COUNTRY REPORT / AFGHANISTAN

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DEC CVA REAL TIME RESPONSE REVIEW: AFGHANISTAN

COUNTRY REPORT Final

DISASTERS EMERGENCY COMMITTEE

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LIST OF ACRONYMS

ANDMA	Afghanistan National Disaster Management Authority
COVID-19	Coronavirus 19,
CHS	Core Humanitarian Standard
CHW	Community Health Workers
DEC	Disasters Emergency Committee
HQ	Headquarters
IDP	Internally Displaced Person
IPC	Integrated Food Security Phase Consolidation
KIS	Kabul Informal Settlements
MEAL	Monitoring, Evaluation, Accountability and Learning
MPCA	Multi-purpose Cash Assistance
PDM	Post Delivery Monitoring
PLW	Pregnant and Lactating Woman
RTRR	Real Time Response Review
PPE	Personal Protective Equipment
SCUK	Save the Children UK
WHO	World Health Organisation
URD	Urgence Rehabilitation Development
UK	United Kingdom
WASH	Water Sanitation and Hygiene

SUMMARY

ANALYSIS

Nbr	Engagements	Quality Criterion	Analysis
1	Communities and people affected by crisis receive assistance appropriate and relevant to their needs.	Humanitarian response is appropriate and relevant	The "no regrets" approach was justified and provided assistance was overall both appropriate and relevant.
2	Communities and people affected by crisis have access to the humanitarian assistance they need at the right time.	Humanitarian response is effective and timely	The 5 to 6 months delay between the beginning of the crisis and the response was used to adjust the response to new risks and needs. The pandemic however delayed the response to pre-crisis needs.
3	Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action	Humanitarian response strengthens local capacities and avoids negative effects	The presence of capable local partners was of strategic advantage to adapt and respond. Empowered local communities and well-established working relationships provided a strategic advantage to DEC Member Charities to identify needs, respond and monitor the response.
4	Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them	Humanitarian response is based on communication, participation and feedback	DEC partners undoubtedly allocate time and resources to communication and participation. However, the pandemic had a negative impact. The level of information and participation was lower than usual despite genuine efforts to cope/adapt.
5	Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints	Complaints are welcomed and addressed	Overall, complaints mechanisms were in place. However, online systems relied on remote communication and networks which are not always reliable. Feedback from local communities regarding the functioning of these mechanisms was nuanced.
6	Communities and people affected by crisis receive coordinated, complementary assistance	Humanitarian response is coordinated and complementary	Coordination was disrupted as a direct consequence of the pandemic and subsequent restrictive measures. However, DEC Member Charities did maintain good information exchange mechanism in place in the context of Afghanistan to prevent duplication and share lessons.
7	Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection	Humanitarian actors continuously learn and improve	DEC Member Charities had a joint mechanism in place to share lessons learnt. Individually all agencies have an internal learning mechanism in place. Some of DEC Member Charities are already collecting and analysing data to learn from the pandemic and adapt their response.
8	Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers	Staff are supported to do their job effectively, and are treated fairly and equitably	The RTRR did not take staff competency into consideration. However, the staff at country and HQ level worked together to adapt and respond to the best of their abilities.
9	Communities and people affected by crisis can expect that the organisations assisting them are managing resources effectively, efficiently and ethically.	Resources are managed and used responsibly for their intended purpose	DEC Member Charities have up to standard resource management systems in place and well disseminated codes of conduct, principles and standards. However, bureaucracy is too heavy and more adaptive measures are required to respond faster and prevent overburdening staff with administrative requirements. This observation includes donor requirements.

KEY RECOMMENDATIONS

FOR PHASE 2 APPEAL

1. AN MPCA FOCUSED RESPONSE

Based on the review's main findings, and depending on local context and market dynamics, Multi-purpose Cash Assistance should be considered as a priority for DEC Coronavirus Appeal phase 2.

2. DUE ATTENTION TO PROTECTION AND PSYCHOSOCIAL CARE

The pandemic has resulted in increased protection needs. The loss of income, economic difficulties, coupled with lack of prospects and personal space have resulted in increased levels of domestic violence, affecting particularly women and girls, and therefore an increase in the need for action to sensitise the population, prevent acts of violence and provide appropriate support to the victims.

3. SUSTAINED AWARENESS RAISING AND PROVISION OF BASIC HYGIENE EQUIPMENTS

Provision of adequate PPE, adapted hygiene kits, training of health staff in prevention measures and awareness raising campaigns were justified during phase 1 and remain relevant for phase 2. The use of social media, health actors campaigning via radio and phone networks, must be continued as long as the contamination risk exists and the vaccination campaign has not covered the most at-risk people.

4. PREVENT MISCONCEPTION AND PROMOTE BEHAVIOUR CHANGE

Misconceptions and rumours should receive full attention during phase 2. DEC partners should closely monitor the situation in their intervention areas and support appropriate actions to prevent / reduce the effects of misconceptions on people's behaviour and health.

MID- TO LONG-TERM RECOMMENDATIONS

5. REDUCED BUREAUCRACY AND MORE FLEXIBLE PROCEDURES

Procedures should be simplified during emergencies and decision makers trusted more at the operational level. A change of paradigm is required – field staff judgement, capacity and honesty should be trusted more. During an emergency, field managers should enjoy more flexibility to decide and allocate resources and the administrative workload should be considerably reduced. Such a paradigm shift does not exclude solid post-intervention control mechanisms.

6. MORE INCLUSIVE COORDINATION MECHANISMS

There is a deficit of trust between international aid agencies and local actors. Regardless of the reasons why, the coronavirus pandemic highlights the strategic importance of local actors' inclusion in coordination mechanisms. In the case of Covid-19, it took several months for mixed committees composed of national authorities and aid agencies to be operational. The lack of participation or representation of national authorities and line ministries in humanitarian coordination forums resulted in miscommunication, confusion and delayed response.

7. OPTIMISED EXISTING COMMUNITY FORUMS

Community forums offer multiple strategic opportunities such as a community-embedded response capacity. Building on this existing network to respond to emergencies, such as the primary needs caused by a pandemic, provide a strategic advantage to understand and respond. With adequate equipment, training and support, local communities can be a direct responder to their own needs.

8. A DEC MEMBERS JOINT, GEOGRAPHICALLY-FOCUSED, MULTI-SECTOR APPROACH

DEC Member Charities have set up a good information-sharing mechanism to build on each other's technical skills. Considering the pandemic's multi-faceted impact, DEC Member Charities should consider a joint geographically-focused multi-sector integrated response. A concerted effort covering several key sectors would help communities to recover more rapidly. Such concerted effort would more efficiently address the "symptoms" of the pandemic and provide an opportunity to address some of the root causes of poverty and thus would stand a better chance of building resilience.

1. INTRODUCTION

1.1. CONTEXT OF THE REVIEW

1.1.1. APPEAL CONTEXT

In response to the global Covid-19 pandemic, the Disasters Emergency Committee – DEC - launched a coronavirus appeal on 14th July 2020. By the end of August, the campaign had raised over £11.3 matched by UK Aid to reach a total of £22.5 million. Unlike previous appeals the DEC coronavirus appeal was proactive. At the time of the selection, prioritising countries in anticipation of the humanitarian need from the Covid-19 pandemic was challenging. Based on the likely humanitarian impact a 'no regrets' approach was supported by DEC and its members[1].

Mobilised resources were allocated to 42 projects in 7 priority countries:

- In Asia - Afghanistan and Bangladesh (for the Rohingya crisis)
- In Middle East - Yemen and Syria
- In Africa - DRC, Somalia and South Sudan

Funds were used to adapt on-going health and non-health interventions or support new projects. In July 2020 the DEC allocated £13 million for Phase 1 of the response, covering the period from 14 June 2020 to 31 January 2021. A second allocation of £6 million was confirmed in November 2020 that could be used indifferently for phase 1 or phase 2 covering the period from 1 February to 31 January 2022. The Real-Time Response Review (RTRR) is part of DEC's accountability policy. It is also motivated by the necessity to respond to the high demand for accountability among the British population who generously responded to DEC Coronavirus 2020 Appeal.

1.1.2. COUNTRY CONTEXT

Among the lowest living standards in the world

Despite improvements in life expectancy, incomes, and literacy since 2001, Afghanistan is extremely poor, landlocked, and highly dependent on foreign aid. Much of the population continues to suffer from shortages of housing, clean water, electricity, medical care, and jobs. Corruption, insecurity, weak governance, lack of infrastructure, and the Afghan Government's difficulty in extending the rule of law to all parts of the country represent challenges for future economic growth. Afghanistan's living standards are among the lowest in the world. Since 2014, the economy has slowed, in large part because of the withdrawal of nearly 100,000 foreign troops who had artificially inflated the country's economic growth.

36% of the population facing acute food insecurity

Decades of instability have made Afghanistan fragile, with struggling public services, a faltering economy and a vulnerable population relying on external assistance. The escalating conflict, combined with the recent pandemic, has exacerbated existing vulnerabilities – most notably for the 3 million[2] displaced people and host communities living in poor sanitary conditions and densely populated areas. According to the initial HRP 2018-2021[3], an estimated 9.4 million people were in need of humanitarian assistance before the pandemic. The number of people in need was revised to 14 million people in need of support out of a total population of 35 million. According to the last IPC, released in November 2020, 36% of the population is facing acute food insecurity. According to the same report, 42% of the total population is likely to experience acute food insecurity in the next 6 months. 3.5 million under five-year-old children – half of all under 5s - is severely malnourished

[1] As data about the prevalence of Covid-19 at the time of the decision were not available and/or accurate in most of the countries, the DEC secretariat used the INFORM COVID-19 Risk Index and the Global Health Security Index in order to identify countries most at risk from the health and humanitarian impacts of Covid-19.

2 According to the last IDMC figures

3 Following the Covid-19 pandemic the HRP 2018-2021 was revised recently to update needs and figures. Doc. still not available on Relief Web.

according to UNICEF. The World Bank estimates that the Afghan economy has lost 5% of its value due to Covid-19. This recession is the result of a national lockdown and other accompanying public health measures which have severely disrupted trade and commerce and dangerously reduced daily wages. The loss of livelihoods, and subsequent widespread food insecurity, has further eroded people's resilience. The most vulnerable families are adopting disruptive coping mechanisms such as debts, cutting meals, and reducing medical expenses.

Poor development prospects despite continuous international support

The international community remains committed to Afghanistan's development, having pledged over $US 83 billion at ten donors' conferences between 2003 and 2016. In October 2016, at the Brussels conference, donors pledged an additional $3.8 billion in development aid annually from 2017 to 2020. Even with this help, and despite the current administration's dedication to instituting economic reforms, improving revenue collection and fighting corruption, the country still faces a number of challenges, including low revenue collection, anaemic job creation, high levels of corruption, weak government capacity, and poor public infrastructure.

Widespread corruption and instability fed by the world's largest opium production

Afghanistan is the world's largest opium producer. Poppy cultivation has almost doubled since the Taliban era. The 2017 crop yielded an estimated 9,000 MT of raw opium. The Taliban and other anti-government groups participate in and profit from the opiate trade, which is a key source of revenue for the Taliban inside Afghanistan. The drug trade also promotes widespread corruption and instability, undermining Government authority and actions.

A capable and confident insurgent fighting force

The Taliban remains a serious challenge for the Afghan Government and the aid community in almost every province. The Taliban still considers itself the rightful government of Afghanistan, and it remains a capable and confident insurgent force fighting for the withdrawal of foreign military forces from the country, the establishment of sharia law, and the rewriting of the Afghan constitution. Building on momentum that began in late 2018, negotiations between the US and the Taliban reached its peak in Doha in 2019. Underlying the negotiations is the unsettled state of Afghan politics and prospects for a sustainable political settlement.

The deadliest conflict in the world for civilians

In terms of security the Covid-19 pandemic may have had some positive outcomes; since the beginning of the pandemic, the number of attacks and military operations has fallen. According to UNAMA's latest reports, the number of civilian casualties is the lowest since 2012[4]. Nevertheless, "*the conflict in Afghanistan remains one of the deadliest in the world for civilians*" according to the United Nations Human Right Commission. Since peace negotiations resumed in September 2020, the level of insecurity and civilian casualties has increased again. UNAMA reported 12 targeted health facilities between March and May 2020, and 3 impacted as collateral damage.

People's trust in their Health system impacted by the pandemic

The first confirmed case of Covid-19 was identified in Herat in March 2020. The government reacted quickly and movement restriction measures were in place by the third week of the month. Though most actors suspect that the figures do not entirely reflect the real situation, the Covid-19 pandemic has not had the expected medical impact. In May 2020 the Economic Times reported that 80 per cent of the country's total population of 36 million could be infected and that Afghanistan could be one of the most affected country in the World. According to the latest figures from WHO, 43,630 people out of a total population of 36 million have been infected, of which 1,638 have died. Urban centres, such as Kabul and Herat, are the most affected clusters. Rural areas seem less affected, even though there is no clear information about the real situation. 20% of infected people are health workers. More than the people, the health system itself seems to be the main victim of the Covid-19 crisis. The pandemic has had negative consequences in terms of the functioning of medical facilities due to numerous health workers being absent from work. The fear of contamination among the public has impacted the image of health facilities. Misconceptions and rumours have damaged the reputation of the health

4 October 2020

sector and resulted in a loss of trust. There have been rumours that only non-believers are at risk and that Muslims do not get infected. According to WHO, the number of daily visits to health facilities has fallen. The number of under-5s who are being vaccinated has also fallen.

It is therefore in an extremely complex and challenging environment that DEC Member Charities have responded to the Covid-19 pandemic.

1.2. OBJECTIVES AND SCOPE OF THE REVIEW

The Real-Time Response Review is structured around three main tasks:

- An inception phase, including a desk review and the design of information collection tools;
- A country level Real-Time Response Review of DEC-funded programmes to draw key lessons that can benefit the programming of phase 2 of the DEC Coronavirus 2020 Appeal;
- A preliminary findings workshop;

1.2.1. OBJECTIVES

As the first step of a two-year learning process, the country level Real-Time Response Review (RTRR) supports real-time collective learning to draw key lessons to build on for the second phase of the response.
The three main objectives of the country level RTRR are:

- **Objective 1**: Improve understanding of the **impacts of the Covid-19 pandemic on contexts**, Member Charities, their partners and key stakeholders;
- **Objective 2**: Analyse **adjustments** that have already been made and that are still needed in humanitarian programming in each country and globally;
- **Objective 3**: Facilitate **collective thinking** between DEC Member Charities about lessons and innovative ideas with regard to responding to the Covid-19 pandemic.

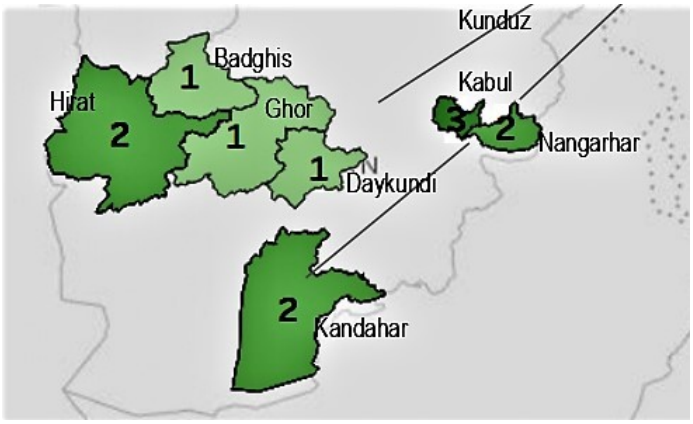
The primary purpose of this exercise is to generate real-time learning, in particular for the DEC Member Charities before the start of phase 2 of the Appeal. A secondary purpose is to share lessons which might be profitable to all DEC Member Charities in similar global pandemic situations.

1.2.2. SCOPE OF THE REVIEW

The reference framework: the review assessed programmes according to the CHS commitments, with a special focus on the relevance of responses and processes - due diligence, safe management of resources, coordination, the involvement of the population, and accountability.

Geographical coverage: the review covers all the projects implemented by DEC partners. The project sites visited included Kabul, Herat, Kunduz and Nangarhar out of the 8 different locations covered by DEC Member Charities involved in the Coronavirus 2020 Appeal in Afghanistan. Unfortunately, Tearfund's implementing partners could not be consulted.

Map 1 – DEC partners present in Afghanistan – sectors and geographical coverage



Site were selected on the basis of representativity and feasibility, taking into account access and time constraints. Distance interviews were organised with all DEC Member Charities, including those whose projects were not visited.

Time: the review focused on the present situation and the level of achievement as most projects had just started. The review looked at decision and implementation timeliness and how informed decisions were.

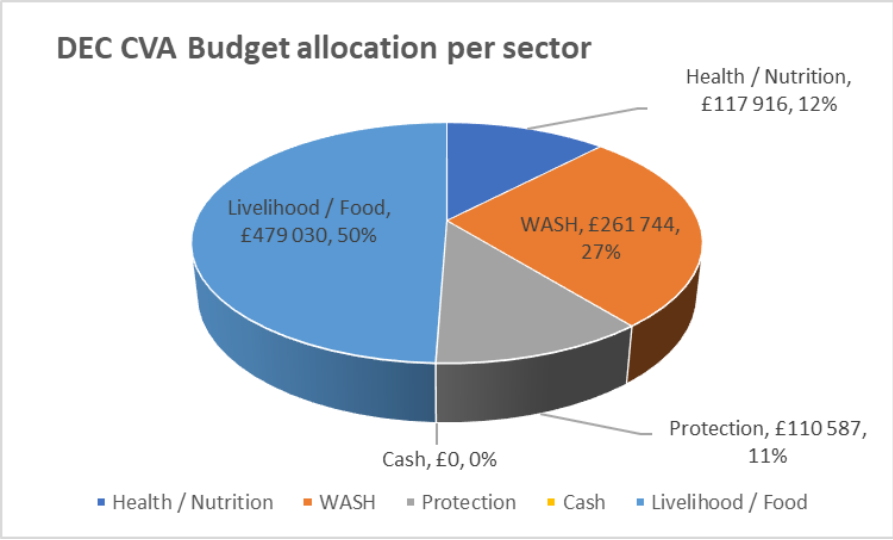
Funded projects and activities: Overall, priority sectors funded by the Coronavirus 2020 Appeal across the 7 countries are, WASH (33%), Health (22%), Food (12%), Livelihoods (11%), Protection (11%) and Multipurpose Cash Assistance (9%).

The priority sectors in Afghanistan are presented in the table and chart below.

Table 1 – Detailed project list

Nbr	Organisation	Local partner(s)	Project type	Type of intervent.	Dates / duration	Sector	Title	Location	Budget in GBP	Health / Nutrition	WASH	Protection	Cash	Livelihood / Food
1	Action Aid	N/A	Continuation of an existing Project	Direct access	6 months	Health, WASH, livelihood, Protection	COVID-19 emergency assistance to the most vulnerable families of Kabul, Afghanistan	Kabul	£133 832	£3 333	£13 556	£6 889		£46 717
2	Christ. Aid	2 NGOs	New	Indirect access	6 months	Health, WASH, livelihood, Protection	DEC Coronavirus appeal	Badghis & Kabul (KIS)	£143 605	£10 412	£12 737	£2 382		£49 032
3	Concern	N/A	New	Direct access	6 months	Food sec & WASH	Mobile COVID-19 emergency WASH and food response in hard-to-reach, conflict-affected communities of Khanabad district, Kunduz Province	Kunduz, Khanabad	£390 000		£41 940			£189 880
4	Oxfam	ADA	New	Direct in Herat Indirect access in Daikundi	6 months	WASH	WASH Response to COVID-19 in Daykundi and Herat of Afghanistan	Daikundi & Herat	£291 320		£165 327			
5	Save the Children	N/A	New	Direct	6 months	Health, Nutrition, Protection, livelihood and food	Integrated response to the primary and secondary effects of the COVID-19 pandemic in Kandahar and Nangahar Provinces of Afghanistan	Nanghrar and Kandahar	£668 787	£104 171		£99 053		£168 545
6	Tearfund	IAM & SERVE	New	Indirect access	6 months	WASH, Food & Protection	Reducing the transmission of Covid-19 and supporting those impacted to meet Basic and Psychosocial needs in Afghanistan	Herat, Ghor Kabul, Nangarhar, Kandahar & Laghman	£88 023		£28 184	£2 263		£24 856
Total									**£1 715 567**	**£117 916**	**£261 744**	**£110 587**	**£0**	**£479 030**

Chart 1 – DEC CVA Budget allocation per sector in Afghanistan



2. METHODOLOGY AND LIMITATIONS

2.1. ANALYSIS FRAMEWORK AND KEY QUESTIONS

After analysing the context - political, conflict, economic, institutional capacity, humanitarian needs - to better understand the country, its challenges and opportunities, the review focused on projects with the aim of drawing lessons from the experience of the past months.
The purpose of the review is to answer three key questions linked to the three identified objectives presented in the previous section of this report.

2 retrospective questions:

- **Key Q 1:** What has been the impact of Covid-19 on DEC Member Charities (as organisations) and their operational environment (context and needs)?
- **Key Q2:** What measures have already been taken or still need to be taken to adapt to the new working environment?

And 1 prospective question:

- **Key Q3:** What lessons and innovative ideas in each country can help to prepare Phase 2, and which can be of use to DEC member charities more broadly, and to the DEC Secretariat in their efforts towards accountability.

For each key question, specific lines of enquiry were selected in order to focus on the relevant information to be collected. For each line of enquiry, detailed questions were formulated. Key questions, lines of enquiry and sources of information constitute the analytical framework of the review, which was used to draw up specific questionnaires. The analytical framework is presented in Annex 2.

2.2. SOURCES AND TOOLS

INFORMATION SOURCES:

- Desk reviews of relevant literature, evaluations and data sources provided by the DEC secretariat and gathered at country level[5] or from open sources;
- Interviews with DEC Member Charities at HQ level;
- In-country / field-level interviews with key stakeholders including field staff, local partners, government entities, local authorities, and international aid agencies;
- Discussions with affected populations through focus group discussions. For cultural reasons, focus group meetings were organised based on gender. The means of selecting participants was jointly decided between Group URD and DEC Member Charities and their local partners to ensure that they were representative.
- Direct observation of programme activities.
- An initial findings workshop was held online on 30 November 2020 with 20 participants, plus the facilitators – the main findings of the review were presented to the participants who were then able to make comments and add new elements regarding lessons learnt and recommendations for phase 2 of the DEC Appeal. See list of participants in Annex 4.

TYPE OF INFORMATION COLLECTED:

- General information about the Covid-19 pandemic - time of first detection, information about virus circulation, measures taken by the national authorities.
- Specific information linked to the different projects - duty of care, health-specific measures, adaptation of existing projects, new Covid-focused projects, population targeting, accountability mechanisms.
- Key lessons learnt.

[5] The DEC team already gave the review team access to Covid-19 Appeal background information and project documentation via a tailored access to Box.

The general questionnaire based on which KII specific questionnaires were developed is presented in Annex 3.

2.3. CHALLENGES AND OPPORTUNITIES

Access: Access to the field and to the population was complicated by the combination of conflict and the pandemic. Field visits and interactions with communities were therefore somewhat limited, though possible.

Remote management: Modern technology was used to reduce the consequences of remotely managing the field work and the data collection phase. National counterpart consultants were technically competent and dedicated. However, organising this kind of work appears to be more time-consuming when it is done remotely. It also limits the capacity to provide optimal support and guidance when required, which in return may have an impact on the quality of the information collected.

Limited feedback from affected people: Feedback from the local population was limited mainly due to the fact that activities are just starting and the population does not have much information to share.

Women's participation: Involving women during the review was a challenge. While both men and women were interviewed during the review, women's participation in Focus Group Discussions (FDGs) was less than expected. This is an indicator of the consequences of the pandemic on women and girls which was mentioned throughout the review by all DEC Member Charities.

Time constraints: Time dedicated to the Real-Time Response Review was limited. Therefore, some FGD could not take place has planned and some of the findings could not be fully investigated.

Communication: On occasions communication was delayed due to bad connectivity.

3. MAIN FINDINGS

3.1. KEY QUESTION 1 / IMPACT

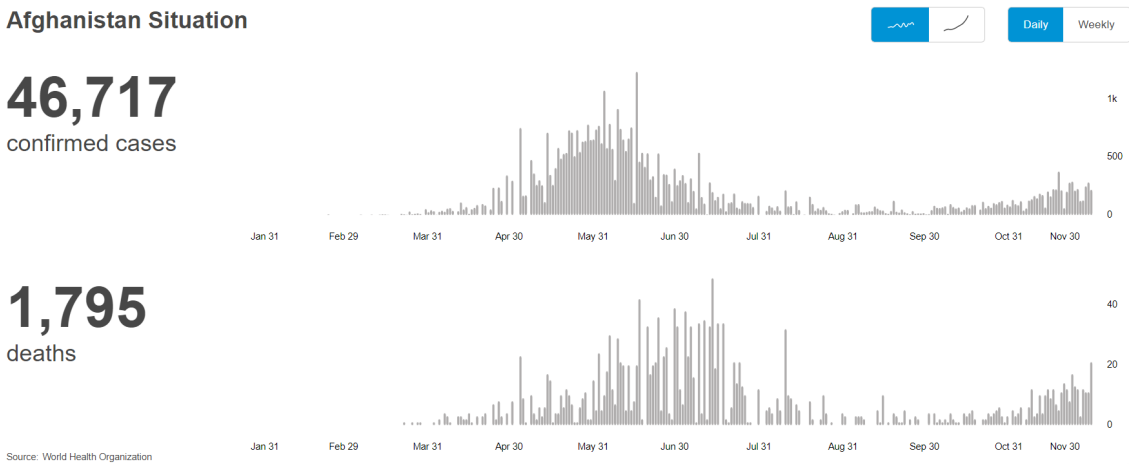
The first case of Covid-19 was confirmed in Herat city in March 2020. The humanitarian situation was preoccupying before the coronavirus pandemic was declared in Afghanistan. The government decision to apply strict preventive measures and a 1-month lockdown, later extended to 3 months, had multiple consequences. Almost all businesses, education facilities and public offices, were closed. Borders were closed and humanitarian operations were put on hold. The catastrophic health scenario announced in April in newspapers did not materialise, however.

To answer the first key question - *What has been the impact of Covid-19 on DEC Member Charities and their operational environment (context and needs)?* – we will look at 4 aspects: the health impact, the non-health impact, the impact on local partners and their role and, finally, the impact on the coordination of aid / humanitarian programming.

3.1.1. HEALTH IMPACT

Despite the absence of solid evidence, the health impact of Covid-19 is believed to be smaller in rural areas than in the main urban centres, such as Kabul and Herat, where most cases are reported. However, lack of means, limited capacity and the high cost of the Covid-19 test have meant that there has been limited testing of the population. Therefore, to date, there has been no reliable data about the number of people infected, the number who have recovered or the number who have died because of the pandemic.

Chart 2 – Covid-19 official figures for Afghanistan – Source WHO



- Official figures reflect part of the reality. Most actors do not rely on official figures. Official figures are just "some sort of indicator". The low testing capacity does not allow for the proper tracing of Covid-19 infected victims. There is no reliable death rate.
- The health system is under extreme pressure. The pandemic has increased demand for beds, technical skills, equipment and management capacity.
- There is still limited in-country capacity and resources to manage severe cases of Covid-19.
- Global supply shortages (including PPE, laboratory reagents, and RNA extraction kits) affect testing and the medical response.
- Global logistics constraints are also limiting supplies of essential equipment such as ventilators and oxygen concentrators.
- ***20% of Covid-19 victims are health workers – which has had a double negative impact: 1. it has hindered medical response capacity and; 2. it has damaged the reputation / perception***

of health facilities by the population. People are afraid to visit health centres including for the treatment of other illnesses.

- As a result, the number of daily visits to medical facilities has dropped according to health authorities[6].
- The Covid-19 pandemic has had a direct effect on routine health service delivery such as mother and child health, and routine vaccination. The number of children being vaccinated has fallen, according to the same authorities.
- Widespread misinformation and rumours have further contributed to the undermining of preventive measures and the credibility of the health system / official response.
- It is widely believed that the pandemic is over now despite the fact that the health authorities expect a spike in the months ahead.
- The psychological impact of the crisis was unexpected, but assessments have revealed a need for support. Lack of income, economic stress, lack of privacy and depression have been responsible for increased domestic violence.

DEC Member Charities other humanitarian actors who were interviewed reported that women have been tested less than men due to movement restrictions. They also reported that there was lower attendance of training and awareness-raising sessions by women, which potentially exposed them more than men due to a lack of access to information.

To conclude: despite its official responsibility to monitor the evolution of the pandemic, the Ministry of Public Health (MoPH) is unable to do so effectively due to a lack of resources. Nevertheless, the Ministry coordinates with all stakeholders in order to harmonise the response and monitor the evolution of the pandemic to the best of its ability. According to the Review, ***one of the collateral victims of the pandemic is the health system itself***.

Main lessons learnt

1. A pandemic like Covid-19 requires specific knowledge, capacity and equipment – all are lacking.
2. Urban centres tend to be more affected than rural areas – especially densely-populated areas lacking adequate facilities (sanitation in particular) such as IDP camps (e.g., KIS).
3. Medical staff were not sufficiently protected, resulting in multiple contamination cases.
4. The widespread contamination of medical staff further reduced the capacity of the health system.
5. Extensive contamination of medical staff had a side effect on "perception and trust" in the health system and resulted in reduced daily visits / including routine vaccinations.
6. In the event of a pandemic, it is equally important to focus on medical aspects, logistics, trust in the health system, and how it is perceived.

3.1.2. NON-HEALTH IMPACT

In addition to health, the Real-Time Response Review focused on 4 main sectors: economic impact, nutrition, food security, water and sanitation.

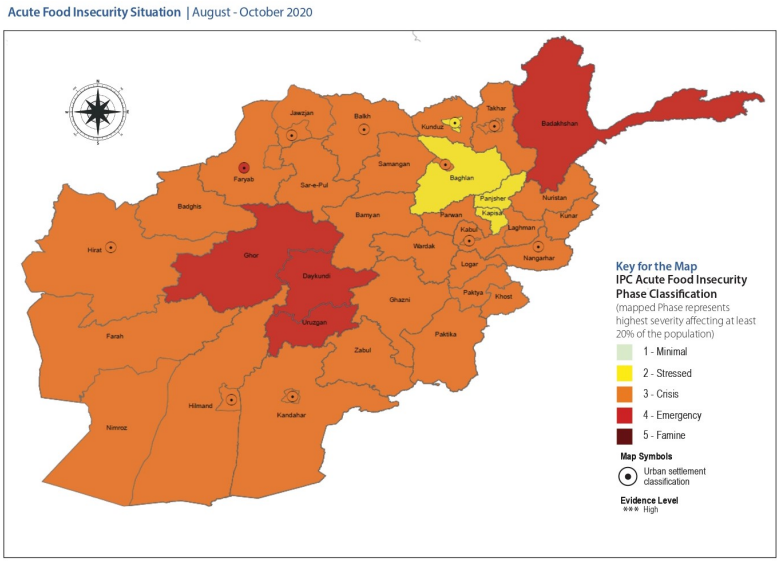
The economic impact of the pandemic has been felt in both urban and rural areas and, so far, has had potentially **disastrous** effects on the most vulnerable households. According to the last IPC report – October 2020 – 40% of the population faces chronic food insecurity and, as a result, malnutrition rates are increasing.

- Before the pandemic the country was already affected by chronic, widespread insecurity related to the ongoing conflict, multiple natural hazards, economic difficulties, limited infrastructures and development perspectives.
- According to DEC Member Charities and government officials, the pandemic and the 3-month lockdown have exacerbated already significant needs.

6 No precise figure communicated

- The most vulnerable households, who rely on casual daily labour/the informal economy, have partially or entirely lost alternative income sources, further aggravating their precarious economic situation.
- The closure of borders has further impacted households who rely on remittances to survive.
- Afghanistan is a land-locked country. The supply of imported products was disrupted and prices went up, including food items, according to WFP's monthly market surveys.
- The shortage of food items caused by border closures and reduced activities in neighbouring countries (e.g., Karachi port) impacted prices and distributions.
- The pandemic's impact on the national economy and trade further deepened poverty and food insecurity according to the last IPC report. 16.9 million people (42% of the population) are IPC level 3 (Crisis) or 4 (Emergency).
- Due to the economic situation, food is being distributed, including in urban centres, which had not happened in many years. Cash assistance is not enough. In-kind assistance is also necessary to prevent high food commodity prices.
- Half of all children under five years of age - 3.5 out of 7 million children - require nutrition assistance[7]. There has been a 13% increase in SAM cases - 15.3% of children under 6 months are affected by wasting.
- The revised HRP estimates that in 2021, 18.4 million people will need assistance.
- IDPs are particularly impacted due to poor housing and high population density. IDPs are commonly considered to be the most vulnerable and exposed population in the country.
- WASH - Covid-specific hygiene kits are in high demand but are in short supply.
- The pandemic has also caused a funding gap in the WASH sector, which was not anticipated.
- There has been a reported increase in petty crime, theft, robberies. Is this a direct consequence of increased poverty?
- A DEC partner reported that some restrictive measures had had unexpected consequences, such as an impact on the local capacity to clean irrigation canals. Traditional mechanisms were stopped as a result of the preventive measures decided by the government. This resulted in a lack of water for irrigated land and thus less production, less income, less food and higher prices.

Map 2 – The Food Security situation in Afghanistan – source IPC Oct. 2020



Main lessons learnt

1. Protective measures to prevent the pandemic from spreading too rapidly have increased poverty levels across the country.
2. Urban households who rely on daily wages tend to be more impacted by the lack of income opportunities resulting from preventive measures.

7 *Source – Nutrition cluster*

3. Vulnerable populations – children, PLW and IDPs are particularly at risk and their situation is likely to deteriorate further in the coming months.
4. 40% of the population will be in urgent need of food and cash in the coming weeks/months.
5. Protection needs, particularly for women and girls, have increased sharply since the beginning of the pandemic.

3.1.3. LOCAL PARTNERS

Local NGOs and local communities play a central role in the humanitarian response in Afghanistan. Due to the conflict, changes in the way international aid actors are perceived, and limited access, national NGOs and local communities have been playing an increasing role over the past two decades. Therefore, most DEC Member Charities had established a robust network of active national NGOs and strong, long-term, relationships with local communities, long before the pandemic.

- 50% of the DEC Coronavirus Appeal related response was delivered by local NGOs who have better access, especially in unsecure areas. The fact is that their security standards tend to be *lower* than INGOs[8].
- Despite a solid network of local actors, the response capacity to a global pandemic which requires specific safety measures, and the appropriate attitude and equipment had to be built.
- The strategic role local actors could play in this pandemic context was recognised and supported by the national government which relied on local NGO networks to support the national Covid-19 response.
- However, national actors were also impacted by restrictive measures during the lockdown. Like DEC Member Charities, they were only able to resume a level of activities after one month, once special travel permits had been issued.

The RTRR does not show any evidence of a significant effect of the pandemic in terms of promoting the role of local actors and pushing forward the localisation agenda. DEC Member Charities were already working closely with local actors long before the pandemic. However, the limited access of national NGOs to funding, compared to DEC Member Charities, undermined their response capacity. Donors, however, did not significantly increase their financial contribution to respond to the pandemic[9]. Most aid agencies had to adapt their pre-Covid interventions to respond to the most urgent needs.

DEC Member Charities worked closely with local communities who played an active role in designing projects, for example, identifying and estimating needs. They took part in the monitoring of project implementation, and conducted quality control visits - for example, visiting individual households to enquire about distributed items. This good practice reinforces the idea that community-level capacity is instrumental in achieving a timely and more impactful response during such emergencies when, in addition, movements are restricted.

Main lessons learnt

1. The presence of a strong network of local partners – CSOs and local communities – and having systems in place are significant advantages in terms of maintaining information flows and activities when movements are restricted.
2. However, in the case of the Covid-19 pandemic, both DEC Member Charities and their national counterparts were limited in their movements, and therefore in their capacity to assess, adjust and respond rapidly.

8 *The question of security standards and management between INGOs and NGOs is a complex issue. This observation does not necessarily mean that local NGOs do not take their security seriously enough. It may be the case sometimes, but what this sentence means mainly is that NGOs tend to apply more flexible rules and tend to be less "visible" and/or more "accepted", and therefore less exposed to security risks.*

9 See chart 3 page 18 of this report

3.1.4. COORDINATION / HUMANITARIAN PROGRAMMING

According to the DEC Member Charities and the other humanitarian actors we met, the pandemic has had a significant impact on humanitarian programming and coordination. The aid community had to revise their plans and figures. Priority sectors had to be reconsidered. A comprehensive countrywide re-evaluation of humanitarian needs was conducted in July 2020 – 4 months after the pandemic was declared. The total humanitarian funding requirement was revised from US$ 750 million to US$ 1.1 billion – a 50% increase. All clusters had to reconsider their budget requirements and priorities (e.g., the Health and Nutrition cluster, the Food Security cluster and the WASH cluster had under-estimated their budget requirements) due to anticipated funding gaps.

- The pandemic impacted the presence of in-country human resources. Some international aid workers left the country or were unable to return to their duty station. Most of these were decision makers. Their absence had an impact on the capacity of organisations to adapt and respond. Processes were slower.
- Some organisations hibernated for several months – 1-month of slow-motion operation mode was standard.
- Furthermore, movement restrictions – even after the delivery of special permits - and the lack of supplies further slowed down DEC Member Charities' response capacity.
- Covid-19 contamination risk and movement restrictions were imposed on *non-essential* staff, who then had to work remotely, thus reducing the overall tempo of DEC Member Charities' humanitarian programming, delivery and coordination capacity.
- This had an impact on DEC Member Charities' ability to carry out the necessary quality controls and engage with the affected population.
- Moreover, out of precaution and in order to protect affected populations, monitoring activities were delayed or postponed.
- The lack of coordination among national authorities – line ministries – further delayed the response. In addition to the required permission to circulate, a specific authorisation was required from MoPH for Covid-19 specific projects. Due to the lack of coordination among line ministries, the validation of Covid-19 specific projects was slow – 1 to 2 months on average according to DEC Member Charities.
- No proper coordination mechanisms were in place between government and non-government actors. It took several months before relevant committees could be formed.
- However, there was a silver lining: after some confusion, development and humanitarian actors started sitting around the same table to look at the best options to respond to the crisis and to address the different types of needs, whether acute or chronic. For example, OCHA and the clusters worked closely with the World Bank to identify people who were eligible for a safety net programme.

> *"Because of the quarantine during the Covid-19 crisis/lockdown, the coordination was very weak. There were no physical meetings or gatherings and, really, it was a big challenge for us, because we conducted meetings through Skype and it was not effective. We can say 30-40 % effective. Most of the time we had remote coordination through mobiles, Skype and email but it was not effective"*
>
> *A DEC member key informant*

- Coordination meetings were virtual. According to DEC Member Charities who were interviewed, some participating NGOs did not have adequate equipment and/or connections, which impacted on information-sharing, decision-making and overall coordination and programming – e.g., the cash and voucher WG usually share guidelines and information. Access to information was more challenging and impacted humanitarian analysis and response.
- Donor coordination faced similar challenges.
- At the national level, before the pandemic, ANDMA organised regular meetings with all key stakeholders. During the pandemic, these meetings were suspended, and as a result, community problems were not shared on time with NGOs.

Regarding DEC Member Charities – limited actions, but some coordination initiatives are in place.

- Concern has initiated a coordination mechanism on Skype for the DEC group. The group meets on a monthly basis. It is considered a good learning platform by the participants.
- Information was shared among Member Charities when responding to the DEC Coronavirus Appeal in order to avoid overlapping or duplication.

Main lessons learnt

1. The aid community, including DEC Member Charities, national authorities and donors were unprepared for the consequences of movement restrictions, which subsequently disrupted coordination mechanisms and organisations' work.
2. The setting up of online coordination mechanisms was useful but not as inclusive and efficient as the more traditional mechanisms. This resulted in a lower level of information sharing and therefore less informed decisions and a higher risk of duplication and/or gaps.
3. The pre-existing online information exchange mechanism between DEC Member Charities allowed them to maintain the flow of information despite the pandemic and restrictive measures.

3.1.5. CONCLUSION

Afghanistan is a fragile state which was faced with multiple challenges long before the pandemic was declared. The pandemic has accentuated pre-existing vulnerabilities. The country did not have the capacity to absorb such a shock, which had multiple negative impacts on the country and its people. The health sector's reputation has been damaged, causing negative secondary effects, such as a reduction in medical follow up and vaccination. The economic impact is considerable. Domestic food production has decreased, and the importation of food commodities has fallen, causing prices to increase. Poverty levels have increased sharply. 40% of the Afghan population is chronically food insecure. Levels of malnutrition are high. Afghanistan is on the brink of a major humanitarian crisis affecting the most vulnerable communities. Protection needs have increased too. As a direct consequence of the pandemic, a sharp increase in GBV and the domestic violence caseload was reported during the review.

Humanitarian programming was disrupted by the pandemic. It took several weeks before the aid community and DEC Member Charities could coordinate with the broader aid community and resume their activities. Communication was slower, and less efficient, and the level of information sharing was limited. Donor agencies, generally prompt to respond in the event of an emergency, did not respond apart from supporting their partners' no-cost extension requests to adapt ongoing projects to the new working environment and needs. Flexibility, adaptation, and reactivity have been challenging partly due to an unprecedented pandemic, but also due to bureaucracy. The interviewees reported that the DEC Coronavirus Appeal 2020 was one of the few sources of Covid-19 specific funding available. It allowed Member Charities to adjust their response to new needs.

3.2. KEY QUESTION 2 / ADAPTATION

The Aid community, including DEC Member Charities, faced very difficult choices when the pandemic started. It had to find a compromise between following the government's preventive measures, maintaining priority interventions to respond to existing pre-Covid-19 needs, adapting to new challenges and the safety of their staff. Ultimately, the aid community was able to respond during the initial months of the pandemic, but slowly and in a disorganised manner. The delayed response is partly due to the one-month process to obtain special travel permits. However, this is not the only reason. Adjusting to new working conditions was challenging. Developing new guidelines, providing training and adequate equipment to staff, and adopting a new modus operandi – i.e., a limited number of people in offices, staff working from home, essential travel only, supply of PPE, online coordination - was challenging.

DEC Member Charities had to revise their priorities and develop new action plans. The level of productivity was lower given the new constraints. Discussions with their main institutional donors[10] for no-cost extensions and for the revision of their projects' activities was time consuming. It resulted in additional administrative workload and pressure. Once DEC Member Charities were ready to respond, the dissemination of information and the distribution of basic hygiene kits was their first priority along with attempting to continue to respond to pre-existing needs – food, WASH, health, and livelihoods. Despite genuine efforts, the response was slowed down by the lockdown and supply challenges. Cultural barriers, rumours and misinformation circulating among the population[11] was a complicating factor for DEC Member Charities and the entire aid community.

To answer the second key question - *What are the measures already taken or still needed to adapt to the new working environment?* – the RTRR took 5 elements into consideration: Duty of care, ongoing activities, new activities, partnership and coordination and, last but not least, accountability and communication.

3.2.1. DUTY OF CARE

DEC Member Charities responded in a professional manner to their obligations. Staff exposure to Covid-19 was taken seriously and resulted in new guidelines and protocols that were rapidly developed and implemented. However, duty of care did not always extend to local partners, or not with the same level of requirements. Protective measures towards the local population were incorporated into DEC Member Charities' responses. However, genuine efforts[12] were undermined by multiple factors, including rumours, misinformation and cultural barriers, which resulted in a lack of cooperation and the non-respect of recommended protective measures by the local population.

Among the main reported consequences:

- Team movements reduced to essential only - Emergency team only travelling to project sites.
- Field trips increased after authorization was granted.
- Reduction of the number of staff in offices / the reorganization of teamwork into 2 shifts.
- Part of staff working from home via internet.
- Office space sharing with more distance between staff members.
- Impact on productivity, motivation and connectivity was an issue.
- Increase of staffing at field level to cope with new operational constraints – more sites, more work, more *home delivery* type of humanitarian response, which required more staff.
- Increased number of distribution sites and days – reduction of number of people per site.
- DEC Member Charities' adaptation measures partly depend on local actors' willingness and capacity to support and apply them. They tend to follow their own sets of rules.

In line with WHO guidelines on Covid-19, DEC Member Charities adopted additional precautionary measures and developed new SOPs to protect their staff, as well as national partners' staff to some extent, and local actors. The main new measures focus on informing, training, equipping (PPE), reorganising office space, optimising online exchanges, supporting staff adjustment to a rapidly changing environment and preserving a good psychological status. In most cases a referral mechanism for suspected cases was set up.

"It was first time in my life that I faced such a pandemic, it was very strange and different, meetings banned, gathering limitation, social distance, working in multiple shifts or working from home, but we learned how to manage activities remotely and how to conduct meetings by phone. The best lesson was to stop unnecessary movements, any one coming from other country or city should isolate for 14 days and after that should come to office for work"

10 This observation does not include DEC which, on the contrary, was flexible and reactive

11 Rumors of herbal treatments, unauthorized and unproven vaccines for Covid-19, belief that non-Muslims only can be infected – were reported by multiple sources.

12 Such as open aid discussions, the supply of PPE equipment, a reduced number of beneficiaries per distribution site, an increased number of distribution points, and awareness raising campaigns

Most DEC Member Charities intend on supporting local partners efforts to adopt Covid-19 specific precautionary measures. Regular updates and training are provided to local partners' staff. More rarely, explicit written consent to work in a pandemic context is required from staff members. In principle, all DEC Member Charities have a robust due diligence policy in place. In practice, its application depends on individuals' level of understanding and willingness to comply. It also depends on what local actors perceive as the *most pressing priorities* between aid delivery and applying safety measures.

Main lessons learnt

1. The observance of duty of care in a pandemic situation requires specific procedures and a strict follow up at field level as well as the involvement of field staff and local partners.
2. The adoption of new/adapted SOP is useful to guide field staff. However, to integrate new procedures, field staff need adequate training/guidance. The production of a support document is not enough.
3. Rumours, misinformation and cultural barriers can result in a lack of cooperation and the non-observance of protective measures which undermine duty of care related policy/actions.

3.2.2. ON-GOING ACTIVITIES

Specific guidance on programmatic remote monitoring for Covid-19 responses - where and when there is limited physical access to project sites, such as during lockdown, or where government movement restrictions are in place – has been developed by DEC Member Charities. This was appreciated by field staff as it provides valuable information on remote monitoring and includes data collection tools, good practice examples and details of information and communication technologies that support remote monitoring. This "new approach" was not entirely new to field staff in the Afghan context.

There is only 1 Health intervention out of the 6 DEC Covid-19 Appeal funded projects in Afghanistan. A few other interventions have a hygiene/health promotion component and others a GBV and mental health component alongside their main activities - Nutrition, WASH and Food Security. In this regard, Covid-19 Health-related issues received due consideration from DEC Member Charities within the limits of their technical expertise and capacity.

The aid community has provided extensive support to the Health sector to enhance its capacity to cope with the pandemic - support for more beds in intensive care units across the country, equipment for isolation wards - training of medical staff in different domains including in contested areas (surveillance and risk communication, MHPSS, laboratory testing, psychosocial first aid) – providing equipment for medical staff - supplying hospitals[13]. However, the lack of medicine for regular diseases remains a more pressing issue than the Covid-19 pandemic according to focus group discussions with the local population.

In remote locations, to access communities for hygiene promotion and Covid-19 risk awareness, DEC Member Charities and their partners work alongside local public health workers. They provide training to Community Health Supervisors (CHS) and Community Health Workers (CHW) who then organise hygiene and stress management awareness-raising sessions in places where NGOs do not have access. To train staff in Community Health Facilities where visits are not permitted, training is organized at the district central level. Peer to peer support is also promoted between a larger structure - with more staff and experience - and a smaller structure, with less means – e.g., staff in Lal district trained on the Basic Package of Health Services (BPHS) by Herat medical team, who also provide remote support.

Existing DEC supported projects adapted to deal with Covid-19 related priorities - main measures:

- **WASH** / distribution of new items (PPE for health workers), masks, hand washing stations, Covid-19 specific hygiene kit and awareness raising sessions.

13 12% of DEC Appeal funds provide direct support to the medical sector – DEC funds also support hygiene/health components through the WASH sector – 27% of DEC funding

- WASH facilities have been upgraded or built at strategic locations: bazars, mosques, schools, densely populated areas such as KIS, IDP camps, in villages, at the border at key entry points (Tolkham, Islam Qala, Milak). Hygiene kits, soap bars, leaflets, PPE, locally-made masks.
- **Food Security** - Similar to what was done before the pandemic. Protective masks however will be produced locally, supporting job creation and small businesses.
- **GBV** - no significant changes observed compared to a *classic* GBV intervention prior to the pandemic**.** A higher demand for such services is however observed as a direct consequence of the pandemic. For patients who do not have access to face-to-face counselling services, an on-line counselling service via mobile phones has been made available.
- **Risk communication** receives special attention through social media and Rapid Response Teams. Specific M&E of education facilities in terms of social distancing, mask wearing and sanitation.
- Special **MEAL** system in place including community-based M&E and the use of technology (WhatsApp groups) for post-delivery feedback, to assess the impact of awareness-raising sessions, to follow up GBV cases, etc.

Also:

- At leadership level, the project management team is receiving remote management support from the senior leadership team through Skype and Zoom sessions. There is a weekly leadership coordination meeting to coordinate work between national and international staff.

Main lessons learnt

1. Supporting the existing network of public health professionals – CHS & CHW – provided a strategic advantage to both DEC Member Charities – in terms of access to the population and working with trained staff with an official status – and to the Ministry of Public Health – in terms of benefiting from welcome extra resources to fulfil its mission
2. Specific equipment – such as protective masks – when produced locally offers multiple advantages: in terms of supply – less dependency on imported products and importation constraints and delays – in terms of economic benefits – it supports local employment and the economy
3. Technology and social media provide promising perspectives in terms of overcoming constraints, such as movement restrictions and limited access, and promising perspectives in terms of empowering local communities (e.g., community-based M&E)

3.2.3. NEW ACTIVITIES

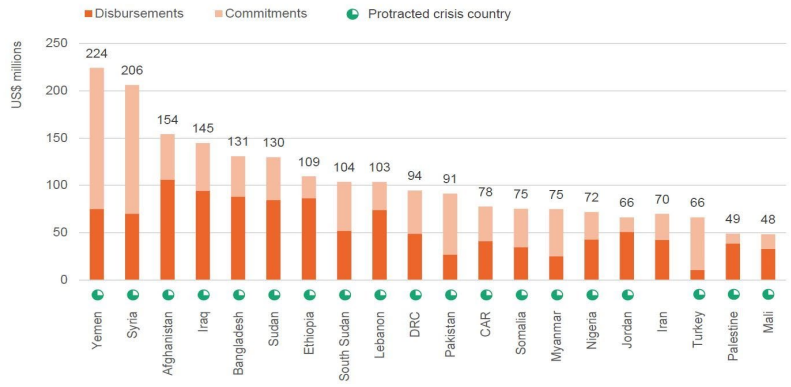
The number of new Covid-19 specific interventions is limited. The absence of additional funding limited DEC Member Charities' options. Instead, aid actors adjusted existing projects and reallocated resources – with heavy bureaucracy in terms of reporting and validation procedures, as already mentioned in this report. This brought an extra workload at a time when country teams had other pressing priorities, such as understanding the consequences of the pandemic and addressing needs. This resulted in staff fatigue / exhaustion. ***In this regard, DEC was one of the few available extra resources that could provide extra funding for unplanned interventions. In this regard, the DEC Coronavirus Appeal was a sound decision.***

Each organisation developed its own approach and set of tools to promote, implement and monitor Covid-19 sensitive interventions. The main elements identified during the desk review and field mission are as follows:

- Improving access to water, especially handwashing stations in public places (bazars & schools);
- Preventing / reducing Covid-19 contamination risk within communities, which requires three main actions:
    - a. raising awareness and accompanying behaviour change;
    - b. providing basic equipment (PPE + sanitizer + adapted hygiene kits);
    - c. avoiding unnecessary contact and optimizing the use of technology when possible (safety distancing) to exchange information / data;
- Reducing poverty caused by the loss of economic opportunities and business closures, and its social impacts, with a specific focus on Food Security, Nutrition and Livelihoods support;
- Anticipating a rise in cases of GBV and an increased protection caseload;
- Flexibility in planning and adjusting;

- Adequate monitoring mechanisms of Covid-19 referral caseloads – A DEC member developed a referral database to keep track of all referred cases to make sure they received adequate support – An excellent follow up initiative.
- Additional risk mitigation measures – such as remote data collection through project team and programme participants, including phone and visual evidence (photo films with all required authorisations) – to reduce exposure of staff and local population. Such practice has, however, been in place for many years in the context of Afghanistan.

Chart 3 – Largest recipient countries of humanitarian grants for Covid-19 pandemic response – Oct. 2020



Afghanistan is the third largest recipient of Covid-19 focused international aid. However, the lack of adequate resources remains one of the main challenges faced by aid actors. The number of people in need has sharply increased, which results in more selective selection criteria, and therefore more people to exclude, more claims and pressure to handle, and tensions to defuse for all DEC Member Charities.

Main lessons learnt

1. The DEC Appeal was one of the few available extra resources that could provide extra funding for unplanned interventions. In this regard, the DEC Coronavirus Appeal was timely and useful.
2. Reallocation of existing resources due to evolving needs is a cumbersome and bureaucratic process which generates an extra workload and stress for field staff and reduces time spent understanding changes, focusing on aid delivery, working with local actors, and identifying appropriate solutions.

3.2.4. PARTNERSHIP AND COORDINATION

In terms of coordination, the desk review highlighted the active participation – and occasionally the leading role – of all DEC Member Charities in multiple coordination forums. DEC Member Charities actively engage in the UN-supported Cluster system, which is the main coordination structure bringing together the largest number of stakeholders involved in multiple disciplines. This coordination network is now fully operational again.

Despite the general confusion at the beginning of the crisis, one silver lining has been that it has required collaboration between humanitarian and development actors. The crisis has brought the two "worlds" to the table, and it has helped to get the message across about how humanitarian actors work. For example, OCHA assisted the targeting for the WB safety net initiative. The use of social safety nets is an interesting avenue which offers long-term perspectives. Humanitarian actors and development actors have a complementary approach, which might explain why they found common ground to coordinate. It is worth noting that the discussion on how to optimise a social safety net to address/prevent a humanitarian crisis took place at an operational level. It brought together the key players at cluster coordination level instead of the usual political heads of agencies level. It proved to be more effective in this context.

It should be noted that Concern Worldwide has taken a lead role in establishing a country-level coordination mechanism with DEC Member Charities, prioritising Afghanistan for this appeal. Specifically, Concern has created a technical working group with Oxfam, Save the Children, Christian Aid, ActionAid, and Tearfund to promote strategic coordination among all agencies as well as potential collaboration for agencies implementing their response within the same geographic areas. The DEC members group serves as a platform to share lessons learned and best practices, prevent duplication of efforts and targeting, and discuss innovative approaches to enhance the quality of project implementation. It would be useful to investigate further what this group has been producing since it was established. It may constitute a positive example of coordination between DEC Member Charities that could be replicated in future appeals. Unfortunately, the field mission did not provide enough information to draw any particular lessons.

The role of local NGOs has become increasingly important over the past 20 years, long before the pandemic. The pandemic highlighted, and is a reminder of, the importance of having such a network across the country when an emergency takes place.

Main lessons learnt

1. The pandemic re-emphasised the importance of an existing network of capable local actors – national NGOs and empowered local communities.
2. Changing from an in-personae to a virtual coordination mode necessitates adapted equipment, connectivity and protocols. Such a shift requires time and if not planned in advance leads to confusion and wastes precious time.

3.2.5. ACCOUNTABILITY & COMMUNICATION

The review highlights that accountability and maintaining good communication with local communities was a priority for all DEC Member Charities during the Covid-19 response.
DEC Member Charities involve the local population in the design and monitoring of their interventions. In some cases, the M&E team is made up of local community actors and DEC Member Charities' staff. DEC Member Charities use technology in innovative ways to involve the local population as much as possible and get their feedback: in M&E teams, FGDs, one-to-one online interviews, PDM, workshops, complaints mechanisms, etc. Overall, M&E mechanisms receive due attention and are robust.

"In this Covid-19 response, more than ever, we need to proactively communicate and promote a two-way dialogue with communities to understand risk perceptions, behaviours, existing barriers, specific needs and knowledge gaps, and then provide communities with accurate information tailored to their circumstances"

Mixed feedback from local communities regarding involvement and accountability mechanisms:
In some cases, community volunteers were solicited to compensate for DEC Member Charities' lack of access. Volunteers were chosen based on their status – well-respected elderly people – and good economic situation. Focus group discussions held during the field review confirm the positive role played by these intermediaries. Community-based monitoring committees were helpful during project implementation. They were well informed about project details and in return provided valuable advice. Phones and social media – WhatsApp groups – were used to maintain contact, follow up progress and adapt project activities.

In other cases, community participation was limited. Due to Covid-19, sessions were less frequent. However, community feedback and complaints mechanisms were in place, relying on technology for information exchange. In most cases, it was not possible to carry out satisfaction surveys as planned due to communication challenges.

Among the main criticisms shared by participants during FGDs:

"No, we have not participated in these processes (design process)
There was no complaint mechanism therefore we have not reported any issue.
Through religious schools we became aware of our rights, no organization has conducted awareness for us.

Due to the pandemic, lots of problems have been observed in the mobile networks."

FGD Participants

It is also worth mentioning that the significant increase in poverty, and the limited increase in resources resulted in more selective criteria. This, in turn, resulted in an increase in the number of complaints due to the limited number of selected beneficiaries and a higher level of resentment and frustration among the people. Early feedback provided by one of the DEC members showed that these tensions could be diffused through extensive dialogue. This was not easy to plan and organise in the current context and was time consuming. Most registered complaints questioned beneficiary selection criteria and processes.

Some DEC Member Charities developed specific guidelines to mitigate contamination risks for frontline workers, thus maintaining access to and involvement of beneficiaries. The new recommended measures resulted in higher operational costs – PPE was provided to all participants for all meetings – the number of meetings increased as a result of the reduced number of participants. More staff were required.

Main lessons learnt

1. In the context of the pandemic, maintaining good accountability and communication standards requires additional staffing and generates extra costs for which local partners need a budget.
2. The involvement of well-trained local community actors in M&E teams, and the use of technology, provides good alternative solutions in an emergency context, with limited to no access.
3. Increased needs and scarce resources lead to tighter selection criteria and thus more complaints, and more tensions to diffuse. In the context of the pandemic, diffusing tensions became more challenging due to movement restrictions.

3.2.6. CONCLUSION

The pandemic was sudden and had serious consequences on humanitarian programming and response. However, the aid community in general and DEC partners in particular mobilised their energy and resources to adapt and maintain their activities to the best of their ability. Staff safety, as well as the safety of their partners and the local population, received full attention. New Standard Operating Procedures were developed to guide field work and reduce risk exposure. In order to adapt ongoing activities, DEC partners rapidly added a few components aimed at raising awareness among the population, providing basic hygiene kits, and training their staff and community workers. At a later stage, when the economic impact of the pandemic started to be felt at household level, DEC Member Charities and their partners realised that it was necessary to pay more attention to protection issues, GBV, domestic violence and psychosocial services. In this regard the DEC appeal and funding was timely and provide them with the necessary extra resources to adjust and cover unplanned needs.

Following the pandemic shock wave, coordination mechanisms were disrupted and it took a few weeks before they were operational again. DEC Member Charities maintained their coordination platform under the leadership or facilitating role of Concern Worldwide. It is worth mentioning that the pandemic had a positive impact in the sense that it brought humanitarian and development actors together to identify joint solutions. Their decision to work together to support a national social safety net has brought encouraging prospects. In terms of accountability and communication with local communities, the RTRR reveals a mixed picture. DEC Member Charities genuinely tried to maintain good standards, but despite their efforts the level of inclusion was low. Similarly, monitoring, quality control, and complaints mechanisms relied mainly on technology, social media and connectivity. The communities we interviewed felt dissatisfied with the way the relationship was handled. However, the level of dissatisfaction is partly influenced by increased needs and limited resources, which has resulted in the application of more selective criteria.

4. RECOMMENDATIONS

FOR PHASE 2 OF THE APPEAL

1. A MORE MPCA-FOCUSED RESPONSE

While 50% of the DEC Appeal phase 1 funds focused on Nutrition, Food Security and Livelihoods, none of the funds were used to support MPCA. Based on the Review's main findings regarding the economic impact at country and household levels, Multi-purpose Cash Assistance should be considered as a priority for phase 2. Alternatively, a response combining both cash and in-kind assistance could be considered, depending on the specific characteristics of local contexts and local market dynamics. The last IPC report – Oct. 2020 - and the revised HRP indicate high levels of food insecurity and malnutrition. Therefore, any initiative aimed at addressing this primary emergency would be justified.

2. DUE ATTENTION TO PROTECTION AND PSYCHOSOCIAL CARE

As mentioned by DEC Member Charities during the Review, the consequences of the pandemic have resulted in increased protection needs. The GBV caseload, the number of reported cases of domestic violence and people needing psychosocial support have increased during the pandemic. Loss of income and economic difficulties coupled with lack of prospects and lack of privacy, overcrowding, have resulted in an increase in violence at the household level. Action was therefore needed to sensitise the population, prevent acts of violence, adequately address confirmed cases and provide appropriate support to victims. House-to-house GBV awareness-raising, using community health workers and/or properly trained local actors, was effective according to DEC Member Charities and gave good results. The number of cases subsequently fell.

3. SUSTAIN EFFORTS ON AWARENESS AND BASIC HYGIENE EQUIPMENT

DEC Member Charities' response during phase 1 with regard to the provision of adequate PPE, adapted hygiene kits, the training of health staff in prevention measures and awareness raising campaigning was justified. Based on the Review's feedback from field actors, there is a need for continuous efforts in this sector. It is therefore recommended that phase 2 keeps supporting these initiatives. Social media, like Facebook and Twitter, the WHO's websites, and campaigns by Health actors via radio and phone networks played an important role in the prevention of Covid-19. People were made aware of the importance of wearing a mask and basic hygiene measures. Unfortunately, attitudes are evolving and more and more people are under the impression that the pandemic is over.

4. FOCUS ON MISINFORMATION AND BEHAVIOUR CHANGES

In order to support the previous recommendations, misconceptions and rumours should receive more attention during phase 2. Considering the undermining effects of rumours on efforts to educate, sensitise and inform people about Covid-19 risks and prevention, DEC partners should closely monitor the situation in their zones of intervention. Appropriate action should be taken to reduce the negative effects of misinformation and rumours on people's health. Mass campaigning alone is not enough to raise awareness. The focus should be more on behaviour change, with repeated messaging, regular follow up and community level discussions. Potential *game changer* actors and actions should be identified at the community level. Religious leaders, for example, could be strong allies in relaying key messages.

MID- TO LONG-TERM RECOMMENDATIONS

5. REDUCED BUREAUCRACY AND MORE FLEXIBLE PROCEDURES

Administrative procedures and project management requirements in terms of reporting, transparency and accountability are heavy and time-consuming. During the emergency, the administrative workload mobilised significant resources and diverted the attention of aid workers who, instead of focusing on practicalities to address operational challenges – supply, storage, distribution, training – spent long working hours meeting

administrative requirements. Processes should be more flexible and simplified, especially during emergencies. Such a change requires a change of paradigm within the aid system – a change from mistrust to trust; trusting operational decision-makers to use good judgement and be honest, with solid post-intervention control mechanisms. Procurement policies proved to be particularly cumbersome and inappropriate in the context of the pandemic. Procedures should be simplified in case of emergency. This particular point was raised numerous times during the Review. Fastidious procedures delayed the procurement of essential items and thus the response. The bureaucracy involved adds to the workload of already under pressure teams.

6. MORE INCLUSIVE COORDINATION MECHANISMS

There is a clear deficit of trust between international aid agencies and local actors. National authorities, national NGOs, and local communities, inspire limited trust among international aid actors. Regardless of the reasons why, the pandemic, like previous emergency situations before, has highlighted the strategic importance of involving local actors in coordination mechanisms. When they are not involved, the response is delayed and the needs of the most severely impacted people increase. In the case of Covid-19, it took several months for mixed committees composed of national authorities and aid agencies to be organised. The lack of participation or representation of national authorities and line ministries in humanitarian coordination forums resulted in miscommunication, confusion and delayed response. The trust deficit must be addressed. The lack of trust between national and international aid actors is prejudicial to a timelier, better coordinated, complementary response. DEC Member Charities who have extensive experience working closely with national actors in the Afghan context should join forces to propose a paradigm change in the way the aid community operates. This specific issue has been a constant challenge for numerous years in Afghanistan.

7. OPTIMISE EXISTING COMMUNITY FORA

In relation to the previous recommendation, Afghanistan offers the strategic advantage of having project implementation-oriented community forums such as CDCs established progressively across Afghanistan with the expansion of the National Solidarity Programme (NSP). The NSP no longer exists, but the CDCs remain. These structures offer multiple strategic opportunities, such as a community-embedded response capacity. CDCs have been trained to identify needs, develop simple project proposals, manage resources, implement activities and report on progress made. Building on this existing network and potential to respond to emergencies such as the primary needs caused by a pandemic can provide a strategic advantage. However, these existing structures may require specific adjustments, such as the inclusion of IDPs, when relevant. With adequate equipment, training and support, local communities can be – and have been in the past - a direct responder to their own needs, which could improve timely response. DEC Member Charities are already involving local actors at different stages of the project cycle, as mentioned in the accountability and communication section. The initiative is good and is appreciated by local actors. At the same time, one can sense a certain frustration from the local community perspective about not being empowered enough to do more, and not being trusted more. Past experience shows that communities tend to be better at handling difficulties such as beneficiary selection, and preventing and diffusing social tensions within the community. **Community-based monitoring committees (**voluntary) can give great results. Community-based monitoring committees constitute a great alternative to more *traditional* M&E mechanisms, when access is limited. However, they require robust post-distribution monitoring mechanisms to reduce the risk of misappropriation. The presence of women in these committees is instrumental to the success of such an approach as this allows better access to houses, and thus to women and children.

8. A JOINT DEC MEMBER CHARITIES, GEOGRAPHICALLY-FOCUSED, MULTI-SECTOR RESPONSE

DEC Member Charities have set up good information sharing mechanisms - Save the Children shares information with other DEC Member Charities related to Protection of children, Concern does this for WASH, and Oxfam for Food Security. These mechanisms contribute to a more harmonised and more consistent overall DEC funded response. Considering the pandemic's multi-faceted impact – economic, health, nutrition, livelihoods, WASH, and protection - DEC Member Charities should consider a joint, geographically-focused, multi-sector, integrated response. A concerted effort, simultaneously covering several key sectors, would help communities to recover more rapidly and in a more sustainable way. Such a concerted approach would not

only be more effective in addressing the "symptoms" of the pandemic, but would also provide an opportunity to address some of the root causes of poverty, and thus would increase the chances of building resilience.

5. ANNEXES

ANNEX 1 –INTERVIEW & FGD LIST

Interview

Organisation Name	Position / Title	Date	KII family
Action Aid	Emergency Manager	10.11	DEC member
Christian Aid	Programme Manager in Kabul	11.11	DEC member
Concern	Programme Director in Kabul	12.11	DEC member
Concern	Project Manager in Kunduz	09.11	DEC member
Concern	M&E Officer in Kunduz	09.11	DEC member
DoPH	DoPH Representative in Nangarhar	11.11	Local Authorities
DoPH	DoPH Representative in Herat	22.11	Local Authorities
DoPH	DoPH Representative in Kunduz	09.11	Local Authorities
DoE	Directorate of Education Representative in Herat	22.11	Local Authorities
DRRD	DRRD Representative in Nangarhar	11.11	Local Authorities
DRRD	DRRD Representative in Kunduz	09.11	Local Authorities
MoPH	Senior Technical Advisor/Health Minister Kabul	23.11	Local Authorities
Oxfam	Project Manager in Herat	22.11	DEC member
Oxfam	Funding Coordinator in Kabul	13.11	DEC member
Oxfam	Emergency Manager in Kabul	23.11	DEC member
Oxfam	HQ – London -	16.11	DEC member
Save the Children	Project Manager in Nangarhar	09.11	DEC member
Save the Children	Project Officer in Nangarhar	13.11	DEC member
Save the Children	Award Manager in Kabul	10.11	DEC member
Save the Children	DEC project Manager in Kabul	10.11	DEC member
OCHA	Inter-cluster coordinator	17.11	IO/INGO
OCHA	Humanitarian Affairs Officer in Kabul	15.11	IO/INGO
IOM	Program Manager in Kabul	24.11	IO/INGO
DG ECHO	Head of Office for Afghanistan	10.11	IO/INGO

FGD

Location	DEC Partner	Participants	Topics
Nangarhar	Save the children	25	Impact of COVID 19 and mitigating measures
Kunduz	Concern	6	Impact of COVID 19 and mitigating measures
Kabul	Action Aid	10	Impact of COVID 19 and mitigating measures

To be noted that FGD involved both men and women and separate groups

ANNEX 2 – ANALYSIS FRAMEWORK

Objective 1 /	Better understand the impacts of Covid 19 pandemic on contexts and needs (+global level on organisations- no flight, HR problems, etc.)									
Objective 2 /	Analyse adaptations already done and still needed in humanitarian programming in each country (and at HQ level?)									
RTE key questions	Lines of enquiery / Sub-questions			Related CHS criterion	indicators/info to collect	Desk R.	Ext. S.	KII	Field obs.	FGD
	Context &	L1	Main measurable / commonly agreed consequences of the pandemic on each context (health - e.g. situation of the health system, caseload, and non-health related - e.g.specific focus on food security, livelihood, domestic violence, etc. impact on air traffic, on mobility, on supply chain, logistics). More broadly - political / economical consequences of the pandemic / how it has influenced key stakeholders and perhaps influenced power dynamics.		C1	nb of covid cases (country/camp levels) + mortality and morbidity rate if available	X	x			
					Impact on the country health system and staff	X	X			
					economic indicator at HH level		X			
					dynamics in food markets		X	X	x	
					dynamics in access to labor		X	X	x	
					level of domestic violence	X	X	X		
					Evolution of level of poverty / food insecurity / malnutrition?	x	x	x		
					other health related indicator ???		x			
					monitoring system in place	x		x		

ANNEX 3 – GENERAL QUESTIONNAIRE

RTE key questions	DEC Sec	DEC members - strategic level	DEC members - country level	DEC members local partners	Local actors (authorities and pop.)	Other IA organisation	General questionnaire
Key Q 1 / What has been the impact of covid 19 on DEC members and their operational environment (context and needs)?			X	X		X	1.1 What are the main consequences of the pandemic in your country/region (Political, economical, in terms of power dynamics?) What are the main consequences in terms of health and non-health related - e.g. food security, livelihood, domestic violence, etc.? What was the impact in terms of mobility, on human resources, on supply chain & logistics? On Security?
			X		X	X	1.2 How is the sanitary situation being monitored - who with what system in place and what resources - how accessible and reliable the information is at country level?
			X		X	X	1.3 What are the measures taken by the Authorities and their impact on aid actors and their ability to deliver? How did aid agencies cope with the safety measures and movement restrictions? What consequences on their programme / for the pop.?
			X	X		X	1.4What was the impact of the covid crisis on humanitarian programming and coordination (3 levels to look at - a. with national authorities; b. with the wider aid community; c. among DEC members) - What leassons learnt?
			X	X	X	X	1.5 What is covid 19 impact on participation of local population to the project cycle? What is covid 19 impact or influence over accountability mechanisms? Over access to information / communication with aid actors?
Key Q2 / What are the measures already taken or stiil needed to adapt to the new work environment?		X	X				2.1 What are the measures in place for the safety of aid workers (int. & nat. staff)?
			X	X			2.2 What are the measures in place for the safety of local implementing partners? Has the role of local partners evolved during the pandemic? If yes to what extent? What has changed?
			X		X		2.3 What are the measures in place for the safety of the local populations / beneficiaries?
		X	X	X		X	2.4 What are the main changes brought or still required to existing humanitarian programming as a consequence of the covid 19 pandemic? What has changed the most in the way humanitarian actors work? Has the pandemic contributed to encourage or reinforce the localisation process for example?
			X	X		X	2.5 What are the most important changes to health interventions in connection with covid 19? What are the main challenges and/or opportunities due to these changes? What impact in terms of relevance, efficiency, effectiveness of humanitarian interventions?
			X	X		X	2.6 What are the specific changes brought to non-health interventions in connection with the covid 19? What are the main challenges and/or opportunities due to these changes? What impact in terms of relevance, efficiency, effectiveness of humanitarian interventions?
			X	X			2.7 What are the main M&E challenges faced by DEC members as a consequence of the pandemic? Was a solution found? Did it provide deliver according to expectation? What lessons learnt if any?
			X	X		X	2.8 Were covid 19 related risks well identified and were mitigation measures adpated / efficient? What are the key lessons learnt during this pandemic situation from an operational point of view? If any.
				X	X		2.9 What does exist in terms of complaints and feed back mechanisms
			X	X			2.10 What were the main specific measures taken regarding gender and environmental issues in relation to the covid crisis? Any lessons learnt worth sharing?
Key Q3 / What are the lessons learnt and innovative ideas in each country that can benefit the group?		X	X				3.1 What differences has it made to members to access the DEC funding (and ultimately to people)? What difference has it made / financial / programmatic?
		X	X				3.2 Was DEC proactive enough or reactive enough? Was it a struggle for partners to access DEC funding or respond to this appeal? DEC funding mechanism is flexible – but do members realise that? Do they know how to optimise this flexibility?
		X	X				3.3 How ready were DEC and its members as a collective to respond?
		X	X				3.4 Any multiplying factor(s) that might have been generated/initiated (any leverage effect) by DEC appeal?
		X	X				3.5 What consequences the delay to respond (from March to July) might have had? Was it a bad or a good thing?

ANNEX 4 –INITIAL FINDINGS WORKSHOP PARTICIPANTS

No	Name	Position / title	Organization
1	Martina Lecci	Women's protection Advisor	Actionaid London
2	Munir Mashal	Programme coordinator	Oxfam / ADA
3	Hassan Karimi	Programme Manager	Actionaid Kabul
4	Zuhal Malekzay	Programme Manager	Christian Aid
5	Martha Medhanie	Programme Director	Concern Afghanistan
6	Sultan Sultani	Project Manager	Concern Afghanistan
7	Pete Knight	Programme Funding Co-ordinator	Concern London
8	Matiullah	Project Manager	Save the Children
9	Kennedy Dhanabala	Project Manager	Tearfund / Serve
10	Wahidsha Amin	Project Manager	Oxfam
11	Pravind Kumar	Head of Programme	Actionaid
12	Georine Hamowoo Sopke	Afghanistan Programme Coordinator	Actionaid
13	Thomas Benn	Global Programme Officer – DEC COVID-19 Programme /London	Christian aid
14	Ben Philips	Humanitarian Officer / London	Oxfam
15	Ziaullah Haidary	Award Manager	Save the Children
16	Kristina Shaw	Based in London	Save the Children
17	Heather Lawless	Based in London	Save the Children
18	Javid Sadat	Programme Manager	Tearfund / IAM
19	Karen MacRandal	Title? / based in London	Save the Children
20	Gracy	Programme officer / Afghanistan	Tearfund / Serve

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