

## HIGHLIGHTS

- UN Secretary-General António Guterres met with displaced families in Kabul.
- Humanitarian organizations provide trauma care that is not funded by the public system.
- Darzab District Hospital damaged in an airstrike on the first day of fighting.
- Families returning from Pakistan after decades face a difficult future.
- The country faces an import requirement of 1.4 million tons of wheat but no substantial rise of the market price of flour.
- CHF-Afghanistan funded with one third of its target halfway through the year.

## HUMANITARIAN RESPONSE PLAN FUNDING 27% FUNDED

**550 million**  
requested (US\$)

**149.7 million**  
Received (US\$)

<http://fts.unocha.org>  
by 7 July 2017



A man is being lifted into an ambulance in Helmand. Photo: WHO

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## Guterres: Solidarity with displaced people

During the month of Ramadan, on 14 June, UN Secretary-General António Guterres paid Afghanistan a one-day visit. In the morning, he visited displaced families in an informal settlement behind the Arzan Qeemat fruit market in an eastern outskirt of Kabul. In a mud house where one of the displaced families lives he met separately with elders and a group of women from a displaced community from Tagab district, Kapisa.

"The women and men I met spoke of their houses destroyed and members of their families being killed, but they also spoke about the will to rebuild their life, the will to have their children in school and the will to go back home as soon as peace and security are re-established," Secretary-General Guterres told journalists the same day.

The lives of the 85 families living in the informal settlement are representative for the lives of approximately 70,000 displaced people currently living in similar settlements in Kabul.



Secretary-General António Guterres meets Mr. Agha Shireen and another elder from a displaced community in Kabul. Photo: Kirk Kroeker/UNAMA.

Some of the families from Tagab arrived one year, others only three months ago. "The first families to flee were those whose houses were destroyed by the fighting," Mr. Agha Shireen, one of the elders of the displaced community, explained. "Most of us were farmers. We grew corn, wheat and pomegranates on our fields."

### Only a few children can go to school, many are sent to collect garbage or beg

When they were forced to leave their homes, they decided to come to the capital Kabul, in search of security and livelihoods. "We came here for work, but there are no jobs for us," he adds. The fathers and sons try to find work as day labourers, earning at the most AFN300 (US\$4.40) a day if they get hired, at all.

"We do not want to be beggars," one of the elders declared. Rather, they would hope to receive small cash grants to kick-start small businesses, as some returnees have done, benefiting from UNHCR cash grants. The reality, however, is that displaced families across the country receive humanitarian assistance for two months upon arrival in an urban centre and not much else. With protracted displacement, many of them join the ranks of the urban poor, struggling every day to buy food.

Displaced girls and boys are even more vulnerable than adults. Often, they get sent to sift through garbage or to beg. "Living here is dangerous for our children," one of the women told Guterres. "We live next to a big road and two or three of our children have already



*"In our village, everything is green and our life was good. We want to go back. The moment the security allows us to return, we go back to our village and to our fields."*

been killed in road accidents." Only very few girls and boys can continue their education, as most of them lack the school achievement certificates to be admitted to public schools in the city.

One older woman pointed out the difficulties to access health care services. "There never seems to be place for us when we go to a Government hospital and we cannot afford to pay for a private clinic," she explained. Pregnant women mostly deliver their babies in the camp, with assistance by some of the grandmothers. "We have done that many times, but sometimes the mothers die and there is nothing we can do."

None of the displaced women in the informal site wants to stay in the city, instead they dream to go back to their homes. "In our village, everything is green and our life was good," one of the women said in the exchange with Guterres. "We want to go back. The moment the security allows us to return, we go back to our village and to our fields."

## A country in conflict lacking public trauma care

In a country where conflict causes a record high of casualties, typical war surgery like extracting shrapnel or amputating severed extremities is in high demand. A demand, that in Afghanistan has to be met most often by humanitarian health delivery partners, as trauma care is not part of the basic public health service.

This fact is grounded in how the modern Afghan health system was conceived 15 years ago: Faced with severe underfunding and a weak network of health facilities, key donors decided to provide health services by contracting NGOs. These NGOs were and are required to provide all the services defined by the Ministry of Public Health (MoPH) in the so-called Basic Package of Health Services (BPHS). The BPHS was later complemented by the Essential Package of Hospital services (EPHS).

Together, these two documents are the framework of the public health system in the whole country from a health post or basic health centre in rural areas to district and provincial hospitals in the urban centres.

The BPHS covers maternal and new-born health, immunization, childhood illnesses, malnutrition, communicable diseases, mental health and disabilities. Emergency trauma care was never part of these basic services catalogued by the BPHS.

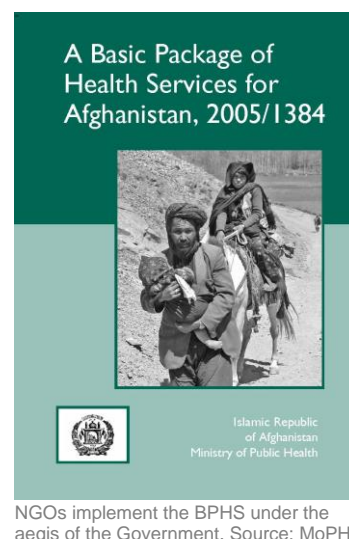
The expectation at the time was that mostly road accidents would cause trauma injuries which would be dealt with in hospitals after a swift referral. Therefore, the focus was laid on improving some of the world's worst public health indicators.

### BHPS was successful in improving some of the worst public health indicators

The model of delivering the BPHS via NGOs under the aegis of the MoPH proved to be a big success: Within two years, three quarters of the population had access to health care, according to the Ministry. To date, under-five child mortality dropped by 30 per cent and maternal mortality by 75 per cent since 2003.

At the Presidential Summit on Health Care on 1 June President Ashraf Ghani emphasized that the partnership between the MoPH and NGOs had come a long way in improving health conditions of millions of Afghans. He also remarked that this system had proven remarkably resilient at reaching patients despite the many operational and security-related challenges the NGOs face.

Rolling out a health system by contracting NGOs has even become a model for other countries, like Rwanda or Uganda, too, and it continues strongly in Afghanistan: Currently, a total of 19 NGOs are contracted by the Government as implementers of the BPHS-services, funded notably by the European Union, USAID and the World Bank with an estimated \$200 million every year.



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## Humanitarians increasingly fill a void

*In the last twelve months, humanitarian partners have treated more than 38,000 patients with significant trauma injuries.*

For years, humanitarian health partners have worked with their own funding alongside the BPHS-implementing NGOs to provide supplementary health services or reaching patients in underserved, uncovered or hard to access areas. Last year, the Afghan Red Crescent Society (ARCS), 22 national and 14 international NGOs were active in addition to the government's (BPHS) health partners across the country.

With intensified conflict, the number of patients in need of life-saving treatment is increasing. The majority of these patients seek assistance in health facilities run by partners providing trauma care and are not paid by the MoPH. In the last twelve months, humanitarian partners have treated more than 38,000 patients with significant trauma injuries.

Humanitarian partners also have helped the hospitals run by the MoPH to better deal with this type of arrivals in the emergency rooms: In six provincial hospitals they trained doctors and staff how to provide effective trauma care or how to deal with mass casualty incidents.

But capacities of humanitarian partners are limited. Some health NGOs providing trauma care in conflict areas had to curtail their services and only still treat conflict-casualties, focusing on life-saving war surgery.

### \$30 million for the health sector from the CHF-Afghanistan in three years

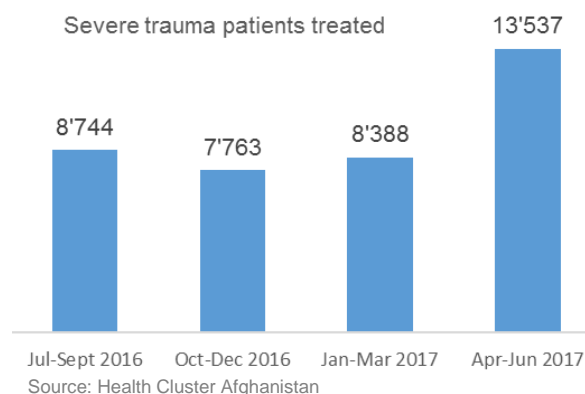
Faced with the current intensity of conflict the lack of trauma care provided via the public health care system has become a veritable structural gap that humanitarian partners struggle to fill.

The growing pressure on life-saving health services is also reflected in the 2017 Humanitarian Response Plan (HRP) in which the Health Cluster requested more than \$52 million, up from \$40 million the previous year. One of the key priorities of the Health Cluster is to expand availability of effective trauma care for people affected by conflict. Halfway through the year, partners of the Health Cluster have received just over \$12 million or 23 per cent what is required this year.

The Common Humanitarian Fund (CHF)-Afghanistan has stepped in with each of its allocations, keeping trauma care up and running in parts the country most affected by conflict. For three years in a row, the health sector has been the largest recipient of CHF funds, receiving more than \$37 million or roughly 30 per cent of the total of the allocations.

This is however not enough money and nearly 180 health facilities run by humanitarian partners had to close down due to lack of funding end of last year, leaving over 850,000 people with no access to basic health care service.

National and international NGOs working in Afghanistan have called on stakeholders to recognise the state of emergency and suffering in the country and to adequately fund trauma care. This could mean to include life-saving trauma care into the BPHS or to shift funding from development activities to humanitarian action to help to finance trauma care.



*Some 180 health facilities run by humanitarian health partners had to close down due to lack of funding end of last year.*



Across the country, Afghans depend on humanitarian health care providers for life-saving trauma care. Photo: WHO/Sino Ramo



## A return to Afghanistan after nearly 40 years

"I never thought I would ever come back to Afghanistan. My family fled 40 years ago to Pakistan, I was only a boy," says Mr. Habib Shah. "I married my Afghan wife in Pakistan, I raised my family in Pakistan, I worked all my life in Pakistan." Standing at the Torkham border crossing, Nangarhar, one hot day end of April, he was one of 3,700 people that week alone to cross into Afghanistan in Torkham, according to the International Organization for Migration (IOM).

He did not seem to fully comprehend, why he was forced to return. But staying in Pakistan was no longer an option for him and his family of six. He tells of pressure and seemingly incessant harassment of police. "It was unbearable. We had the feeling they wanted to get rid of us as quickly as possible."

What he knew, is that his life would be getting even harder. Having never attended school, he had etched out living as a taxi driver on daily wages in Taxila, Punjab. Back in Afghanistan, he faced uncertainty and insecurity.

"I cannot return to my village. It is as if the conflict never stopped in my village for nearly four decades," he says with a sigh. His village of origin lies in Chapadara, Kunar, only about 100 kilometres from Torkham, but firmly under control of a Non-State Armed Group (NSAG). As a first step, he and his family plan to move to his brother in law in Jalalabad who had returned to Afghanistan already last year, before a four-month border closure.

### Assistance differs based on status in Pakistan

In 2016, Pakistani authorities started to pressure Afghans to return to their home country through new visa requirements, shorter extension of proof of registration cards, increased police raids, detentions and deportations, restricted access to livelihoods, health care and education. Afghans have sought refuge from conflict in Pakistan since 1978, with many of them staying there for decades.

Habib Shah had obtained a Pakistani identity card, but his family had never registered as refugees. Therefore, they count towards the category of undocumented returnees. Some 317,000 undocumented returnees have arrived in Afghanistan since 2016. They are registered by MoRR at the border crossings of Torkham and Spin Boldak and assisted notably by IOM and partners based on their vulnerability.

Some 403,000 Afghans to date are returning refugees who hold a Proof of Registration card valid until end of March 2017. This guarantees them rights in line with international refugee law. Their return is facilitated by UN Refugee Agency (UNHCR). Upon arrival in Afghanistan, they receive a cash grant of \$200 per capita.

### Day laboring is the only livelihood for many

At the border crossing, Mr. Habib Shah received post-arrival assistance from IOM, the World Food Programme (WFP) and the UN Children's Fund (UNICEF). He lugged large bags from the warehouse to the bus he had rented. He was in a hurry to keep the cost for the vehicle down but already he could see that the assistance would not keep his family afloat for very long. "This is barely enough food for a few weeks," he said. "There is no help for us to reintegrate."

An economic survey by IOM in April showed that nearly one third of the returnees are unskilled labourers, like Habib Shah, who see no other opportunity than hoping for work on daily wages in urban centres where rents have already spiked with the many new arrivals from Pakistan.

*"I cannot return to my village. It is as if the conflict never stopped in my village for nearly four decades."*



Mr. Habib Shah shows his IOM beneficiary card he received in Torkham. Photo: Said Alam Khan/OCHA

*"This is barely enough food for a few weeks, even if we stretch it. There is no help for us to reintegrate."*



Undocumented returnees from Pakistan receive assistance at Torkham and Spin Boldak. Photo: IOM

## Lower wheat production expected for the year

The production of wheat is predicted to reach 4.44 million metric tons for the agricultural year 2017/2018, according to the Ministry of Agriculture, Irrigation and Livestock. This is below the five-year average of 4.7 million metric tons and the second year in a row that production falls short.

Reasons for the lower production are notably the lack of timely rainfall in Hirat, Badghis, Jawzjan and Samangan, the lack of use of certified seed and fertilizers and an increase in the cultivation of cash crops like poppy.

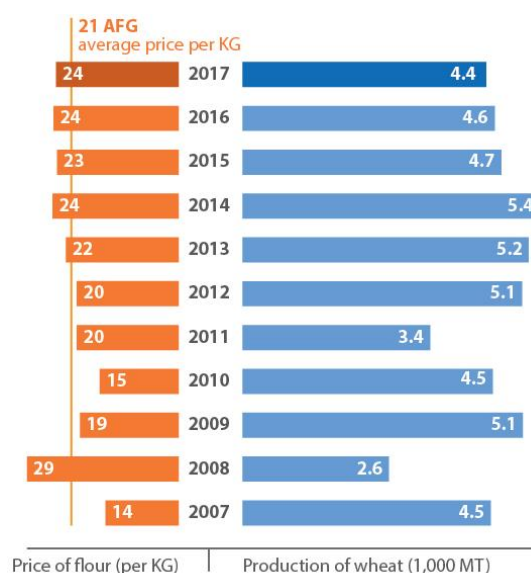
Wheat is by far the main crop in Afghanistan, cultivated by nine out of ten farmers and bread is a key staple food across the country. The consumption of nearly 30 million Afghans is calculated to be 5.8 million metric tons, leaving the country with an import requirement of 1.4 million metric tons of wheat.

The impact of the lower wheat production will very probably be felt by some of the poorest communities in the country, but no serious deterioration of food security is expected. The Famine Early Warning System Network (FEWSNET) [expects that normal imports of wheat flour](#) from neighbouring Pakistan and Kazakhstan will continue to support market stability.

This year, wheat flour prices have remained largely stable compared to the ten-year average (see chart). The reliance on more imports, could however increase the impact of movements on the international markets on domestic staple food prices.



Bread from wheat flour is a staple in Afghanistan. Lower local production of wheat will increase market prices.  
Photo: Fardin Waezi /UNAMA



### Locust infestation in Badghis and Ghor provinces

Orchard crops, vegetables, and livestock production conditions are all reported to be generally normal for this time of year, according to FEWSNET. Seasonal improvements are expected over the next several months, and harvests of orchard crops are likely to be above last year.

These harvests are likely to provide income for the farmers as well as poor households who are employed in collecting and marketing these fruits to domestic and neighboring country markets.

Locally, a locust infestation that hit parts of Badghis and Ghor provinces in May will have at least local impact on food availability and prices in the markets, according to a [mobile Vulnerability Assessment and Mapping \(VAM\)](#) conducted by WFP.

According to the Department of Agriculture, Irrigation and Livestock of Ghor Province, a 70 per cent deficit in the crop harvest is expected in Dawlatyar and Chaghcharan districts because of the locust infestation and lack of timely rainfall hampering crop cultivation. It is the second year in a row that a locust infestation hits the Western Region.

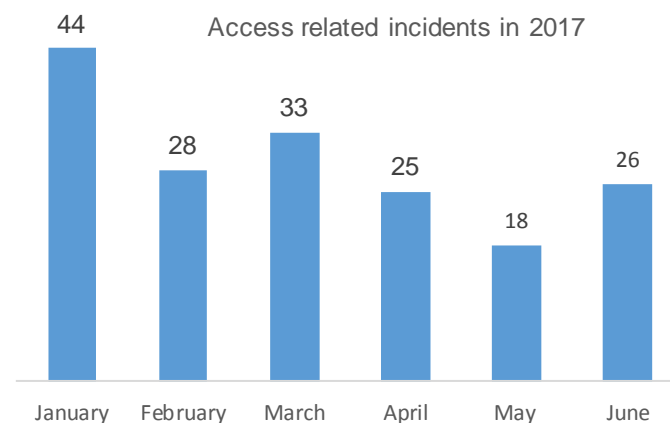
*The impact of the lower wheat production will very probably be felt by some of the poorest communities in the country, but no drastic deterioration of food security is expected.*

*A locust infestation in parts of Badghis and Ghor in May will have local impact on food availability and prices in the markets.*

## Humanitarian access: aid worker incidents

In the first six months of the year, 174 access related incidents have been reported. This is a 60 per cent increase compared to the same period in the previous year and 87 per cent of the total of 200 reported incidents in 2016. Partly, these higher numbers can be attributed to better monitoring and reporting of incidents through the new Access Monitoring & Reporting Framework (AMRF).

Conflict dynamics also explain the higher number of incidents: Protracted state of conflict in an area correlated strongly with the amount of reported incidents. The highest number of incidents was reported from Nangahar and Uruzgan (22 cases each), closely followed by Hilmand (19) and Badghis (18). Incidents in these four provinces where conflict is in a protracted stage account for nearly half of all incidents reported from across the country.



Source: OCHA AMRF

Access constraints include incidents as violence against staff, assets and facilities, restriction of movement, military operations, interference in programme implementation and restriction of communities in need to access to services and assistance. A current example are the ongoing military operations in Nangarhar and the cross border shelling from Pakistan. Both affect the ability of humanitarian workers to access people in need and at the same time deny communities access to critical basic services.

### Afghanistan extremely dangerous for aid workers

Health-related incidents have more than tripled, from 19 cases in whole of 2016, to 69 in the first half of 2017. Clinics have been closed, used as military bases, directly attacked and damaged by the fighting (*see next article*). Incidents were perpetrated by all parties to the conflict, showing the importance of outreach activities and dissemination of messages on protection afforded to health facilities under international humanitarian law (IHL).

Overall, Afghanistan remains an extremely dangerous country to work in for aid workers. In the first half of 2017, nine aid worker have been killed or 60 per cent of all 15 aid workers killed in whole of last year and 10 have been injured, two thirds of all 26 injured aid workers in 2017.

A total of 20 aid workers were abducted to date in 2017, a substantial decrease compared to the 88 aid workers who had been abducted in the same period of the previous year. The reason for this is that 2016 witnessed a spike in abduction of demining contractors and workers.

### Facing additional challenged to stay and deliver

The operating and overall security situation cannot be expected to improve anytime soon. Indicators are the fact that Non-State Armed Groups (NSAGs) are moving from sporadic attacks on Afghan National Security Forces (ANSF) to engaging them in more protracted conflict, the expansion of a NSAG in the Eastern Region and the splintering into factions of the biggest NSAG.

Humanitarian partners, following the humanitarian principles of neutrality and operational independence, will face additional challenges to stay and deliver, ranging from sensitizing their own staff to negotiating access with leaders of NSAG in the field or on higher hierarchical levels. Impossible to record is the level of self-imposed access constraints due to organizations' own security management systems, bunkerisation or military operations.

### INCIDENTS IN JAN-APR 2017



174

Incidents



9

Aid workers killed



10

Aid workers wounded



20

Aid workers abducted

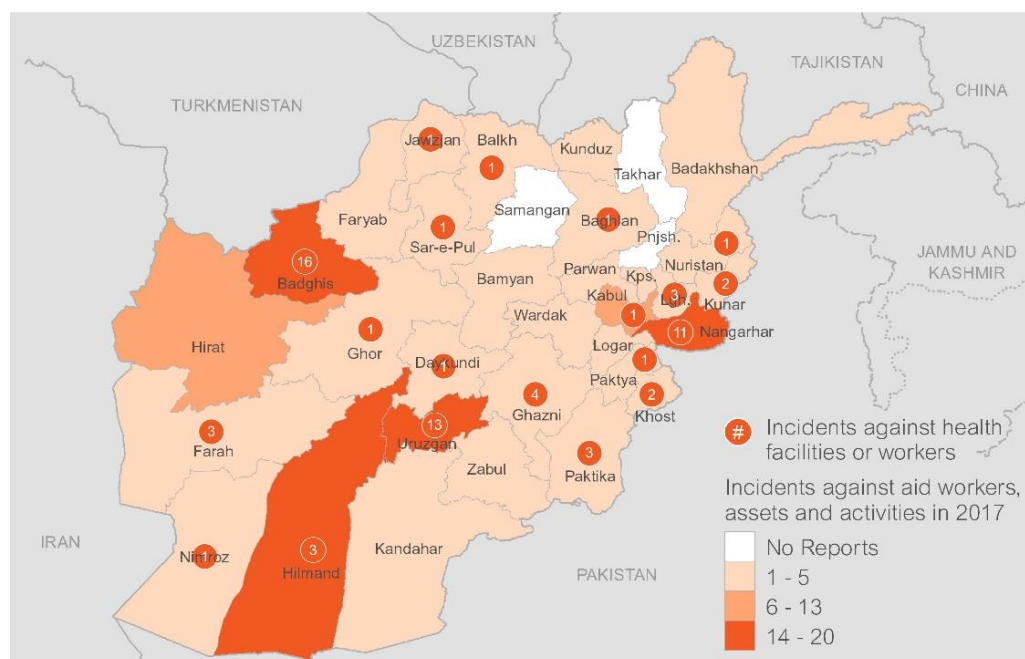


67

Incidents against health facilities and workers



## Incidents against aid workers, assets and activities (Jan-June 2017)



Source: various

[The Health Cluster contributed to the following article](#)

## Every month 13 attacks on medical facilities

On 19 July, the first day of a week of heavy fighting over control of the District Administrative Centre of Darzab, Jawzjan, an airstrike damaged the district hospital. Fortunately, no medical personnel or patients were injured or wounded.

At the core of IHL is the special protection afforded to healthcare workers, medical facilities and patients. In Afghanistan, however, medical facilities endured more than 240 attacks by armed groups in 2016 and 2017, or an average of 13 every month. They resulted in extensive damage to equipment and buildings, death of staff members and patients and an overall worsened health situation of the people affected.

The airstrike on Darzab District Hospital damaged the operation theatre, the pediatric outpatient department and the gynecology section, according to reports from health workers after the fighting. They also discovered that the only ambulance in the district had been hit by bullets and is no longer operational.

### The damage to health facilities is far more than bricks and mortar

Prior to the airstrike, members of a Non-State Armed Group reportedly had established a presence in the in the hospital. If true, this would constitute a violation of the protection principle but even this in return would not legitimize an attack on the hospital without due warning and remaining proportional.

“There is not much understanding of the sanctity of the health system in Afghanistan,” says Health Cluster Coordinator David Lai. Even the simple rule of not allowing weapons

*“Soldiers and fighters regularly bring in their injured comrades and demand their treatment at gunpoint.”*



An airstrike damaged Darzab district hospital, Jawzjan, on the first day of heavy fighting. Photo: Health Cluster

*Every attack on health care has a domino effect. Such attacks not only endanger health care providers; they also deprive people of urgently needed care when they need it most.*

in a health facility is often impossible to enforce. "Soldiers and fighters regularly bring in their injured comrades and demand their treatment at gunpoint."

The damage to health facilities is far more than bricks and mortar. Darzab District now faces significant disrupted services, until money is found to fix the damage and staff can work again. Every month, the hospital provided nearly 3,500 consultations for children and pregnant women, including 400 admissions to the hospital and 125 deliveries. That the ambulance is out of service could negatively impact on the 600 trauma cases the hospital saw every month on average.

Those paying the price when warring parties reject the neutrality of medical facilities are not just the patients, doctors, nurses, and medical staff, but Afghan civilians, including alarming numbers of girls and boys, who are denied essential health care.

## Humanitarian funding

As of 7 July, the [Financial Tracking Service](#) showed a total of \$149.7 million of funding towards activities in this year's Humanitarian Response Plan (HRP) representing 27 per cent of the \$550 million requested by the humanitarian community in Afghanistan.

Humanitarian action outside of the HRP has to date received \$83.6 million funding. The clusters with the highest percentage of their 2017 funding needs are Emergency Shelter and Non-food Items (26%), Health (23%), Food Security and Agriculture (18%) and Protection (14%). Nutrition, Water, Sanitation and Hygiene and Multi Sector Cash are funded 10 per cent or less.

### Sweden and Australia fund CHF-Afghanistan with over \$6 million each

Halfway through the year, the Common Humanitarian Fund (CHF)-Afghanistan has received \$17.6 million or one third of the 2017 target of \$55 million.

So far this year, four donors have contributed to the CHF-Afghanistan. The Swedish International Development Cooperation Agency (SIDA) and Australia's Department of Foreign Affairs and Trade (DFAT) contributed the highest amounts this year, \$6.5 million and \$6.1 million respectively.

Taking into consideration pledged funding from the United Kingdom's Department for International Development (DfID) and the Swiss Agency for Development and Cooperation (SDC), it is expected that the fund reach approximately \$36 million in contributions for 2017, or just below two thirds of its goal.

### Second Standard Allocation over \$25 million for aid in hard to access areas

The Humanitarian Coordinator, Toby Lanzer, decided to provide approximately \$25 million for the Second Standard Allocation in 2017. The focus will be on the provision of life-saving assistance to communities in need in hard to access and underserved areas.

*Four governments have contributed \$17.6 million to the Common Humanitarian Fund (CHF)-Afghanistan this year.*

Contributions received	US\$
SIDA (SWE)	\$6.5M
DFAT (AUS)	\$6.1M
Denmark	\$2.8M
Norway	\$2.1M

Source: OCHA HFU, 7 July

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