable to afford basic hygiene items in the 2019 Whole of Afghanistan Assessment. Poor WASH conditions contribute to disease outbreaks, especially diarrhoea, that spread at a rapid pace. In a 'normal' year, 13 per cent of all deaths among children under five in Afghanistan are associated with diarrhoeal diseases. Furthermore, the immune response of children affected by acute watery diarrhoea is highly compromised, increasing their risk of mortality when exposed to other diseases – such as COVID-19. Some 33 per cent of schools (nearly 6,000 schools serving 2.3m students) lack water and WASH facilities.

Displaced people

Such is the violence and hardship facing many households in conflict-affected parts of Afghanistan, that displacement remains a constant feature of the crisis. More than four million people displaced since 2012 are estimated to remain displaced in 2020. Displaced people often live in over-crowded conditions, in close proximity to others, with inadequate access to water and sanitation services. These conditions are ripe for virus transmission of the virus. Informal settlements on the fringes of urban areas are of particular concern. Internally displaced people are also especially reliant on either humanitarian assistance or casual labour and any breaks to humanitarian supply pipelines or employment opportunities will hit these vulnerable groups hard. Partners hold particular fears for the health of 87,000 people still living in displacements sites in Hirat and Badghis after the drought and recent conflict. This includes an estimated 10,000 school-aged children. Assessments have shown these IDPs are in poor health, making them more vulnerable in the context of COVID-19. COVID-19 awareness raising efforts are underway in the displacement sites in the west, in line with a 'do no harm' approach.

Disruption to education and concerns for the wellbeing of children

As of 14 March 2020, schools were advised that they should remain closed until 18 April. In a country where some 3.7m children are already out of school, this further widens the education gap – increasing the probability of permanent drop-outs and affecting children's general well-being. The closure of schools further exacerbates the burden of unpaid care work on girls, who usually absorb the additional load of supervising children. The Education in Emergencies Working Group (EiEWG) and its partners are presently preparing for catch-up arrangements for the time when schools resume and are re-purposing some 6,000 teachers as agents of community awareness about preventive measures people can take against the virus. FSAC partners are exploring the feasibility of distributing a take-home package for students to replace nutrition assistance that is usually distributed in schools.

COVID-19 is quickly changing the context in which children live. Quarantine measures, school closures and restrictions on movement disrupt children's routine and social support structures, while also placing new stressors on parents and caregivers who may have to find new childcare options or forgo work. Stigma and discrimination related to COVID-19 may make children more vulnerable to violence and psychosocial distress. Disease control measures that do not adequately consider the gender-specific needs and vulnerabilities of women and girls may also increase their protection risks and lead to negative coping mechanisms. Children and families who are already vulnerable due to socio-economic exclusion or those who live in overcrowded settings are particularly at risk.

Particular risks facing children include:

- Physical and emotional maltreatment
- Gender-based violence (GBV)
- Mental health and psychosocial distress
- Specific child protection-related risks such as - Child labour, separation, social exclusion

Malnutrition

The lingering impact of the drought in rural communities, combined with consecutive years of conflict, widespread displacement, annual exposure to flooding and the subsequent interruption to agriculture, have resulted in high levels of hunger and malnutrition. As a result of these combined factors, 14.28 million people are estimated to be in either crisis or emergency food insecurity (IPC 3 & 4) in the first three months of the year, based on Flowminder population projections for 2020. The most recent nutrition surveys across Afghanistan showed that 25 out of 34 provinces are currently above the emergency level threshold of acute malnutrition. Annually, an estimated 2 million children under the age of five and 485,000 pregnant and lactating women (PLW) are affected by acute malnutrition. This compromises people's overall health and well-being and is likely to worsen the symptoms of people who contract COVID-19.

Fragile economy and reliance on seasonal agriculture

Depending on the degree to which the economy is interrupted, loss of livelihoods may overwhelm current coping mechanisms. More than 80 per cent of people are living on less than the internationally applied poverty line (\$1.90 per day) to meet their needs, undermining the dignity of their living conditions and eroding the community's resilience to shocks such as COVID-19. In rural areas, with the lack of income due to any reduced movement, people will have to prioritise the money they have left for life sustaining needs such as health, food

and education. June and July are the main harvest months and if people lose their crops due to lack of movement or any other disasters like floods, maintaining livelihoods remains a big challenge beyond the currently planned three months. Questions also remain regarding what happens to livestock if movement is restricted. Impoverished families who lose loved ones in the outbreak will struggle with both the emotional impact and the additional financial burden imposed by burial costs.

People with specific needs and vulnerabilities

Women, the elderly, adolescents, youth, and children, persons with physical and psychological disabilities, indigenous populations, refugees, migrants, and minorities experience the highest degree of socio-economic marginalisation. Marginalised people become even more vulnerable in emergencies. This is due to factors such as their lack of access to effective surveillance and early-warning systems, and health services. The COVID-19 outbreak is predicted to have significant impacts on various sectors.

The populations most at risk are those that:

- Depend heavily on the informal economy or are indebted
- Occupy areas prone to shocks
- Live in high-density formal or informal settlements
- Have inadequate access to social and health services or political influence
- Have limited capacities and opportunities to cope and adapt
- Have limited or no access to technologies

The population of Afghanistan is characterised by all of the above. It has a population that is grappling with continued conflict, poverty and repeated natural disasters. The country's labour market is dominated by an unskilled labour force. Millions of citizens of Afghanistan cannot access basic services including health, education and water. Many are struggling to recover from past shocks and are highly indebted. Afghanistan also has millions of people living in high-density formal or informal settlement who are vulnerable partly because of the health risks associated with movement/displacement, overcrowding, increased climatic exposure due to sub-standard shelter, and poor nutritional and health status. By understanding these issues, we can support the capacity of vulnerable populations in emergencies. We can give them priority assistance, and engage them in decision-making processes for response, recovery, preparedness, and risk reduction. These groups have specific risk communications needs which must be taken into account during the response – see Pillar 2.

In line with humanitarian response planning parameters, the COVID-19 Strategic Response Plan ensures that affected people are at the centre of humanitarian action. This includes recognising affected people's different needs, unique vulnerabilities and exposure to risks. Timely identification of people with specific needs (women household heads, unaccompanied minors, people with disability, people with pre-existing medical conditions, elderly people) for referral to immediate, tailored assistance is a core component of the ICCT's planning. Older people and those with other health conditions, particularly hypertension, diabetes and heart disease, are more likely to become more seriously ill with Covid-19.

The 2019 Whole of Afghanistan Assessment showed a clear correlation between vulnerability and debt, particularly in terms of people with disabilities. This is only likely to be exacerbated by economic stress and higher prices which may be caused by COVID-19. Movement restrictions/self-isolation will disproportionately affect people with specific needs and vulnerabilities, especially people with a disability and the elderly. It will be critical to support the mental health of elderly people through continued, safe interaction with visitors who are trained to avoid infection risk. Significant pressure will be placed on carers in the new environment if their ability to move around and access medical care for those they look after and for themselves is reduced. Those without carers will be especially vulnerable and may need additional support to source household items and food during any period of isolation. Where healthcare systems are stretched by efforts to contain outbreaks, care responsibilities are frequently "downloaded" onto women and girls, who usually bear responsibility for caring for ill family members and the elderly. The closure of schools further exacerbates the burden of unpaid care work on women and girls, who absorb the additional load of caring for children. There is also a higher risk of child labour and early marriage in situations where families become economically stressed.

Cultural norms in Afghanistan limit the role of women outside the home. Women's ability to access healthcare is seriously diminished due to limited availability of female health workers. This may mean they are less willing or able to get tested if they have symptoms. As of 23 March, all but one of the current cases were men. Gender-segregated wards will be provided in hospitals as much as possible for those who are being treated or isolated. Efforts are being made to ensure frontline medical personnel are gender-balanced and services provided in health facilities are culture, age and gender sensitive. The humanitarian community will take steps to strengthen

the leadership and meaningful participation of women and girls in all decision-making processes in addressing the COVID-19 outbreak. Engaging with women on prevention messages is a proven way to improve the effectiveness of this plan – see Pillar 2.

Past outbreaks have demonstrated that where women are primarily responsible for procuring and cooking food for the family, increasing food insecurity as a result of a crises may place them at heightened risk, for example, of intimate partner and other forms of domestic violence due to increased tensions in the household. Other forms of GBV are also exacerbated in crisis contexts. For example, the economic impacts of the 2013-2016 Ebola outbreak in West Africa, placed women and children at greater risk of exploitation and sexual violence. In addition, life-saving care and support to GBV survivors (i.e. clinical management of rape and mental health and psychosocial support) may be disrupted when health service providers are overburdened and preoccupied with handling COVID-19 cases. Evidence from past epidemics, including Ebola and Zika, indicates that efforts to contain outbreaks often divert resources and physical spaces away from routine health services including pre- and post-natal health care and contraceptives, and exacerbate often already limited access to sexual and reproductive health services. Adolescents have particular needs in this regard. Furthermore, critical needs include access to clean and safe delivery of babies, particularly for treatment in complications in pregnancy, treatment of STIs, availability of contraception, and provisions for clinical management of rape.

Mental health and psychosocial support needs

The COVID-19 pandemic is a threat not just to people's physical wellbeing but also their mental health. Large numbers of people are expected to be adversely affected by loss of livelihoods and sudden uncertainty about their future due to the economic consequences of the pandemic. Physical separation from extended family will also be distressing for many people in Afghanistan. In many countries, fear from the virus is spreading faster than the virus and inducing mental health and psychosocial consequences among those affected directly and those who are following the news.

Fear, depression and anxiety/worry are likely common reactions in all affected countries. Concerns about health, beloved older relatives and financial stability and feeling of helplessness are all very common emotions reported around the world among all age groups. Physical distancing, self-isolation, quarantine, and working from home may trigger reactions of isolation, loneliness, and loss of social contacts among large number of people. Extreme stressors may induce, worsen or exacerbate pre-existing mental health conditions. Older adults and people with pre-existing health, mental health and substance use conditions are among the most vulnerable. There are mental health and psychosocial consequences of discrimination towards people who have been infected and their family members and there is social stigma towards those treating and caring for people with COVID-19.

Underlying mental health issues will only be further complicated and exacerbated by COVID-19. Even before COVID-19, the prevalence of mental health issues in the community is already estimated to be high. Constant exposure to high-stress, conflict situations is taking its toll on the mental health of people living in Afghanistan. Repeated loss is also an ever-present part of life with survivors left to cope with their grief and, when breadwinners are killed in conflict, the added financial struggle that follows. With extremely low availability of psychosocial support services and repeated exposure to traumatic shocks, recovery opportunities are likely to be minimal, with people instead resorting to negative coping mechanisms. One of the only nationwide studies of the mental health situation in Afghanistan conducted in 2018 indicated consistently high levels of mental distress. According to this survey, one in every two people (50 per cent) is suffering from psychological distress and one out of five (20 per cent) face functional limitations to his or her role because of mental health problems. According to the survey, almost 10 per cent of children encounter challenges in fulfilling life habits (going to school, playing etc.) due to mental health problems, with grave consequences for their education and development.

Children might find it difficult to understand what they are seeing online or on TV – or hearing from other people – with regard to COVID-19 so they can be particularly vulnerable to feelings of anxiety, stress and sadness. But having an open, supportive discussion with children can help them understand, cope and even make a positive contribution for others. In light of the stress COVID-19 may create for children, special guidance has been provided by the Education in Emergencies Working Group on talking to children about the virus. It is available in various languages including Dari and Pashto here: <https://www.unicef.org/coronavirus/how-talk-your-child-about-coronavirus-covid-19>

Funding Situation

The 2020 Humanitarian Response Plan (HRP) requirements are 3 per cent funded as of 23 March. Without adequate funding, humanitarian partners cannot respond to the existing and COVID-19-related needs of people affected by crisis across Afghanistan. The costings outlined in this plan include:

1. New activities that were not originally included or costed in the HRP that was published in December 2019
2. Existing activities already outlined in the HRP that are accelerated, expanded to new caseloads or being rolled out in new locations, requiring additional funds
3. Existing activities outlined and costed in the HRP that might support preparedness and community resilience to the virus

This plan will form the basis of an imminent HRP revision to reflect new needs and activities related to COVID-19. This plan will also feed into the Global COVID-19 appeal.

The Health Cluster has either been pledged or received \$3.5m for COVID-19 response for preparedness and containment activities.

On 25 February, the Government of Afghanistan announced the availability of US\$15 million to respond to COVID-19 outbreak and an additional US\$10 million in reserve funds for MoPH.

PILLAR 1: COUNTRY-LEVEL COORDINATION AND RESPONSE PLANNING

Coordination Arrangements

The Government of Afghanistan is primarily responsible for managing the response. The Ministry of Public Health (MoPH) has enacted a series of committees to prepare, contain and respond to COVID-19:

1. Surveillance and Early Detection
2. Coordination and Resource Mobilisation
3. Health and Mental Health Care Provision
4. Health and Mental Health Promotion and Risk Communication
5. Infection Prevention and Protection

The UN and non-government organisations are actively supporting response activities with MoPH or the relevant line ministry (e.g Ministry of Education) to address preparedness and emergency coordination, particularly in the border provinces with Iran and Pakistan (Nangarhar, Kandahar, Nimroz and Hirat). Support includes: secondment of staff for cross border surveillance; material support; publication of MoPH and WHO Information, Education and Communication (IEC) materials; billboards; community-level awareness raising and sensitisation efforts through health education sessions and Displacement Tracking Matrix focus group discussions; and use of IOM transit facilities as temporary isolation/quarantine spaces.

The humanitarian community's overall efforts towards the response are coordinated under the Humanitarian Country Team as the strategic decision-making body and the inter-Cluster Coordination Team as its operational arm. At the regional-level, Humanitarian Regional Teams are engaged in local planning for the outbreak and are liaising closely with local Government and health authorities. Price rises in local markets are being monitored by staff on the ground. In the West, focal points have been identified for each of the relevant pillars under this plan and 3Ws (Who does what where) are being collated.

Inter-Cluster Planning

Summary of preparedness and response priorities

The COVID-19 outbreak, which was recently categorised as a global pandemic, presents an unprecedented challenge to existing humanitarian needs and the ongoing response in the country. Clusters have prioritised a number of preparedness and response activities to simultaneously manage existing and COVID-19-related needs. Detailed cluster plans are available in Annex 1. A summary is below.

CLUSTER	EXISTING BENEFICIARIES TO BE REACHED	NEW BENEFICIARIES TO BE REACHED	NEW REQUIREMENTS (US\$)	COSTED IN HRP (US\$)	TOTAL COST (US\$)
EIEWG	170 K		\$ 2.1 M		\$ 2.1 M
ESNFI	270 K	168 K	\$ 4.3 M		\$ 4.3 M
FSAC	278 K	220 K	\$ 18.7 M	\$ 2.8 M	\$ 21.5 M
Health	320 K	5.3 M	\$ 20.2 M	\$ 1.5 M	\$ 21.7 M
Nutrition	225 K	161 K	\$ 5.8 M	\$ 15.3 M	\$ 21.1 M
Protection	396 K	320 K	\$ 6.1 M	\$ 3.2 M	\$ 9.3 M
WASH	800 K	400 K	\$ 6 M	\$ 9 M	\$ 15 M
UNHAS			\$ 7.5 M	\$ 5.1 M	\$ 12.6 M
DTM			\$ 0.5 M		\$ 0.5 M
TOTAL	800 K	5.3 M	\$ 71.2 M	\$ 36.9 M	\$ 108.1 M

Prioritisation

The ICCT has collectively agreed that all Health and WASH activities listed in this plan, as well as UNHAS, should be considered priority actions for funding. Each of the other clusters has prioritised their most urgent activity/activities – these are outlined in the detailed cluster pages in the Annex to this plan. UNHAS is prioritised to boost confidence among partners that they will have access to domestic and international flights if they keep staff in-country. Without this, there is a risk that implementation will be compromised by capacity gaps.

Mitigating the risk of interruptions to the existing response

While COVID-19 presents an unprecedented challenge to the humanitarian situation in Afghanistan and will create new needs, the ICCT is anxious to ensure that interruptions to existing assistance are minimised. Even before the COVID-19 outbreak, in 2020, 9.4m people were considered to be in humanitarian need. Of these, the humanitarian community already had plans to reach 7.1m with assistance. Advocacy is underway to encourage partners to stay and deliver this planned support where ever they can and the ICCT is committed to supporting partners that decide to remain. Advocacy is also underway at the political level to ensure cross-border movements of humanitarian supplies continue. Cluster partners are employing a range of measures to preserve their existing programming as far as possible to ensure those who are vulnerable and reliant on assistance continue to receive the support they need. Examples of such measures include:

- Food security is planning to conduct double-ration food distributions over the next three months to support people in the event of movement restrictions. Distributions are being phased to limit exposure of beneficiaries when they receive food packages.
- Education colleagues are planning for catch-up hours or possibly months at the end of the school closure period to ensure students can complete their full academic year of studies. In the West, teachers are also delivering classes via TV for those students who are at home and can access a TV. Out-of-school children may also benefit from this teaching if they can access the broadcast.
- WASH colleagues are pre-positioning stocks of key hygiene items around the country to ensure these are available for distribution in-situ if movement restrictions limit our ability to move goods around

- In an attempt to retain its workforce, the nutrition cluster will provide non-monetary incentives for community volunteers, including creating more opportunities to participate in training on public health nutrition including infant and young child feeding counselling, as well as the provision of food vouchers.

Air services

The humanitarian community's ability to travel to affected areas is partially dependent on the ability to access flights from the UN Humanitarian Air Service (UNHAS). Disruptions to these services will further limit the ability of humanitarian organisations to move staff to hot spots and to monitor the response. This plan requests \$12.6m in financial support for UNHAS to maintain essential domestic flights in the face of reduced cost-recovery and to establish an international airbridge for humanitarian staff to a destination outside Afghanistan. An international flight service will enable partners to keep staff in country with the confidence that they can leave the country and return as needed.

Health response

The focus of activities in Afghanistan is on preparedness, containment and mitigation. The Ministry of Public Health (MoPH) is working closely with the World Health Organisation, Health Cluster partners, IOM, donors, NGOs and other relevant stakeholders to rapidly expand in-country preparedness and containment capacity, to strengthen detection and surveillance capacity at points-of-entry into Afghanistan, such as airports and border-crossing sites (especially in the west), and to continue the training of medical staff on case-management, risk communication and community engagement. At present, the Health Cluster, via WHO, is supporting the Government in the establishment of a national isolation centre with a capacity of 100 beds, as well as regional and provincial isolation centres with total capacity of 991 beds. The level of support and activities in all key areas will need to be expanded rapidly to manage the further spread of the disease. The mental health and psychosocial support (MHPSS) response will be integrated within the overall health response, ensuring that frontline workers as well as community members are provided with psycho-education (focusing on reducing fear, stigma, and negative coping strategies) in response to COVID-19, as well as psychosocial support through the existing systems (MoPH health system, and community-based health structures). The provision of MHPSS is a cross-cutting issue relevant across all clusters in the emergency.

Awareness raising on COVID-19 prevention and spread

It is acknowledged that a scale-up of messaging is required to allay fears in the community and provide practical advice that dispels rumours and misinformation. A COVID-19 Risk Communications Working Group is being stood up to ensure individuals are equipped with the necessary information about COVID-19, including on what it is; how it is transmitted; and how individuals and households can play a role in undertaking preventive measures, all clusters have ongoing and planned awareness raising activities – including at border crossings; internal displacement sites and schools. Strategic messaging around normal reactions to stressful situations and positive coping mechanisms, promotion of positive psychosocial wellbeing, through Health Facilities, Mobile Health Teams, Therapeutic Feeding Units, Women and Child Friendly Spaces, Shuras, and through community health workers will also be critical. Messaging is being done in a culturally-appropriate manner that is tailored to people with varying levels of literacy and in various languages. IEC materials; TV and radio announcements and social media platforms are also being used to disseminate messages to the public. Mobile Health Teams and teachers are also being used as targeted vessels of information dissemination. Awaaz is already sharing preparedness messages with callers to their call centre and is exploring the potential for targeted SMS messages to at-risk provinces to combat rumours and mis-information, as well as promote good hygiene practices. Additionally, it will be vital to include key MHPSS messages around managing fear and anxiety, prevention and reduction of self- and social stigma, promotion of psychosocial wellbeing especially during social isolation/quarantine, as well as providing further support to people who may be vulnerable to experiencing high levels of stress or who have pre-existing health conditions. See Pillar 2 for further details on plans for scaled-up risk communication with communities.

Scale-up of sanitation and hygiene

The WASH Cluster and partners will focus their response efforts on establishing hand washing facilities at border entry points, health and nutrition facilities and in IDP sites. To minimise the risks of rapid spread, the Cluster will also prioritise spraying chlorine on common equipment; improving safe excreta disposal; solid waste management; and safe drinking water supply in isolation wards, 'at risk' locations and affected hotspots.

Pre-positioning of key medical and sanitation supplies

In areas at higher risk of COVID-19, clusters will work towards pre-positioning personal protective equipment, critical WASH supplies (soaps, buckets with taps, chlorine drums, sprayers, household water treatment supplies, and latrine slabs etc) and household items. While planning is in place, early pre-positioning is contingent on partners' ability to frontload resources to ensure sufficient stocks are available around the country.

Isolation spaces in displacement sites

The ES-NFI Cluster and its partners will strengthen efforts to set up of isolation centres within IDP sites designated for the initial reception of possible patients, delivery of psychosocial support and general information dissemination. The idea is not to provide extended care or isolation in these tents unless there are no alternatives. Rather they will be initial stopping points where people can be assessed by health professionals while isolated from the general population.

Catch-up classes for students and re-deployment of teachers

With all schools suspended for an initial month starting from 18 March, the EiEWG and its partners are planning for catch-up arrangements for whenever schools resume. They will also re-deploy some 6,000 teachers as agents of community awareness about the preventive measures against the virus. Should schools open quickly, the EiEWG has mapped 'at-risk' schools – those without access to water and sanitation facilities to allow for a targeted WASH response in these schools. The working group is specifically concerned about 756 schools in the border provinces (Hirat, Nimroz, Kandahar and Nangarhar) serving 862,000 children where there is currently no access to clean water. The working group is actively exploring longer-term options (TV, radio and online) to ensure continuation of classes if school closures are extended.

Protection assistance for people with specific needs and vulnerabilities

Protection Cluster partners will ensure timely identification of people with specific needs (women-headed households, unaccompanied minors, persons living with physical and psychosocial disabilities, people with pre-existing serious medical conditions, and elderly people) to be referred for immediate tailored assistance. They will also conduct close monitoring for the adoption of negative coping mechanisms fuelled by COVID-19. The response will include child protection activities to raise awareness of COVID-19 mitigation measures including at Child Friendly Spaces and Juvenile Rehabilitation Centres. Dignity kits will be distributed to women and girls in high risk areas, solar radios will be provided to the elderly and people with disabilities for COVID19 messaging and other NFIs to increase safety and dignity of beneficiaries. Cash-for-Protection payments may be provided to people with specific needs who are unable to access healthcare facilities, to mitigate negative economic effect of lost livelihoods for household members in isolation, or to reduce the economic burden of unpaid work to women and girls. The sharing of messages on positive coping strategies will also be critical. Overall, a 'Do No Harm' principle will be applied across the response, particularly with regard to distributions where clusters will be led by WFP's global guidance on risk reduction at distribution points.

Minimising the risk of further food insecurity and malnutrition

FSAC and its partners will continue to closely monitor food prices and strengthen market supervision to share information and mitigate against the unfettered price rises that often drive inflation in emergency situations. FSAC will also distribute food to at-risk population and provide livelihoods assistance. The Nutrition Cluster will promote safe nutritional practices and increase the treatment of SAM and MAM amongst children and lactating women in high-risk districts.

Advocacy on containment methods and maintaining transportation links

The Protection Cluster will work with national and local authorities to avoid them resorting to detention as a containment measure. Partners will further aim to raise awareness and contain risks of contagion in prisons. FSAC will engage the Government to facilitate the smooth operation of regional agricultural and food supply chains and to maintain the functionality of key transportation links. The cluster and the humanitarian leadership will advocate for 'humanitarian corridors' for critical life-saving relief commodities. It is critical that in line with International Humanitarian Law, both parties to the conflict and civilian authorities allow aid agencies to safely distribute life-saving items to the most vulnerable.

Monitoring of cross-border and internal movement patterns

DTM will continue to provide real-time analysis of movement trends both cross-border and within the country to support operational decision making and identification of at-risk areas.

Modalities of assistance - Cash

The response outlined in this plan will be delivered via a combination of in-kind, cash and voucher assistance (CVA). Most clusters are already planning some element of cash programming but this may need to be stepped up in the event of more severe movement restrictions or pipeline interruptions for in-kind supplies. Cash and vouchers have the potential to support humanitarians to provide continuous life-saving support to the most vulnerable people and provide them with additional choice and flexibility. CVA usually does not require a heavy and consistent staff presence, is not subject to the same logistical barriers as in-kind assistance and can often continue during peaks of disruption and displacement. However, as with in-kind programming, it is important that the risks linked to the use of cash are mitigated by:

- Good planning, feasibility assessments, market monitoring and analysis of risk transfer
- Ensuring that staff considering cash or voucher modalities are trained in safe implementation
- Decreasing project complexity
- Adapting structures and procedures to make cash easier to manage
- Making additional and regular checks on procedures and resources
- Prioritising well-documented communications with staff/partners, stakeholders and donors
- Implementing distribution precautions² to minimise the risk of COVID-19 exposure to personnel, partners and beneficiaries.
- The current security context, it is important that partners considering cash or voucher assistance carry-out periodic security risk assessments of existing and potential project locations and provide resources for context-specific safety and security training.

PILLAR 2: RISK COMMUNICATION AND COMMUNITY ENGAGEMENT

Awareness raising and evidence-based sensitisation on COVID-19 facts remains a key concern and requires further strengthening in the response. A dedicated COVID-19 Risk Communication Working Group has been stood-up to allow work to be undertaken on rumour management and more effective sharing of safety messages with the general public. This will later be absorbed by the AAP Working Group.

The Government and humanitarian partners have already developed and widely shared messaging on COVID-19. Health and other partners have adapted and printed of 980,000 IEC materials distributed across 21 provinces. These materials are shared in several languages spoken in Afghanistan. There is continued messaging via radio and television at the national level on hygiene and case identification. Health partners have further sponsored social media sites for mass awareness. Other partners continue to use wash committees, school teachers, mobile health teams, polio teams and other community-based disease reporting volunteers, as well as immunisation communication networks to support ongoing risk communication and community awareness. The health cluster is providing technical guidance and dissemination of WHO guidelines on COVID-19 including case definition and case management to health facilities to implementing partners and surveillance teams. Together with MoPH, the Cluster is continuing to promote advocacy and guidance on mass gatherings including cultural, religious and sport events.

With regard to communications preferences, the Whole of Afghanistan (WOA) Assessment results from late 2019 clearly showed that a one-size-fits-all approach to communication should be avoided in Afghanistan. In the Whole of Afghanistan Assessment, the majority of displaced households reported that their preferred communication modality with aid providers was either via the phone/SMS (49 per cent) or via a community leader (34 per cent). However, these preferences are not static and appear to change over time, by gender and according to geography, suggesting the need for frequent reality checks on the best ways to reach specific

² Recommendations for adjusting food distribution standard operating procedures in the context of the COVID-19 outbreak https://reliefweb.int/sites/reliefweb.int/files/resources/20200319_covid_sop_food_assistance.pdf

beneficiaries in any given location at any given time. With the volatility of the results, there is a need for constant crosschecking of communication choices by responders. In focus group discussions, women also said they often preferred to share concerns about their needs for humanitarian assistance via letters directed to Directorate of Women's Affairs, as a result of its connections with women's organisations.

Global guidance has been issued on ways to ensure responders are communicating in an appropriate and effective way with marginalised and vulnerable groups on COVID-19 risks and prevention measures. Previous epidemics illustrate the value of engaging with women when communicating about risks:

- Women are a disproportionate part of the health workforce.
- As primary caregivers to children, the elderly, and the ill, we must recognise and engage women in risk communication and community engagement
- When we don't recognize gendered dynamics during outbreaks, we limit the effectiveness of risk communication efforts
- Women's access to information on outbreaks and available services are severely constrained when community engagement teams are dominated by men
- Tailoring community engagement interventions for gender, language, and local culture improves communities' uptake with interventions

This global guidance will be applied in the Afghanistan response where ever possible and can be accessed here: https://reliefweb.int/sites/reliefweb.int/files/resources/COVID-19_CommunityEngagement_130320.pdf

In February, Awaaz started to collaborate with the World Health Organisation (WHO) to raise awareness and inform callers about COVID-19. In close coordination with WHO, Awaaz recorded awareness-raising messages which had been heard by 1,975 callers from throughout the country by the end of the February. Up until 14 March, the message was played to an additional 2,695 callers, either while they were on hold or when calling outside of Awaaz's operating hours. In February, Awaaz received 144 calls from 22 provinces with callers enquiring about COVID-19. From 1-14 March, Awaaz registered 185 enquiries around COVID-19 from 28 different provinces.

In addition to the services above, Awaaz is looking into the option of supporting the response through SMS dissemination to targeted at-risk areas (province-level), as well as targeted outbound calls to relevant callers registered through Awaaz in the recent past, i.e returnees from Iran and communities in highly affected areas.

Awaaz is also an important accountability tool, providing a free and simple way for beneficiaries to raise feedback or complaints about the assistance they have received and their interaction with humanitarian organisations. This compliments individual agency complaints mechanisms which are also in place.

PILLAR 3: SURVEILLANCE, RAPID RESPONSE TEAMS, AND CASE INVESTIGATION

Under this pillar, health partners also aim to:

- Enhance surveillance systems for early detection, isolation, and confirmation of suspected cases
- Scale-up surveillance and risk communications at border crossing points, pending the receipt of additional funds
- Ensure rapid detection and confirmation of the suspected cases and immediate isolation and treatment of confirmed cases
- Support rapid response teams and provide technical guidance at all levels
- Ensure guidelines and SOPs and contact tracing and follow up forms available with the teams
- Ensure availability of stockpiles of Personal Protective Equipment (PPE) and consumables for surveillance and diagnostic and case management facilities

While Afghanistan has recently received deliveries of diagnostic kits from UAE and China, diagnostic testing is still stretched given the increasing demand. This is essential to containing the outbreak and is considered a priority.

PILLAR 4: POINTS OF ENTRY

During the week starting 8 March, IOM reported that between 5,000 and 8,000 returnees came into Afghanistan each day through the Islam Qala border crossing alone. Between 14 and 15 March, more than 20,000 returnees arrived into Afghanistan from Iran through this crossing – the largest two-day return ever recorded. Returns slowed significantly over the Nowruz New Year holiday. Effective screening and registration processes for new arrivals from Iran have been compromised by the volume of returnees. This will affect the ability to trace people potentially exposed to COVID-19.

A number of people being held in isolation in hospital in Hirat left the facility on 16 March, potentially exposing the community to disease risk. Distrust of the authorities, loss of livelihoods issues, hospital conditions, stigma and lack of understanding of risk and fear are all contributing to this situation and warrant a scale-up of awareness raising among those being isolated in hospitals and more generally in local communities. The protection cluster will endeavour to negotiate safe access or the delivery of messages to those being held in medical isolation in order to ensure they understand what is happening to them, that their well-being is being protected and that their specific needs are being addressed. Improved awareness raising at border crossings will also support this. Addressing rumours and community fears of seeking medical treatment through community engagement will be critical.

There has been discussion of the possible establishment of camps, encashment centres or quarantine locations for returnees, especially in the country's West. The humanitarian community does not support the establishment of camps for people returning from either Iran or Pakistan. This is not in line with global best practice and has proven an ineffective tool in other contexts such as Pakistan which established a quarantine camp at Taftan on its border with Iran.³ The concentration of individuals in such confined environments increases the risk of disease spread. Containment in hospitals where people can receive medical care and can be isolated from each other is the approach recommended by WHO, where such facilities exist.

The health cluster has prioritised support for health teams to conduct screening at the Points of Entry (ground crossings and airports), as well as the implementation of health measures for travellers. So far, eight points of entry have been equipped with essential supplies (infrared thermometers, personal protection equipment (PPE), and alcohol-based hand sanitisers). But further scale-up is required. Health partners are also supporting the operational costs of response teams at land and air points of entry. Health partners are training surveillance personnel on case definition, screening and contact tracing. Since the outbreak was first reported in Afghanistan, in excess of 100,000 people have been screened.

Humanitarian partners have further installed temporary washing stations for returnees at border screening facilities and are completing the construction of permanent WASH facilities – 19 facilities at the Islam Qala border crossing. Some 55 handwashing stations have been installed in all transit facilities in border areas in an effort to limit transmission.

Community awareness activities have also been provided in internal displacement sites in Hirat and COVID-19 trainings for 15 Mobile Health Teams in Ghor and Badghis provinces.

PILLAR 5: NATIONAL LABORATORIES

The health cluster will continue to support diagnostic facilities for COVID-19, confirmatory testing (both at the national and sub-national levels) and provision of technical guidance to Central Public Health Laboratories (CPHL) on standard operating procedures for specimen collection, packing and transport. The health cluster has expanded the national laboratory capacity in Kabul to conduct more than 50 tests per day. A laboratory has also been established in Hirat and is now able to test samples. Capacity at this laboratory will be scaled-up in the coming weeks. While Afghanistan has recently received deliveries of diagnostic kits from UAE and China, diagnostic testing is still stretched given the increasing demand. Air transport of COVID-19 testing samples to Kabul is proving challenging from some locations. WHO advises that there is an SOP for transporting of

³ <https://www.aljazeera.com/news/2020/03/pakistan-spike-coronavirus-cases-raises-quarantine-concerns-200316090946936.html>

samples. All samples should be transported in the same way that Polio samples are moved to Kabul from each province.

PILLAR 6: INFECTION PREVENTION AND CONTROL

Under this pillar, the health cluster's priorities are:

- Infection prevention and control measures at the health facility level and at designated Points of Entry.
- Ensuring a functioning infection prevention and control program in each hospital/health care facility is in place in the areas where cases are suspected/identified/transferred.

Health partners have so far delivered medical equipment (ventilators, IPC materials, hospital and lab consumables, etc.) to eight facilities. Partners further provided PPE, masks and essential infection prevention supplies to health facilities in eight priority provinces. Health partners have also trained some 360 healthcare workers on case management and infection prevention and control.

WASH cluster partners also have a strong role to play in infection prevention and control through the installation of water and handwashing points at health facilities.

PILLAR 7: CASE MANAGEMENT

While most people with COVID-19 develop mild or uncomplicated illness, approximately 14 per cent develop severe disease requiring hospitalisation and oxygen support. An estimated five per cent require admission to an intensive care unit. In severe cases, COVID-19 can be complicated by acute respiratory disease syndrome (ARDS) and other serious and life-threatening conditions. Older age and co-morbid disease have been reported as risk factors for mortality.

- Health cluster partners will support people affected by widespread transmission of the virus to ensure the continuity of essential health services, including through the provision of personnel, medicines, diagnostics, and other supplies
- Supporting national authorities, with the support of partners where requested, cluster partners should designate referral facilities for care of patients with COVID-19, and map existing public and private health facilities and referral systems in case they need to be brought into the response as surge capacity
- Supplies for case management and infection control will also be reviewed, re-supplied if necessary, and pre-positioned at strategic locations
- In order to strengthen readiness, partners will support national authorities, when requested, to disseminate information, train and refresh medical/ambulatory teams in the management of severe acute respiratory infections and COVID-19-specific protocols. Public health clinical operations should be informed by a COVID-19 clinical guidelines
- Health partners aim to support and equip Isolation wards and intensive care units in designated infectious disease hospitals and provincial hospitals. Currently, there is a national isolation centre with a capacity of 100 beds, as well as regional and provincial isolation centres with a total capacity of 991 beds.

PILLAR 8: OPERATIONAL SUPPORT AND LOGISTICS

The health cluster aims to build the capacity of relevant health staff in the areas of surveillance, rapid response, infection prevention and control and risk communication. Logistics remain a key concern with border crossing closures and congestion, as well as potential pipeline breaks on the horizon. The capacity of humanitarian agencies to import relief items depends on funding, imports, open borders and the stability of local and international suppliers. Even before COVID-19 fully took hold globally, supplies of food were at risk of a partial pipeline break by April/March 2020 unless additional funds were made available. Supplies of hygiene kits, school bags, and nutrition treatment supplements are all at risk of imminent pipeline breaks.

The global COVID-19 outbreak is restricting the movement of people and, critical relief commodities (including food and medicines); and basic consumer goods. The Afghanistan-Pakistan border was closed for several days after 16 March. The border briefly re-opened to reduce backlogs of commercial vehicles but this was short-lived. The border issues have affected the main supply routes for critical relief items – notably food. Several metric tons of food was stuck across the border in Pakistan with further delays in the arrival of life-saving relief supplies expected over the coming weeks and months. Sustained cross-border access from Pakistan is critical to maintaining supplies of both commercial goods and humanitarian items for people in need in Afghanistan. At the time of publication, the Iranian border currently remains open after brief initial closures. Global shortage of key medical supplies is already a concern with a number of countries withholding exports in order to build domestic stockpiles.

The plan is predicated on the expectation that flights by the United Nations Humanitarian Air Service (UNHAS) will continue to areas that are impacted, allowing continued response by humanitarian agencies. Please see Annex 1 for more details on the cost requirement for continuing this service and providing an international airbridge for staff out of Afghanistan. On 17 March 2020, UNHAS informed partners that it is implementing additional preventive measures to reduce the spread of the virus and to protect the health of passengers and humanitarian staff members. UNHAS requires all passengers to undergo temperature checks (using a non-contact infrared thermometer); and to wash and disinfect their hands before entering the UN terminal or UNHAS check-in counters. UNHAS disinfects aircrafts prior to passengers boarding.

ANNEXES

ANNEX 1: Cluster Plans

1. Education in Emergency

EXISTING BENEFICIARIES TO BE REACHED	NEW REQUIREMENTS (US\$)
170,000 PEOPLE	2.1 M

Key sectoral issues and vulnerabilities

- As of 14 March, the Government announced that all schools (which had not commenced for the academic year) were to remain closed until 18 April. This means that more than 7 million children in regular schools and more than 500,000 children enrolled in community-based education programmes will not start regular schooling as per the normal schedule. This is in addition to some 3.7m children that already remained out of school in Afghanistan.
- As such, all school children in Afghanistan are now being considered as being emergency-affected and thus will be in the 'Education in Emergencies' caseload until schools re-open and children catch-up on missed learning.
- If schools do re-open, some 33 per cent (nearly 6,000 schools that serve 2.3m students) lack water and WASH facilities. Some 500,000 children are enrolled in community-based education without access to WASH facilities. Specifically, 756 schools in the high-risk border provinces (Hirat, Nimroz, Kandahar and Nangarhar) serving 862,000 children do not have access to clean water.

Pipeline situation

- The EiEWG only has enough hygiene kits to cover the needs of 10,000 children. This will address only a fraction of the needs of the 2.8m children in over 6,000 schools and community-based education programmes without access to water if schools return in the period covered by this plan.
- EiEWG also has some Temporary Learning Space tents that could be re-purposed for isolation facilities in extreme emergencies. These are about to be pre-positioned in key locations around the country.

Key preparedness actions

- **PRIORITY: Advocating for investment in WASH facilities for schools to ensure good hygiene when students return.**
- Distribution of hygiene kits and WASH supplies in highest-risk areas.
- Support to WASH partners in water chlorination in schools for when they re-open.
- Awareness raising with students, teachers and Shura members to increase their knowledge about the virus; hygiene messaging; and promoting hand washing with soap in all schools and CBEs (when opened).
- Designing key messages; posters/brochures; launching TV/radio ads; and social media posts to raise awareness

Key response activities

- There are nearly 6,000 teachers recruited for EiE programmes and the EiEWG will re-purpose teachers as agents of community awareness about preventive measures against the virus.

Challenges, risks and constraints

- Limited WASH facilities in schools if they re-open
- Limited available stock of hygiene supplies (soaps, bucket with taps and chlorine).
- Continued insecurity may hinder access to high risk areas
- Limited response and resource capacity for partners to respond

- Limited capacity to sufficiently support school-level intervention in high-risk areas
- Flexibility is required from donors to factor-in delays in the programme implementation period

Mitigating against interruptions to the existing response:

- The working group is supporting teachers to record and televise education classes in Hirat each day. The working group is exploring alternative options for the delivery of classes (TV, radio, online) should school suspensions be extended. This includes discussions with the Ministries of Education and Telecommunications, as well as with the private sector (telecommunications providers) regarding the provision free access to electronic learning platforms. The working group is also exploring lessons learned and best practice from other emergencies and contexts that might assist in the development of such learning modalities for Afghanistan.
- The working group is also planning for catch-up arrangements for when schools resume. It is not known how long this might take but it is assumed for the purposes of this plan that schools will remain closed for the full three months covered therein. Depending on the length of the closures, the working group is planning catch-up hours or an extension of the school year into the winter period. This will require donor flexibility to allow an extended delivery period for the full year's existing school support. It will also mean additional costs for winterisation support when the time comes later in the year.
- In the meantime, there are 6214 teachers employed for the school year already. The EiEWG is committed to retaining these staff and that will mean continuing to pay them even when schools are closed. A teacher's salary is \$100 USD per month plus programme costs related to salary distribution. To keep these teachers employed over the three months covered by this plan, they are instead being asked to do risk communication in their communities for three months. This will cost a total of \$715,000 per month including operational costs of contracting/payroll etc. This means a total of \$2.145m

Key response activities

- **PRIORITY:** Procurement and distribution of NFI kits to IDPs and vulnerable households affected by COVID-19 to reduce the number of households sharing core relief items and to replenish existing supplies. The immediate response will rely on existing and pre-positioned stocks
- **PRIORITY:** Isolation spaces - Within IDP sites, ES-NFI partners will focus on identification of land/spaces and setting up of tents or pre-fabricated housing unit (RHUs), designated for border and IDP sites monitoring, storage spaces, temporary offices, psychosocial support and information dissemination.
- Distributions - ES-NFI partners will promote safe handling practices (i.e. cleaning of items included in the NFI kit such as cooking pots and buckets) through mass campaigns to mitigate exposure during emergency shelter and NFI distributions.
- Inclusive programming -The Cluster will ensure involvement of female staff at all sites in mobiliser, assessor and trainer functions. Cluster partners will ensure safe consultative meetings with affected people, including women and girls, to understand needs and preferences for location, design, and methodology of assistance.
- Information sharing - To support effective coordination, the Cluster will disseminate regular updates to all partners on current trends, surveillance recommendations, risk communications for the public in response to local outbreaks, as advised by WHO. Two-way 'channels' for community and public information sharing – such as Awaaz Afghanistan – will be used to detect, rapidly respond to and counter misinformation.

Challenges, risks and constraints

- The current response plan assumes that human-to-human transmission takes place, and that it may be amplified in public gatherings such as in cases of NFI distributions.
- The flood season may place a simultaneous strain on human and physical resources in different parts of the country. Pipelines of key shelter and NFI stocks may be affected.
- Security-related constraints may limit partner's capacity to access affected people.
- The spread of COVID-19 may affect the ability of humanitarians to go to the field and respond – including undertaking assessments, registration and monitoring.
- Immediate response will rely on existing and pre-positioned stocks. This may result in normal programming in existing response locations being compromised by the activities outlined in this plan if new supplies do not arrive.
- Delays in delivery of core relief items to affected regions may be experienced due to movement restrictions/border closures, as well as other factors including conflict and natural disasters.

Mitigating against interruptions to the existing response:

- ES-NFI will pre-position NFI's, emergency tents and Refugee Housing Units (RHU) at national and sub-national levels - in the most COVID-19 at-risk areas.
- The cluster will also undertake a mapping of existing IDP sites particularly in the most COVID-19 at-risk areas, settlements where people are living in overcrowded conditions, with higher densities, with a view to identifying spaces that can be utilised for setting up of isolation centres. This will be of importance when a COVID-19 case is confirmed from the site and/or self-isolation is recommended. Negotiation for additional space for potential isolation needs to be carried out as part of preparedness, ahead of cases being identified.
- The cluster will encourage partners to phase distributions to limit exposure of field staff and beneficiaries.
- Develop and disseminate SOPs on appropriate risk mitigation measures to be undertaken by partners before, during and after emergency shelter and/or household item distribution events.
- The cluster will support information campaigns, from national and local health authorities and provide clear and unequivocal messages focusing on what people can do to reduce risk or which actions to take if they think they may have COVID-19.

- The cluster will continue to closely monitor food and agricultural input prices and strengthen market supervision. Transparent market information will enhance the overall management of the food market, help to prevent the onset of panic, and can guide farmers in making rational production decisions.
- The cluster will engage in advocacy efforts towards smooth logistical operations of regional agricultural and food supply chains, notably the Iran-Hirat transportation link.
- FSAC partners will raise awareness about nutritional food requirements and safe water treatment and storage practices in preparation for a sustained outbreak period.
- The cluster aims to increase the protection of field staff through propositioning of PPE; installing handwashing stations and distributing IEC materials at food distribution and training centres.
- The cluster is exploring alternative modalities of response – cash – if food arrival is delayed due to border closures.

Key response activities:

- **PRIORITY: FSAC partners plan to secure essential food stocks for an initial period of 6–12 weeks to cover food needs during any disruption. The initial aid packages will include emergency food assistance to 408,000 people and livelihood inputs to 90,000 people**
 - For the food aid to 408,000 people there are 278,000 people in the priority districts who have already receive two half rations and 70,000 people who have received no rations; this food aid will top up the ones who have already received partial rations and cover the additional caseload of vulnerable people who have returned and are at a higher risk of COVID-19 impacts
 - The food aid will also target an additional 60,000 people in five districts outside the priority list in Nimroz province which is projected to be in IPC 4 and subject to similar shocks as the districts already listed as priority districts
 - The livelihood aid will provide emergency livelihood inputs to sustain livestock and key spring cultivation activities
- **PRIORITY: FSAC partners will continue to monitor the impact of COVID-19 on agriculture- and livestock-based livelihoods, market prices and consider livelihoods protection response as necessary**
- FSAC will work with national and regional governments to improve food utilisation through awareness raising on the necessity of increased hygiene, nutrition, and safe food and water storage so that people can make the best use of the foods they can access.
- Public awareness raising components about COVID-19 will be a requirement for all FSAC projects.

Challenges, risks and constraints:

- FSAC was already concerned about the limited financial resources for its planned food and livelihoods response without the added burden that a pandemic creates. Partners are also wary of the risk of exposure of humanitarian personnel delivering assistance.
- Already, due to a scale-down of operations being seen among livelihoods partners, FSAC has temporarily paused seasonal support activities that were planned to start in April, while existing livelihood support such as distribution of seeds are planned to continue. This will affect some of the 70,000 people planned to receive livelihoods support each month. While the impact of this temporary suspension is viewed to be minimal in the immediate term, given the extended lead times ahead of delivery of planned activities, FSAC is concerned about loss of value in value and supply chain if the temporary pause extends over one month.
- Border crossing closures and limitations remain the main concern in terms of supply chain. At the moment there are national shortages in wheat flour, pulses are still making their way through northern crossings, rice may reduce in availability, vegetable oil may also reduce slightly. The primary commodities that have been held up at the border have been WSB and some vegetable oil – other commodities have been difficult to find but that is partly due to seasonal interruptions (wheat flour), other commodities are still making their way through partial border closures (pulses), other areas may have good level of localised production (vegetables). The key issue will be whether commercial goods are allowed to cross the Afghanistan-Pakistan border. This will have an impact on market prices and foodstuff availability and accessibility of vulnerable people to markets.

Mitigating against interruptions to the existing response:

- Food Security is planning to conduct double-ration food distributions over the next three months to support people in the event of movement restrictions.

- Distributions are being phased to limit exposure of beneficiaries when they receive food packages.
- Repurposing staff who were working on livelihoods programming where these activities are paused. They are instead supporting the scaled-up food response.
- FSAC is exploring alternate modalities for continued delivery of supplementary feeding previously delivered in schools through a take-home approach. Therapeutic feeding should be able to continue at nutrition centres.

- Tele-psychosocial support will be provided through free online and hotline services including for those at-risk or affected by COVID-19, or concerned family and friends;
- Awareness campaigns about mental health and psychosocial issues and the support available will be conducted using multi-media modalities such as social media, radio, brochures etc
- Frontline workers will be trained on psychological first aid (PFA) in order to continue providing first-phase psychosocial support to people affected by crisis, including, but not limited to COVID-19.

Challenges, risks and constraints:

- The Cluster is concerned by continued violence and access challenges impeding surveillance and testing, as well as spring floods increasing risks of infection (particularly in displacement sites).
- Stretched pipeline of critical medicines and disruption of global supply chains is also a concern for the Cluster.
- Given the limited capacities in place, the Cluster predicts that there will be an inevitable overburdening of the existing and already weak health-care facilities.
- Personal protective equipment (PPE) is not always readily available for field teams working closely over an extended period of time (more than 15 minutes, face-to-face or in groups)
- Staff willingness to go to field may be compromised in coming weeks/months due to the risk of spread of the virus
- WHO key messages may be compromised due to myths and underlying beliefs about the causes and effects of the virus

Mitigating against interruptions to the existing response:

- Health Cluster will continue to source diagnostic kits and medical consumables that are essential to the response.
- COVID 19 Risk Communication Working Group will continue to engage with affected people to increase uptake of risk communication message
- Early and ongoing training of healthcare workers on surveillance, isolation and case management in anticipation of an increase in the number of cases
- Early preparedness planning to increase available isolation and treatment facilities, as well as planning for potential self-isolation options.
- Increase the number of diagnostic testing facilities in the provinces.
- Engage the polio team in surveillance and contact tracing activities.

5. Nutrition

EXISTING BENEFICIARIES TO BE REACHED **225,000 PEOPLE** TOTAL REQUIREMENT (US\$) **21.1 M**

COSTED IN HRP (US\$) **15.3 M**

ADDITIONAL PEOPLE TO BE REACHED **161,000 PEOPLE** NEW REQUIREMENTS (US\$) **5.8 M**

Key sectoral issues and vulnerabilities:

- The nutritional status of children under five continues to deteriorate in most parts of Afghanistan. More than two thirds of the country (25 out of 34 provinces) is at emergency level of malnutrition. A spread in COVID-19 is expected to exacerbate the current nutrition emergency already affecting 2.54m children under 5.

Pipeline situation:

- RUTF pipeline rupture is expected after April 2020 if planned stock arrivals do not eventuate due to border closures and other transportation challenges.

Key preparedness actions:

- The Cluster has updated contact details of Nutrition Cluster Partners in COVID-19 high-risk areas
- The Cluster will undertake mapping of high risk or hotspot areas to review existing human and financial resources among Nutrition Cluster partners in these areas.
- The Cluster aims to secure strategic reserves of nutrition supplies for prevention and treatment of undernutrition and pre-position nutrition commodities and routine drugs in strategic locations.
- The Cluster is undertaking regular Nutrition Cluster coordination meetings to avoid duplication preparedness efforts.

Key response activities:

- **PRIORITY: The Cluster will continue its regular activities – MUAC screening; treatment of severe and acute malnutrition, blanket and targeted supplementary feeding and training on feeding practices.**
- The Cluster has decided to include borderline malnutrition cases for support in order to reduce the health risks faced by these groups in the face of COVID-19.

Challenges, risks and constraints:

- Disruption of nutrition service provision due to overburdened health facilities and staff shortages associated with COVID-19 may worsen the nutrition status of children and lactating women in the high-risk districts.
- Ongoing integrated response with Health and WASH actors may be limited to certain areas
- Diversion of resources to the COVID-19 health response may inhibit meaningful delivery of nutrition services.
- Damaged road networks because of flooding, insecurity and restrictions on access pose challenges to ongoing nutrition response.

Mitigating against interruptions to the existing response:

- The cluster will offer non-financial incentives to nutrition volunteers who are normally unpaid to ensure that MUAC testing, counselling on Infant and young child feeding counselling can continue and this critical workforce is retained.

Protection Committees to assist with case identification, in order to mitigate staff exposure to possible COVID-19 cases.

- **PRIORITY:** Child protection partners will continue to raise awareness on child protection issues, as well as addressing the GBV needs of child survivors, the provision of psychosocial support, and responding to separated children including provision of family alternative care, PSS, medical and other services.
- **PRIORITY:** Individual Protection Assistance (IPA) through the provision of protection kits that include dignity items for women and girls in high risk areas, solar radios to elderly and people with disabilities for COVID19 messaging and other NFIs to increase safety and dignity for beneficiaries.
- **PRIORITY:** Cash for protection payments may be provided for people with specific needs who are unable to access healthcare facilities, or to mitigate negative economic impacts from loss of livelihood for household members in isolation, or to reduce the economic burden of unpaid work to women and girls.
- Protection partners will continue to install handwashing stations in all border transit centres and are actively engaged in sensitising staff on handwashing and best practices to mitigate and prevent disease transmission.
- Protection partners will undertake counselling during household-level assessments and in open air areas to limit mass gatherings due to high risk of contamination.
- The Cluster will monitor the development of negative coping strategies among vulnerable groups as a result of economic challenges, price rises and movement restrictions.
- Protection partners plan to distribute IEC materials and awareness raising sessions on COVID-19 in 440 child friendly spaces, 34 provincial Child Protection Action Networks, and 200 community structures across 34 provinces.
- Advocacy to governmental authorities to continue receiving IDP petitions and referrals for assistance while explaining prevention measures and good hygiene practices to limit contamination.
- Case Management will be adjusted in health clinics for referrals and treatment to be made in safety and dignity.

Challenges, risks and constraints

- The high volume of returnees from Iran has made systematic screening and monitoring difficult, which consequently hampers the identification of persons with specific needs and protection concerns.
- There is insufficient coordination between Afghan and Iranian authorities to manage border formalities to avoid long waiting periods and large crowds.
- Lack of adequate water and sanitation facilities as well as hygiene supplies and promotion materials at IDP sites in Hirat, particularly at Sharak-e-Sabz displacement site, remains a key concern.

Mitigating against interruptions to the existing response:

- An emphasis on increasing public awareness, through various communication channels in order to reach the largest number of community members including those with literacy challenges will be put forward, notably through the use of radio and television broadcasts and through use of mobile teams.
- Adapting modalities of delivering services: no large gatherings, considering outdoor meeting space, resorting to mobile teams to reach out to people at household-level.
- Sub-clusters are conveying consistent messages to limit non-essential interactions and keep appropriate distance, in some cases personal protective equipment is provided.
- Some programmes taking place in crowded government departments have been scaled-down to reduce the possibility of large-scale contamination.

Key response activities: ALL PRIORITISED

- The Cluster will prioritise provision of hand washing facilities in the most COVID-19 'at risk' places with functional water systems. The initial focus is on concentrated IDP sites, nutritional centres (inpatient and outpatient), border entry points, health and isolation centres upon needs, as well as schools and temporary learning spaces depending on their reopening
- The Cluster will also focus on scaling-up of handwashing messaging. At community level, the top priority will remain the promotion of handwashing with soap – proper, frequent and at critical times. In public spaces or at institutional level, hand cleansing with alcohol-based hand sanitizer or handwashing with chlorinated water (0.05 per cent) can be nonetheless more appropriate. However, while alcohol-based hand sanitizer kills the coronavirus, it does not kill all kinds of bacteria and viruses (e.g. norovirus and rotavirus). Consequently, the family hygiene kit will keep the soap as key item without adding hand sanitizer. This will help also to not discredit the value of the soap during and after the COVID-19 crisis.
- To minimise the risks of contamination and spread of other infectious diseases, the Cluster will undertake spraying of chlorine on common equipment; improving safe excreta disposal, solid waste management and safe drinking water supply in isolation wards at the most at-risk public spaces or affected hotspots.
- The Cluster will strengthen the linkages between WASH committees, hygiene promoters and community health workers on reporting of suspected cases, referral and messaging.

Challenges, risks and constraints:

- There was already an imminent break of the WASH supply pipeline forecast in April 2020. This situation will only be exacerbated by the need for immediate scale-up of the WASH COVID-19 response. Funding to HRP activities is critical.
- WASH partners are of the view that continued threat of insecurity might impede accessibility in certain districts of the country.
- The Cluster is cognisant that any increase in the scale of flood response will likely stretch WASH partners' response capacity for COVID-19.
- With the speed and scale of transmission of the virus, it is likely that the willingness of partner staff to engage and support in the response might be diminished due to fear of exposure to the virus.

Mitigation measures:

- As both a preparedness and mitigation measure, the WASH Cluster will pre-position key supplies (soaps, buckets with taps, chlorine drums, sprayers, household water treatments, and latrine slabs etc) at national and sub-national levels - in the most COVID-19 at-risk areas. This will mitigate breaks in assistance should movement restrictions are put in place

8. Air Services

TOTAL REQUIREMENT (US\$)

12.6 M

COSTED IN HRP (US\$)

5.1 M

NEW REQUIREMENTS (US\$)

7.5 M

PRIORITY: Domestic UNHAS flights – \$9.6m

In order to maintain essential air services by UNHAS for the wider humanitarian community in the country until the end of the year, immediate additional funding is required. UNHAS is currently keeping up daily operations to cover the needs of user organisations' essential missions. Due to fewer passengers and reduced occupancy of each aircraft to allow for social distancing, UNHAS is facing a drastic reduction of cost recovery from passengers.

UNHAS has already taken cost reduction measures and cut one fifth of its capacity in 2020. Further reductions would significantly diminish UNHAS' ability to serve the humanitarian community in Afghanistan, both for essential air services and its readiness for medical and security relocations. With the additional funding, UNHAS would be able to respond to the relocation requests for aid workers returning to their field duty stations and to manage an increase of transport needs for the COVID-response.

So far this year, UNHAS received \$2.35m and has \$5.25m in the pipeline from different donors. Cost recovery – initially expected to amount to \$5.2m in 2020 prior to the coronavirus outbreak – cannot be precisely estimated at the moment but will be drastically lower.

To avoid a further reduction of UNHAS capacity in country and ensure essential domestic air services can be maintained for the humanitarian community throughout 2020, UNHAS urgently needs additional funds in the amount of \$9.6m, which will ensure essential air service despite the effects of the coronavirus in the country.

PRIORITY: International airbridge - \$3m for six months

As commercial flights to Kabul are being suspended by major airlines, UNHAS is exploring options to establish an international airbridge at the request of humanitarian agencies. WFP's aviation office in the United Arab Emirates (UAE) is in contact with the UAE aviation authorities in this regard and the authorities have voiced their support and clearance for such flights, if required. Other possible destinations are also being explored. Three commercial air operators indicated their willingness to start such a service on relatively short notice. These aircraft types have passenger capacity of 50-120 seats.

The monthly cost of such an airbridge from Kabul to UAE is estimated at approximately \$500,000, with UNHAS scheduling the flights twice a week. However, this will depend on passenger demand, the type of aircraft and the operators' proposal.

9. Displacement Tracking

NEW REQUIREMENTS (US\$)

0.5 M

IOM's Displacement Tracking Matrix (DTM) will focus its COVID-19 response and coordination efforts in the following areas of intervention: Risk Communication and Community Engagement (RCCE), Surveillance, and Points of Entry.

Community Engagement:

Capitalising upon DTM's extensive outreach and network of 62,000 community leaders and change agents in 12,000 villages nationwide, with technical oversight from IOM's migration health unit and in coordination with WHO and MoPH, IOM will work with relevant counterparts in the Ministry of Public Health to provide culturally and linguistically tailored, mobility-sensitive, public health messaging to migrants, mobile populations and communities affected by human mobility. Key target locations of concern include settlements hosting return and displaced populations, along mobility corridors, and within existing migrant and mobile population networks, including travel agencies, tour operators, and at transit hubs. Community outreach and health messaging will include COVID-19 risk awareness, infection prevention and control, dispelling misinformation, hygiene and access to related health services.

Disease Surveillance and Mobility Mapping:

IOM will enhance existing national level disease surveillance systems through strengthening community event-based surveillance by linking mobility information to surveillance data, particularly among border communities and migrant dense areas. DTM will also conduct Participatory Population Mobility Mapping (PPM) exercises, particularly in areas of high incidence or outbreak, to identify high-risk mobility corridors and Spaces of Vulnerability (SOVs) where mobile populations interact with local communities and other mobile populations, and then jointly develop strategies, response plans, and accountability systems to mitigate the potential risk of spread of COVID-19. Following a standardised methodology established by IOM's Global Migration Health Unit (MHU), mobility mapping exercises will be undertaken by DTM with stakeholders at provincial, district, and settlement levels to create a shared understanding of human mobility and the risks of transmission, setting the stage for strengthening of local health systems to reduce the risk of transmission and contain potential and ongoing outbreaks.

Points of entry:

IOM will support the MOPH and partners to enhance preparedness and response at prioritised points of entry through Flow Monitoring. Through flow monitoring activities at borders, DTM will collect health and mobility data, as well as support active surveillance, risk awareness, and infection prevention and control. Using the origin and destination data collected through flow monitoring from travellers crossing Afghanistan's borders, irrespective of nationality or migration status, DTM will provide a timely evidence base and mobility mapping to highlight the human mobility connectivity between outbreak districts in neighbouring countries and priority destination districts in Afghanistan at potential risk of spread of COVID-19. This information will guide response by defining priority locations where community outreach could be strengthened to promote COVID-19 risk awareness, IPC best-practices and community-based surveillance, as well as to ensure preparedness in terms of trained health personnel, preparation of infrastructure for isolation, and prepositioning of medical supplies.

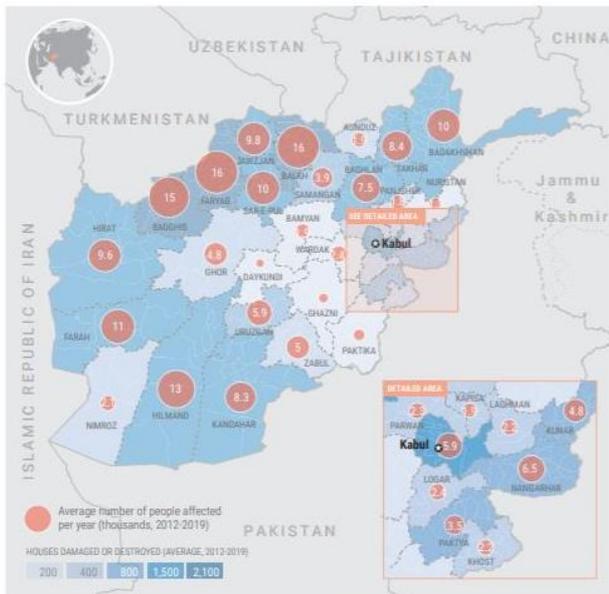
ANNEX 2: Flood Plan Summary

AFGHANISTAN ICCT FLOOD CONTINGENCY PLAN

MARCH – JUNE 2020
ISSUED 20 FEBRUARY 2020

Key figures

PEOPLE IN NEED	PLANNED REACH	ALREADY AFFECTED	HIGH RISK REGIONS	LOW RAINFALL	FUNDING REQUIRED	FUNDING AVAILABLE	FUNDING GAP
200K	170K	20K	Central East West South	Northeast North	\$42M	\$12.8M	\$29.2M



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

Response objectives

- Save lives in the areas of highest need through rapid provision of relief items and emergency services
- Ensure that vulnerable people with specific needs and/or reduced coping capacities have access to assistance that meets their needs
- Provide support for rapid recovery and resilience building, especially in locations that are repeatedly exposed to flood

Planning scenario

Afghanistan is highly prone to natural disasters, the frequency and intensity of which are exacerbated by the effects of climate change, increasing humanitarian needs. Afghanistan has an INFORM Risk Index of 7.9, the fifth highest risk country out of 191 profiled. At the same time, the Notre Dame Global Adaptation Index ranks it as one of the least prepared countries against climatic shocks and the 11th most vulnerable country in the world to climate change. Flooding affected large swathes of the country every year as heavy snow melts and rivers swell, inundating communities. Heavy rainfall also contributes to flash flooding. The typical flood season runs from March to June each year. In 2019, heavy rainfall caused unseasonal flooding in atypical locations, especially in the country's south, affecting some 294,000 people. This was the last in a string of unusual weather years for Afghanistan which included three successive years of low rainfall and minimal flooding amid a drought in 2016, 2017 and 2018.

In 2020, floods are expected to return to a more normal pattern across most of the country in terms of scale and intensity, with some geographical variations. Climate projections indicate the potential for higher temperatures, along with above average snow and rain in the east, west, central and southern parts of the country, which will in turn lead to faster melt and evaporation rates. This will increase the risk of extreme events such as flash floods and flooding of rivers.

ANNEX 3: Links – Resources and more information

WHO

- WHO situation dashboard: <https://experience.arcgis.com/experience/685d0ace521648f8a5beeeee1b9125cd>
- General information: <https://www.who.int/health-topics/coronavirus>
- Advice for public: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>
- Global surveillance for human infection with coronavirus disease: [https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-\(2019-ncov\)](https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov))
- Advice for international travel and trade: <https://www.who.int/ith/2020-24-01-outbreak-of-Pneumonia-caused-by-new-coronavirus/en/>
- Introduction to COVID-19 online course: <https://openwho.org/courses/introduction-to-ncov>
- WHO Afghanistan Twitter page: <https://twitter.com/WHOafghanistan>
- COVID-19 myth busters: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/myth-busters>
- When and how to use masks: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/when-and-how-to-use-masks>
- Social stigma associated with COVID-19: [https://www.epi-win.com/sites/epiwin/files/content/attachments/2020-02-24/COVID19 Stigma Guide 24022020_1.pdf](https://www.epi-win.com/sites/epiwin/files/content/attachments/2020-02-24/COVID19%20Stigma%20Guide%2024022020_1.pdf)
- Mental health and psychosocial considerations During COVID-19 Outbreak: <https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf>
- Coping with stress during the 2019-nCoV outbreak: https://www.who.int/docs/default-source/coronaviruse/coping-with-stress.pdf?sfvrsn=9845bc3a_2
- Helping children cope with stress during the 2019-nCoV outbreak: https://www.who.int/docs/default-source/coronaviruse/helping-children-cope-with-stress-print.pdf?sfvrsn=f3a063ff_2
- IEC material (in English, Dari and Pashtun): <https://www.humanitarianresponse.info/en/operations/afghanistan/health/documents/publication-date/2020?search=COVID-19%20Poster>

United Nations

- Updates on COVID-19 for the public as well as for UN Staff at UNHQ and UN Personnel worldwide: www.un.org/coronavirus
- Recommendations developed by UN Medical Directors: https://hr.un.org/sites/hr.un.org/files/Coronavirus_RMP_2020-03-02_FINAL_0.pdf
- Information and guidelines specifically for UN personnel: <https://hr.un.org/page/coronavirus-disease-covid-19>
- Information on telecommuting: <https://iseek.un.org/telecommuting> with resources and tips for working from home successfully.
- For Secretariat Staff, the [Coronavirus page on iSeek](https://iseek.un.org/coronavirus) remains the central repository of stories, broadcast and announcements sent by Management and Medical services as well as Regional Offices for field missions with specific local information: <https://iseek.un.org/coronavirus>
- Technical Note - Protection of Children during the Coronavirus Pandemic: [https://www.unicef.org/media/65991/file/Technical%20note:%20Protection%20of%20children%20during%20the%20coronavirus%20disease%202019%20\(COVID-19\)%20pandemic.pdf](https://www.unicef.org/media/65991/file/Technical%20note:%20Protection%20of%20children%20during%20the%20coronavirus%20disease%202019%20(COVID-19)%20pandemic.pdf)

Inter-Agency Standing Committee

- IASC-endorsed COVID-19 guidance: <https://interagencystandingcommittee.org/covid-19-outbreak-readiness-and-response>
- Key mental health and psychosocial support considerations in relation to the COVID-19 outbreak: <https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/briefing-note-about>