DREF Final Report

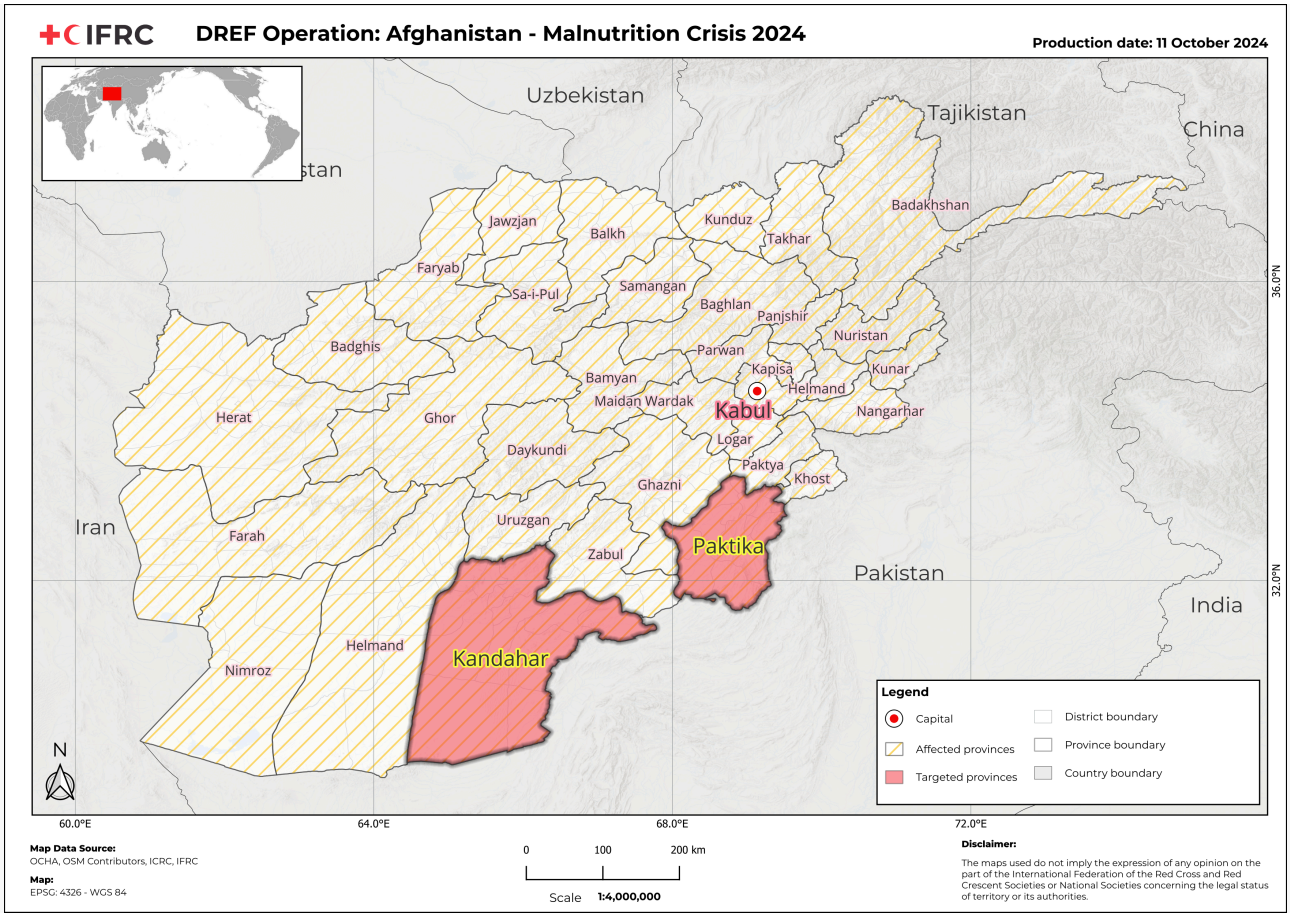
Afghanistan malnutrition crisis 2024

A Nutrition Nurse taking anthropometric measurement at IPD Center. (Photo: ARCS)

Appeal: **MDRAF017**	Total DREF Allocation: **CHF 500,834**	Crisis Category: **Orange**	Hazard: **Other**
Glide Number: **OT-2024-000184-AFG**	People Affected: **2,920,657 people**	People Targeted: **62,834 people**	People Assisted: **205,797 people**
Event Onset: **Slow**	Operation Start Date: **18-10-2024**	Operational End Date: **31-08-2025**	Total Operating Timeframe: **10 months**

Targeted Regions: **Kandahar, Paktika**

Description of the Event



Map of Afghanistan targeted area. (Map: IFRC, IM)

Date when the trigger was met

10-10-2024

What happened, where and when?

Malnutrition has long been a pressing public health concern in Afghanistan, driven by a complex interplay of underlying and immediate factors. Prolonged drought, natural disasters, population displacement, a sharp increase in the cost of living, food insecurity, and widespread unemployment have all contributed to this crisis.

While these factors have been gradually exacerbating malnutrition over the years, the situation took a severe turn between May and September 2024. During this period, malnutrition rates soared to unprecedented and alarming levels, necessitating urgent and concerted humanitarian interventions. A notable increase in acute malnutrition was observed among children and pregnant or lactating women nationwide.

This alarming trend was corroborated by the release of the 2024 Global Hunger Index on 10 October 2024, which underscored the worsening malnutrition and hunger crisis in Afghanistan. Reports indicated that the situation had deteriorated further due to rising humanitarian needs coupled with a decline in humanitarian funding. Although the crisis affects the entire country, Kandahar and Paktika provinces emerged as the most severely impacted provinces.

Following the alarming surge in malnutrition in 2024, the crisis in Afghanistan has deepened further into 2025, with no signs of reduction. As of mid-2025, an estimated 3.5 million children under five were suffering or projected to suffer from acute malnutrition, including nearly 900,000 cases of severe acute malnutrition (SAM) and 2.6 million cases of moderate acute malnutrition (MAM). Additionally, 1.2 million pregnant and breastfeeding women were affected. The situation remained most dire in Kandahar and Paktika, but widespread child food insecurity placed nearly every province under strain. Humanitarian agencies warned that a sharp drop in funding, including partial suspensions by key donors, would threaten the continuity of life-saving nutrition programs. The World Food Programme (WFP) described the crisis as “record-breaking” with children being hit hardest and urgent appeals issued for sustained international support.

IPD SAM pediatric doctor instructing on patient care. (Photo: IFRC)

Kandahar IPD SAM Center. (Photo: IFRC)

Scope and Scale

By mid-2025, Afghanistan remained engulfed in a severe malnutrition crisis, with updated figures from IPAC-Afghanistan indicating that approximately 3.5 million children under five years were either suffering from or projected to suffer from acute malnutrition, including over 867,000 cases of severe acute malnutrition (SAM). The situation is compounded by an estimated 1.2 million pregnant and lactating women facing acute nutritional deficiencies. According to the Integrated Food Security Phase Classification (IPC) analysis released in March 2025, the drivers of this crisis included poor dietary diversity, widespread childhood illnesses such as diarrhea and acute respiratory infections, and limited access to clean water and sanitation. While some seasonal improvements in food availability were noted, the IPC still classified 14.8 million people as acutely food insecure throughout the first quarter of the year.

Kandahar and Paktika provinces continued to bear the brunt of this emergency. The IPC Acute Malnutrition report for March–May 2025 categorized both provinces in Phase 4 (Critical), signaling dangerously high levels of malnutrition. Kandahar, with a population exceeding two million, and Paktika, with nearly 853,000 residents, collectively accounted for tens of thousands of children and women in urgent need of nutritional support. The winter season exacerbated the crisis, as heavy snowfall rendered many districts inaccessible, disrupting supply chains and increasing vulnerability to seasonal illnesses, particularly respiratory tract infections. Although neighboring provinces such as Khost were projected to show improvement, Kandahar and Paktika were expected to remain in critical condition due to persistent access constraints and under-resourced health systems. However, with the implementation of DREF-supported nutrition interventions, a total of 12,899 children and 7,329 pregnant and lactating women (PLW) in Kandahar and Paktika were successfully treated and discharged from the nutrition program — indicating a significant improvement in the overall nutrition situation.

In response, humanitarian organizations intensified their efforts. UNICEF reports that between January and March 2025, over 829,000 children were screened for wasting, with more than 37,000 who had SAM without medical complications being admitted for outpatient therapeutic care. Ready-to-Use Therapeutic Food (RUTF) remains the primary intervention for treating SAM without medical complications, especially in remote and conflict-affected areas. However, funding shortfalls posed a significant challenge. UNICEF's nutrition cluster update from March 2025 revealed that only 16 per cent of the required budget for SAM treatment had been secured.

To address the urgent nutritional needs of vulnerable families in Kandahar and Paktika, this project provided cash assistance to households with malnourished children. Cash support allowed vulnerable families to buy nutritious food, access health services in time, and avoid harmful coping strategies like skipping meals. In provinces like Kandahar and Paktika, where access was limited and needs were high, cash assistance gave families the flexibility to respond quickly to their children's nutritional needs.

Backed by the Afghan Red Crescent Society (ARCS) and the IFRC and funded through the DREF, Multipurpose Cash Assistance (MPCA) was

provided to 900 families in both provinces; each family received USD 156 (about 11,000 AFN) to buy nutritious food items in order to prevent acute malnutrition among children, particularly those under five years.

Beneficiary selection followed clear and rigorous criteria to ensure support is directed to families with children showing moderate to severe malnutrition, maximizing the program's effectiveness. Cash was distributed through a financial service provider to guarantee secure, timely, and respectful delivery. The intervention covered both urban and rural areas in Kandahar and Paktika, reaching those most in need. By providing conditional cash assistance, the initiative supported families' autonomy and dignity while addressing children's immediate nutritional requirements.

Source Information

Source Name	Source Link
1. Integrated Phase Classification Report - Afghanistan	https://www.ipcinfo.org/ipc-country-analysis/details-map/en/c/1157027/
2. Afghanistan Humanitarian Situation Report	https://www.unicef.org/afghanistan/topics/situation-report

IFRC Network Actions Related To The Current Event

Secretariat	IFRC was the focal organization for this emergency intervention and worked closely with ARCS. IFRC provided DREF funding and supported ARCS technically through training and regular monitoring and supervision of activities.
Participating National Societies	While there was no direct support by other PNSs in the country, Dannish Red Cross and Norwegian Red Cross were members of the movement health cluster that supported with coordination of health interventions including those supported by the DREF.

ICRC Actions Related To The Current Event

ICRC provided technical support for procurement of RUTF and RUSF. ICRC was also a member of the health cluster where technical issues were discussed.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	The government has established committees for coordinating the responses to the needs across the affected provinces.
UN or other actors	Led by UNICEF and WFP, the UN and other humanitarian agencies have scaled up their responses to the malnutrition crisis across Afghanistan, particularly in the most affected provinces. UNICEF is taking lead in coordinating the interventions through the Nutrition Cluster at National level.

Are there major coordination mechanism in place?

The Nutrition Cluster is serving as the strategic, policy level, and decision-making forum that ensures unified response to malnutrition through monthly coordination meetings, regular reporting and provision of continuous technical support.

The ARCS and IFRC are members of and participate in national level monthly coordination meetings of the Nutrition Cluster. IFRC is a member of the Technical Working Group (TWG) of the Nutrition Cluster.

Additionally, IFRC and ARCS are also active members of Food Security and Agriculture Cluster, Cash and Voucher Working Group,

Emergency Shelter and Non-Food Items (ES-NFI) Cluster, Accountability to Affected Population Working Group, Health Cluster, WASH Cluster, and Gender in Humanitarian Working Group. IFRC also attends the Inter-Cluster Coordination Team meeting. The Clusters system was established as a sectoral coordination mechanism at the national and regional levels to clarify the roles and responsibilities of each partner, including non-governmental organizations, United Nations (UN) agencies, public authorities, and other stakeholders. Cluster meetings occur monthly at the national level, coordinated by the respective cluster lead agencies such as shelter, food security and agriculture, health, WASH, protection, and nutrition which is coordinated through OCHA.

IFRC coordinated closely with the various nutrition cluster members at national and sub-regional levels to ensure unified response and to avoid duplication, while ensuring meeting people's needs in a timely and efficient manner.

Needs (Gaps) Identified

Multi purpose cash grants

To address the urgent nutritional needs of vulnerable families in Kandahar and Paktika, this project offered cash assistance to households with malnourished children. Cash support allowed vulnerable families to buy nutritious food, access health services, and avoid harmful coping strategies like skipping meals. In provinces like Kandahar and Paktika, where access is limited and needs are high, cash assistance gave families the flexibility to respond quickly to their children's nutritional needs.

Backed by the Afghan Red Crescent Society (ARCS), the IFRC through the DREF funds provided conditional cash assistance to 900 families in both provinces; each family receiving USD 156 (about 11,000 AFN) to buy nutritious foods that were critical for preventing acute malnutrition in children. The conditionality was that the selected beneficiaries needed to attend sessions regarding good nutrition and food preparation.

Although substantial support was delivered through cash assistance, the number of families with children suffering from MAM and SAM far exceeded the 900 households that were reached, primarily due to budget limitations. Cash assistance has proven to be an effective measure in preventing malnutrition by improving household food security and reducing negative coping mechanisms. However, the demand in the targeted communities remains significantly higher than the available resources. Moving forward, there is a critical need to design more robust, long-term, and integrated cash assistance interventions that are closely linked with livelihoods and income-generation programs. Such an approach will not only enhance the preventive impact on malnutrition but also strengthen household resilience and reduce dependency on short-term humanitarian aid.

Health

Prior to implementation of the nutrition interventions through the DREF, the multi-sectoral rapid needs assessment conducted in April 2024 revealed an alarming nutrition situation in the Southern provinces of Afghanistan including Kandahar and Paktika. Outcomes of the assessment revealed a significant reduction in meal size for children less than 5 years of age in 51 per cent of families, while 20.25 per cent reported a decrease in the frequency of complementary feeding. Regarding breastfeeding practices for newborns and infants aged 0 to 2 years, the outcomes of the assessment indicated 34.7 per cent of children were not breastfed because of lack of breast milk as a result of malnutrition among lactating women. While the DREF response significantly addressed the burden of malnutrition, chronic malnutrition —particularly among children under five remains a major public health concern in Kandahar and Paktika. This is attributed to a range of underlying factors, including political instability, entrenched cultural beliefs, poor access to health facilities, limited humanitarian support for nutrition interventions, and ongoing food insecurity. Addressing these root causes will require sustained and coordinated long-term efforts.

Additionally, using mid-upper arm circumference (MUAC), 6,257 children and 4,283 PLW were screened on an ongoing basis in the months of August and September 2025 through 13 ARCS-supported MHTs and 15 static health facilities in Paktika and Kandahar provinces. Of these, it was discovered that 2654 (62 per cent) pregnant and lactating mothers and 4280 (68 per cent) of children had severe and moderate acute malnutrition, respectively. Furthermore, MHTs and static health facilities reported a 6.4 per cent fatality rate among children in the month of September alone as a result of malnutrition and related medical complications; this is a death rate that is far higher than the <3 per cent SPHERE recommended threshold.

Prior to implementation of the DREF response, the most overarching needs included high levels of malnutrition among children and pregnant/lactating women, low coverage as most affected communities were in extremely remote locations, lack of sufficient therapeutic and supplementary food commodities (RUTF and RUSF) for treatment of severe and moderate malnutrition, lack of basic knowledge in infant and young child feeding (IYCF) and lack of knowledge in basic hygiene practices and prevention of malnutrition at household level.

The lack of RUTF and RUSF was attributable to the fact that malnutrition-related caseload was high and supplies from UNICEF and WFP were insufficient. The RUTF and RUSF supplies procured by IFRC were used to provide treatment to MAM and SAM beneficiaries. Consequently, the levels of SAM and MAM have reduced significantly in as much as chronic malnutrition still exists because of intricate underlying causative factors.

By the end of the DREF implementation period, a significant number of children with Moderate Acute Malnutrition (MAM) and Severe Acute Malnutrition (SAM) remained enrolled in the Targeted Supplementary Feeding Program (TSFP) and Outpatient Therapeutic Program (OTP), respectively, and needed further nutritional rehabilitation. Although the underlying drivers of malnutrition remain complex and multifaceted - ranging from food insecurity and poor childcare practices to recurring illness and limited access to health services - the need for ongoing, life-saving therapeutic support is critical. Continuity of care is therefore essential while ARCS, the MoPH and other humanitarian actors explore long-term, sustainable, and culturally appropriate strategies to address chronic malnutrition in Kandahar, Paktika and across Afghanistan as a whole.

Water, Sanitation And Hygiene

Outcomes of the multisectoral needs assessment conducted in the Southern region revealed that 32.15 per cent of the population relied on public hand pumps while 21.5 per cent of the population relied on private hand pumps and piped water, with 69.35 per cent lacking treated water and 79.55 per cent facing issues of insufficient access (79.55 per cent), especially during droughts. Outcomes of the assessment also revealed that 32.05 per cent of households use pit latrines without slabs or platforms while 32.05 per cent engaged in open defecation.

Due to poor sanitation and hygiene practices, the risks of infectious diseases remain high in Kandahar and Paktika provinces - a major predisposing factor to malnutrition. Diarrheal and other WASH-related diseases among children predispose them to malnutrition and other associated medical complications.

Protection, Gender And Inclusion

Protection and gender issues are integrated across all other sectors. Women continue suffering from gender-based violence, sexual violence, lack of freedom including inability to travel to public places (even for health care) without Mahrams. Most children not only suffer from malnutrition, but also there is a lack of essential knowledge regarding Infant and Young Child Feeding (IYCF) practices and basic hygiene measures to prevent malnutrition at the household level.

Community Engagement And Accountability

ARCS has a network of Volunteers working in the communities, and they are involving them more extensively in program activities including screening, defaulter tracing, active case finding and dissemination of key health, nutrition and WASH messages. While recent efforts in Kandahar and Paktika have shown progress in improving communication and feedback collection, including the establishment of simple community based feedback mechanisms through volunteers and suggestion boxes, gaps remain in ensuring that all affected communities can access and use these systems effectively.

Operational Strategy

Overall objective of the operation

To support the Afghan Red Crescent Society (ARCS) to provide emergency, life-saving nutrition interventions to 45,310 children under five years and 17,524 pregnant and lactating women (a total of 62,834 beneficiaries) in Kandahar and Paktika provinces. The DREF operation was designed to support provision of therapeutic and supplementary nutrition interventions to malnourished children under 5 years and pregnant and lactating women respectively.

As part of the revised operational strategy, adjustments were introduced to both the implementation modality and the budget allocation to enhance the effective and efficient use of available resources. During the procurement process, the selected supplier for Ready-to-Use Therapeutic Food (RUTF) and Ready-to-Use Supplementary Food (RUSF) quoted prices that were significantly lower than the initial budget estimates. This resulted in substantial cost savings under this budget line. To ensure optimal utilization of these resources while remaining aligned with the overall operational objectives, the IFRC, through ARCS, reallocated the savings to support affected families

through the Multipurpose Cash Assistance (MPCA) approach. This intervention enabled vulnerable households - particularly those with malnourished children - to access locally available, nutritious food, diversify their diets, and reduce the risk of further deterioration in their nutritional status. However, this change in mode of operation was initiated after issuance of the Operation Update even though the MPCA component was not part of the implementation strategy for the original DREF.

Targeted support through MPCA was provided based on the following Household Vulnerability Criteria:
1. Socio-Economic Status: Households with no stable income source, employment, or livelihood assets.
2. Household Food Insecurity: Families that were unable to afford or access a minimum of three meals per day demonstrated poor dietary diversity and nutritional intake.
3. Child Malnutrition: Households with at least one child enrolled in OTP or TSFP for treatment of Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM) respectively
4. Other Vulnerability Factors: Including but not limited to female-headed or single-parent households, families with orphaned children, recent returnees or displaced persons, and households with members experiencing chronic illness, disability, or terminal health conditions.

This adaptation ensured that the operation remained needs-driven, context-appropriate, and results-oriented while also maximizing the impact of the available funding.

Operation strategy rationale

1. TREATMENT OF MALNUTRITION: IFRC Supported existing ARCS' MHTs to provide treatment of Severe Acute Malnutrition (SAM) services to children under 5 years through Outpatient Therapeutic Programme (OTP) as well as treatment of Moderate Acute Malnutrition (MAM) interventions to Pregnant and Lactating Women (PLW) through Targeted Supplementary Feeding Programme (TSFP). Children with SAM were treated using RUTF while PLW with MAM were treated using RUSF, each carton box containing 150 sachets of RUSF. The number of sachets distributed to children were line with their weight, each carton containing 150 sachets of RUTF. Caregivers were educated on domestic use of RUTF while ensuring hygiene standards are adhered to, to prevent infections.

As a preventive approach for malnutrition, IFRC supported vulnerable families with cash through Conditional Cash Assistance. This enabled families to buy nutritious food items in order to improve dietary diversification and food security at household level.

SAM and MAM beneficiaries were identified through routine anthropometric screening using Mid-Upper Arm Circumference (MUAC) as well as assessment of oedema and where possible, Weight-for-Height (WFH). Screening was conducted at MHT and health facility level by Nutrition Counsellors. Community Volunteers were trained and supported to conduct screening at community level on an ongoing basis. Volunteers also supported with active case finding and referral of SAM and MAM cases, continuous dissemination of key nutrition and hygiene messages and follow up of defaulters and absentees. Volunteers were trained in anthropometric screening including MUAC, assessment of oedema, measurement of Weight for Height (WFH), timely identification and referral of SAM children with medical complications. The key messages that volunteers disseminated at community level included proper handwashing, use of safe drinking water at household level, safe disposal of wastes, domestic utilization of RUTF and RUSF, exclusive breastfeeding for the first 6 months and complementary feeding thereafter with continued breastfeeding up to 2 years, nutrition during lactation and pregnancy and utilization of locally available foods.

ARCS is operating in extremely remote districts of Kandahar and Paktika provinces with no other humanitarian actors. While the Ministry of Public Health (MoPH) is making efforts to address the current burden of malnutrition through sparsely distributed health facilities, the impact is minimal as the few health facilities can only cater for <20 per cent of the needs. This means chances of duplicating interventions are minimal. With robust support through provision of supplies, support for human resources and capacity building, ARCS remains in the best position to provide 'treatment of malnutrition' interventions in Kandahar and Paktika provinces and alleviate the burden of maternal and child morbidity and mortality due to malnutrition.

Due to production capacity constraints, the initially selected supplier declined the contract, prompting a re-tendering process. A new supplier, validated based on the IFRC procurement process, was engaged, and samples were received. The proposed delivery timeline was 50 days, with the overall procurement process took approximately three months, resulting in delays.

WASH: The IFRC supported ARCS in developing and distributing IEC materials containing WASH messages translated into the local language. These messages included information on domestic hygiene, handwashing, safe disposal of waste, and the use of safe drinking water. Community Volunteers conducted hygiene promotion sessions at the community level on an ongoing basis.

PROTECTION, GENDER, AND INCLUSION: During the routine treatment of malnutrition services, ARCS enquired about and supported children related to safeguarding concerns by providing counseling to caregivers and referring them for specialized support. In addition to nutrition services, women were screened for any gender or protection-related issues, including gender-based violence (GBV) and rape, and were referred to tertiary health facilities for specialized clinical management. During service provision, staff were trained to prioritize female beneficiaries at the triage level based on the severity of their conditions. Female beneficiaries were handled exclusively by female

staff, ensuring privacy at both the MHT and health facility levels. To bolster the capacity of women, ARCS ensured that women were included in all training sessions, including the Community Management of Acute Malnutrition (CMAM) training.

COMMUNITY ENGAGEMENT AND ACCOUNTABILITY: Program activities were primarily anchored in the efforts of community volunteers and beneficiaries. Volunteers played a pivotal role in disseminating key messages to the community, as well as in screening, referral, active case finding, and follow-up of defaulters and absentees. ARCS staff ensured that community members were provided with all necessary information about the program and were given opportunities to provide feedback on the impact and effectiveness of the interventions, as well as on setbacks and remedial measures that needed to be taken.

SECRETARIAT SERVICES: MHTs and health facilities collected program data on an ongoing basis and reported using standard reporting tools, allowing ARCS and IFRC to monitor trends and impacts made by the program. ARCS, IFRC, and the Ministry of Public Health (MoPH) conducted two joint monitoring and supervision visits to program areas to ensure quality service provision and address any challenges in a timely manner.

NATIONAL SOCIETY STRENGTHENING: In its quest to fulfill its core mandate of developing the national society, IFRC ensured that ARCS staff were trained in community management of acute malnutrition (CMAM) and were supported in translating the skills gained into practical work. As IFRC was already an active member of the Nutrition Cluster, it ensured that ARCS also attended meetings at the national level.

MULTIPLE PURPOSE CASH ASSISTANCE: The IFRC provided cash support to meet the urgent nutritional needs of vulnerable families in Kandahar and Paktika through a Multiple Purpose Cash Assistance (MPCA) program focused on households with malnourished children. Each eligible family received USD 156 (around 11,000 AFN) to purchase nutritious food vital for preventing acute malnutrition among children. The selection process utilized strict and transparent criteria to ensure aid was given to families with children suffering from moderate to severe malnutrition, optimizing the program's effectiveness. This initiative reached both urban and rural communities in Kandahar and Paktika, prioritizing those most in need.

By offering MPCA, the project supported families' independence and dignity while addressing immediate nutritional requirements as well as other essential household needs. IFRC had strong experience in cash and voucher assistance (CVA) MPCA and already had a framework agreement with RedRose, which was used to deliver assistance to beneficiaries. At the end of the project, a Post-Distribution Monitoring (PDM) survey with a minimal sample of 270 respondents was conducted to measure the effectiveness of MPCA in helping selected communities cope with their nutrition problems, which could be used in future responses.

EXIT STRATEGY: Since the interventions associated with this proposed program were lifesaving and emergency in nature, the program was not intended to be sustainable but was meant to address critical life-threatening needs. IFRC worked closely with the Afghan Red Crescent Society to strengthen its capacity so that it could continue providing the same services beyond the DREF period. IFRC did not set up any new structures or systems but operated within existing ARCS structures and made efforts to strengthen them, including building the capacity of staff to ensure continuity of service provision. Because the interventions were emergency and lifesaving, beneficiaries were educated in more sustainable and locally acceptable ways to prevent malnutrition, including combining locally available foods into a balanced diet, the basics of infant and young child feeding (IYCF), and nutrition during lactation and pregnancy. With this exit strategy, IFRC upheld its 'Do No Harm' principle, ensuring that a large-scale program was not established for a short time, leaving beneficiaries to suffer afterward. IFRC and ARCS also ensured that all beneficiaries enrolled in the nutrition program were treated and discharged appropriately. Additionally, ARCS consulted with the provincial health directorate regarding the Integrated Package of Services (IPD) in Kandahar for proper handover at the end of the project.

Targeting Strategy

Who was targeted by this operation?

The ARCS targeted 45,310 children under five years and 17,524 pregnant and lactating women (62,834 beneficiaries) in Kandahar and Paktika provinces. While the estimated total numbers of children with severe acute malnutrition and pregnant/lactating women with moderate acute malnutrition were 151,033 and 58,412 respectively before implementation of DREF-supported interventions (based on the targeted affected population), a total of 12,899 children and 7,329 PLW were reached per month. As the initial cycle of the DREF period was six months, it was estimated that 75,517 children and 29,206 PLW will be reached. However, 100 per cent of this target could not be reached. Considering the areas of operation are both rural and urban, coverage is estimated at 60 per cent hence 45,310 children and 17,524 pregnant and lactating women were reached.

Based on the outcomes of the 2024 IPC Acute Malnutrition Report for Afghanistan, provinces like Badakhshan, Balkh, Faryab and Ghazni had GAM levels of 16.6, 15.5, 17.6 and 16.7 respectively, all classified as 'critical.' In as much as these provinces are severely affected by acute malnutrition and are equally in need of life-saving assistance, Kandahar and Paktika provinces were instead selected for this DREF response, not only based severity of acute malnutrition (GAM rates of 15.5 and 17.5 respectively) but also due to ARCS' strong presence.

ARCS is already operating MHTs and static health facilities in the mentioned locations hence has a good understanding of the context and interventions can be implemented with minimal constraints.

IFRC also targeted 900 families with malnourished children and provided them with conditional cash assistance, enabling them to purchase locally available nutritious food. This support helped households avoid negative coping strategies such as skipping meals or relying on low-nutrient food options, and contributed to improving the overall dietary intake of children at risk of further malnutrition.

Explain the selection criteria for the targeted population

The interventions primarily focused on treatment of malnutrition among children less than 5 years of age as well as pregnant and lactating women. Selection of beneficiaries was through the following criteria:

1. Children screened through anthropometric (using MUAC) and found to have severe acute malnutrition (SAM) i.e. MUAC of <11.5 cm and no medical complications including oedema.
2. Pregnant women in the second and third trimester screened through anthropometry (using MUAC) and found to have moderate acute Children aged less than 5 years malnutrition (MAM) i.e. MUAC of <21.0 cm
3. Lactating women within less than 6 months of lactation screened through anthropometry (using MUAC) and found to have moderate acute malnutrition (MAM) i.e. MUAC of <21.0 cm

For cash assistance"

The following Household Vulnerability Criteria was used for provision of Cash Assistance.

1. Poor Socio-Economic Status
2. Lack of employment and absence of income-generating assets or sources of sustainable livelihood Household Food Insecurity
3. Inability to afford or access at least three meals per day and poor dietary diversity and inadequate nutritional intake
4. Child Malnutrition: At least one child in the household is currently enrolled in a nutrition program due to Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM)
5. Other Vulnerability Factors: Female-headed or single-parent households, presence of orphaned children, recent returnees or displaced households and family members with permanent disabilities, chronic illnesses, or terminal health conditions

Total Assisted Population

Assisted Women	**42,524**	Rural	**100%**
Assisted Girls (under 18)	**66,648**	Urban	**0%**
Assisted Men	**44,260**	People with disabilities (estimated)	**10%**
Assisted Boys (under 18)	**52,365**		
Total Assisted Population	**205,797**		
Total Targeted Population	62,834		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**Yes**
Does your National Society have prevention of sexual exploitation and abuse policy?	**Yes**
Does your National Society have child protection/child safeguarding policy?	**Yes**

Does your National Society have whistleblower protection policy?	**Yes**
Does your National Society have anti-sexual harassment policy?	**Yes**

Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.

Risk	Mitigation action
Ethnic and social tensions	The ARCS worked through its branches to fully understand the social setting in targeted communities prior to conducting any interventions and use the information provided to design appropriate strategies that took into consideration activities that fostered community cohesion. In the event that the security situation deteriorated; ARCS would adhere to its security protocols during its operations including, where necessary, temporary suspension of activities.
Possible breakages in the supplies pipeline due to delays in procurement, long approval processes, signing agreements/contracts with UNICEF, WFP or local suppliers, harsh weather conditions and unforeseen countrywide shortage of supplies	IFRC assessed all possible impediments in time and took necessary precautionary measures including agreeing on timelines with local suppliers, delivering supplies to service delivery points in time, budgeting for in-country transportation and lobbying with the senior leadership to expedite approvals. While IFRC did its best to mitigate stockouts, there were other factors that prevented this and were beyond IFRC. Such included unforeseen closure of borders between Afghanistan and Pakistan due to increasing political tensions between the two countries.
Change in security situations. While the security situation remains generally stable across the country, there is always a possibility that this could change.	The IFRC constantly monitored the security situation in Afghanistan and worked closely with various partners to potentially pre-empt changes in the country. It also provided advice on the deployment of team members internally and conducted routine assessment in areas it operated or intended to operate. Further, the risk of exposing IFRC staff was minimal as the implementation of the DREF operation was carried out primarily by ARCS who are also guided by their security protocols.
Seasonal changes which could bring additional strain on the population through the impacts on their health, livelihoods and property.	There was constant monitoring of the weather situation across the country, and care was taken not to establish Humanitarian Service Points in vulnerable areas.
Potential delays with delivery of RUTF, RUSF and any other commodities due to unforeseen logistical challenges.	While this remained a challenge throughout the implementation period, IFRC initiated this procurement early enough and engaged the supplier with the capacity to deliver the commodities in time.
Difficulties with finding qualified technical staff, particularly for the IPD SAM.	IFRC worked closely with ARCS to identify qualified female technical staff. Additionally, some DREF funds were set aside for training and building the capacity of the staff. The training includes community-based management of acute malnutrition.
Inability to access some locations, particularly during the winter season.	ARCS used MHTs which could spend more time in the affected locations. Supplies were also prepositioned prior to the winter season.

Please indicate any security and safety concerns for this operation:

The main security-related issues of concern were the volatility of the security situation in Kandahar because of intermittent conflicts between Afghanistan and Pakistan.

Has the child safeguarding risk analysis assessment been completed?	Yes

Implementation

Multi Purpose Cash

Budget: CHF 127,962
Targeted Persons: 6,300
Assisted Persons: 8,160
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of families supported through multi-purpose cash assistance	900	900

Narrative description of achievements

The cash assistance initiative successfully addressed urgent nutritional needs of 900 vulnerable families in Kandahar and Paktika by providing Multipurpose Cash Assistance (MPCA). The “Cash Assistance” component/budget line was not included in the original budget but was introduced subsequently after the selected RUTF/RUSF supplier quoted lower than initially estimated. This component was added to ensure full utilization of the savings while remaining aligned with the DREF objectives.

Even though MPCA was included into the project at the later stage to ensure full utilization of available resources while remaining aligned with the overall operational objectives, it benefited 900 households that had at least one child with MAM or SAM and were enrolled in the TSFP or OTP program. Indirectly, the initiative benefited a total of 8,160 individuals (3,949 male and 4,211 female). Each family USD 156 (approximately 11,000 AFN) as single tranche. This support empowered families to purchase nutritious food and access essential health services, effectively preventing acute malnutrition among children under five years of age. The beneficiary selection process was conducted with clear and rigorous criteria, ensuring that assistance was directed to those with moderate to severe malnutrition, thus maximizing the program's effectiveness.

Targeted support was provided based on the following Household Vulnerability Criteria:
1. Socio-Economic Status: Households with no stable income source, employment, or livelihood assets.
2. Household Food Insecurity: Families unable to afford or access a minimum of three meals per day and demonstrating poor dietary diversity and nutritional intake.
3. Child Malnutrition: Households with at least one child currently enrolled in a nutrition program for Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM).
4. Other Vulnerability Factors: Including but not limited to female-headed or single-parent households, families with orphaned children, recent returnees or displaced persons, and households with members experiencing chronic illness, disability, or terminal health conditions.

Lessons Learnt

Afghanistan is prone to malnutrition; therefore, for future programming, it is essential to ensure that sufficient funding and resources are accounted for MPCA.

Challenges

• The number of beneficiaries was higher than expected, leading to potential resource strain.
• Although ARCS educated beneficiaries in the purpose of the cash, there was less control on what beneficiaries would buy hence the risk of either buying less nutritious food commodities or using the cash for other purposes.

• MPCA was a short term, unsustainable, and cash intensive approach that would address the burden of malnutrition for a short term. There was need for local long-term initiatives e.g. livelihood programs in which communities would participate directly.

Health

Budget: CHF 310,941
Targeted Persons: 62,834
Assisted Persons: 92,506
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of children screened using MUAC	45,310	68,533
# of PLW screened using MUAC	17,524	23,973
# of children successfully treated and discharged from the program	27,186	12,899
# of PLW successfully treated and discharged from the program	10,514	7,329
# of group nutrition counselling sessions conducted	42	580
% cure rate for SAM children under 5 years	85	80
# of SAM children with medical complications referred for inpatient care	240	203
# of people reached with messages on good nutrition and / or food preparation	900	23,973

Narrative description of achievements

IFRC supported 13 ARCS MHTs that provided 'treatment of Severe Acute Malnutrition (SAM)' services to children under 5 years through Outpatient Therapeutic Programme (OTP) as well as 'treatment of Moderate Acute Malnutrition (MAM)' interventions to children with MAM through Targeted Supplementary Feeding Program (TSFP). SAM and MAM beneficiaries were identified through routine anthropometric screening using Mid-Upper Arm Circumference (MUAC) as well as assessment of oedema. Out of the targeted 45,310 children, 68,533 were screened using MUAC. Out of these, 12,899 were enrolled in the program, treated and discharged. Out of the targeted 17,524 PLW, 23,973 were screened using MUAC and out of these, 7,329 were enrolled and treated in TSFP.

Community Management of Acute Malnutrition (CMAM) follows standardized WHO protocols, including anthropometric screening using MUAC, edema assessment, and weight-for-height measurements, to identify Moderate Acute Malnutrition (MAM) and Severe Acute Malnutrition (SAM). In future emergency responses, these protocols will remain unchanged. However, interventions can be adapted to the local context by integrating them with multipurpose cash assistance (MPCA) and livelihoods programs, ensuring sustainability, stronger community engagement, and reduction of chronic malnutrition.

As Social Behavior Change Communication (SBCC) is a longer-term initiative requiring structured implementation and monitoring mechanisms, it was not feasible to measure household-level behavior change regarding malnutrition prevention during this period. However, Community Volunteers provided nutrition education on an ongoing basis at the community level, contributing to awareness and knowledge dissemination.

Use of MHTs is an approach worth replicating in future interventions because of maximum access and coverage, as compared to static health facilities. It will also be critical to ensure malnutrition management is part of future malnutrition programing as there will always

be children with SAM and associated medical complications.

*The % cure rate usually changes every month depending on the number of children cured and discharged against total admissions in the program. It was 81% by the time the OU was done. The cure rate was 80% by the last month of DREF implementation. It is long as the cure rate is >75%.

Lessons Learnt

- Community involvement is crucial for success of emergency community nutrition interventions. This is because there is need for continuous screening at community level by community volunteers and continuous provision of health and nutrition education as a preventive measure.
- Timely preposition of essential supplies (RUTF and RUSF) is key to success of nutrition programs. This is to mitigate unforeseen logistical and procurement challenges.

Challenges

- Inability to deliver RUTF and RUSF on time due to unforeseen logistical challenges and closure of borders between Afghanistan and Pakistan.
- Difficult access to service delivery points (including the IPD SAM) because of high opportunity cost for most poor families, long walking distances, and other cultural dynamics particularly around women.

Water, Sanitation And Hygiene

Budget: CHF 3,195
Targeted Persons: 62,834
Assisted Persons: 113,291
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of WASH related/hygiene IEC materials procured distributed	2,000	2,000
# of people reached with hygiene promotion activities in the response period	50,267	113,291

Narrative description of achievements

IFRC supported ARCS to develop and distribute 2000 copies of IEC materials with WASH messages translated in the local language. The IEC materials included messages on domestic hygiene, handwashing, safe disposal of waste and use of safe drinking water. Community Volunteers conducted hygiene promotion sessions at community level on an ongoing basis.

While the number of people reached was well higher than the targeted, the number may not be absolute because ARCS doesn't have a unique beneficiary tracking system. Chances of some beneficiaries attending sessions more than once are therefore high. Community Volunteers disseminated key messages through one on one and group sessions, focusing of topics such as regular hand washing, domestic hygiene and prevention of infections and proper waste management.

DREF prioritized urgent nutrition needs, with WASH interventions focused on hygiene promotion and mitigated immediate risks. The allocation reflected this limited scope, supplemented by ARCS' existing supplies (e.g., soap) to maximize reach. Considering the WASH access gaps, the ARCS pursued complementary funding and coordination to address them beyond this emergency window.

Lessons Learnt

- Integrated approach to programming is more cost effective and is a much better approach to addressing community needs holistically.

Challenges

- It was challenging for community volunteers to access some remote locations during winter as roads were blocked by snow.
- WASH needs were multifaceted and complex but due to funding limitations, only IEC materials were distributed and health education sessions conducted.

Protection, Gender And Inclusion

Budget: CHF 18,638
Targeted Persons: 3,525
Assisted Persons: 179
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of separated or unaccompanied children identified during the implementation period	174	73
# of female staff included in the response team (MHTs and health facilities)	55	51
% of women who report having been subjected to any form of violence	100	57
# of child friendly spaces established	2	2
# of staff trained in handling basic disclosure on violence and safeguarding concerns and PFA	35	35

Narrative description of achievements

During routine 'treatment of malnutrition' services, ARCS also enquired about and supported children related to safeguarding concerns of children for any protection concerns and provided counselling to caregivers and/or referring them for specialized support. Besides nutrition services, women were also enquired for gender/ protection related issues (including GBV, etc.) and referred to tertiary health facilities for specialized/ clinical management. During service provision, staff were trained to prioritize female beneficiaries at triage level based on the severity of their conditions.

Female beneficiaries were handled only by female staff and privacy was ensured at both MHT and health facility level. As a way of bolstering the capacity of women, ARCS trained 35 female staff and volunteer in PGI and PFA.

Lessons Learnt

- Involvement of Cross-Cutting Technical Team: Engaging the cross-cutting technical team during the design and planning phases of the project proved essential.
- Collaboration with ARCS: Working closely with the Afghan Red Crescent Society (ARCS) and providing ongoing technical support was invaluable.
- Training on Code of Conduct and Safeguarding: It is crucial to plan training sessions on the Code of Conduct, safeguarding, and child safeguarding specifically for ARCS staff and volunteers.

Challenges

- Time Constraints: The training sessions for cross-cutting topics required three days to cover essential content adequately.
- Project Timeline: The training was planned for the end of the project, which created pressure to complete all other project activities on time. Balancing the completion of project objectives with the training schedule was a significant challenge, requiring effective coordination and time management.

Community Engagement And Accountability

Budget: CHF 3,728
Targeted Persons: 312
Assisted Persons: 565
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of Community Volunteers trained and engaged in program activities	135	178
% of people of who feel their opinion is taken into account in decisions about services, programs and operations	60	77
# of defaulters traced and re-admitted in the program	312	310

Narrative description of achievements

ARCS continued to involve its network of over 625 community Volunteers to conduct community sensitization, defaulter tracing and anthropometric screening at community level. IFRC was also able to establish community feedback mechanisms both in Kandahar and Paktika provinces, enabling affected communities to voice their concerns, share suggestions, and actively participate in improving program delivery.

As part of the broader malnutrition response in Kandahar and Paktika, several community engagement activities were carried out to ensure that families understood the purpose of cash assistance and how to use it effectively. Before the start of the distribution, ARCS and IFRC teams held community meetings with local leaders, mothers, and health volunteers to share key messages about child nutrition, hygiene, and proper food utilization. Information posters in Pashto were displayed at health centers and distribution sites, explaining eligibility criteria and how complaints or questions could be raised. A simple feedback mechanism was established—both through community focal points and suggestion boxes—to collect beneficiaries' comments and address any issues quickly. During the implementation, field staff conducted household visits to verify that families were receiving assistance and using it as intended. These activities not only improved transparency but also helped strengthen trust between the implementing teams and the local communities, ensuring that the support reached those most in need in an accountable and dignified manner.

Lessons Learnt

- The experience highlighted the importance of maintaining simple, accessible, and community driven feedback system. Involving trusted local volunteers as focal points proved highly effective in encouraging participation and ensuring that feedback reached the program teams quickly. Regular community meetings and visible information materials helped strengthen transparency and mutual trust. Most importantly, the process demonstrated that when communities are actively engaged in both communication and decision making, humanitarian intervention become more responsive, inclusive, and sustainable.

Challenges

- Despite the overall success of community engagement and feedback mechanisms, several challenges emerged during implementation. Limited literacy levels among community members made it difficult for some families to fully understand written materials or the complaint process, requiring additional verbal explanation from volunteers. In remote areas, accessibility and network

coverage issues also delayed feedback collection and response times. Furthermore, ensuring consistent follow-up on reported cases proved difficult due to the wide geographic spread of communities and limited staff capacity, which sometimes affected the speed of resolution.

Coordination And Partnerships

Budget: CHF 0
Targeted Persons: 0
Assisted Persons: 0
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of Nutrition Cluster meetings attended by IFRC and ARCS	6	6
# of Nutrition Technical Working Group meetings attended by IFRC and ARCS	3	9

Narrative description of achievements

IFRC and ARCS participated in 6 Nutrition Cluster meetings and 3 Nutrition Technical Working Group meetings, engaging 112 individuals. These meetings supported the effective implementation of the nutritional DREF activities in the targeted province, address nutritional challenges and enhanced community health through collaboration.

Lessons Learnt

- Coordination with other partners is key to effective implementation. While operating inpatient nutrition centres was a new initiative to IFRC and ARCS, there were other partners who had better technical expertise in this and could provide technical support.

Challenges

- Few humanitarian agencies responding to the malnutrition crisis.
- Disconnected coordination among partners

Secretariat Services

Budget: CHF 12,141
Targeted Persons: 0
Assisted Persons: 0
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of joint monitoring and supervision visits conducted	2	4
# of MHTs submitting monitoring data/ reports	8	13

# of health facilities submitting monitoring data/ reports	12	15
# of PDM conducted	1	0

Narrative description of achievements

During the project implementation, 4 joint monitoring and supervision visits were conducted, alongside 13 Mobile Health Teams (MHTs) submitting monitoring data and reports. Additionally, 15 health facilities reported monitoring data, enhancing accountability in addressing malnutrition in Kandahar and Paktika. However, due to the late inclusion of the Multi-Purpose Cash Assistance (MPCA), no Post-Distribution Monitoring (PDM) was conducted.

Lessons Learnt

- Sufficient Funding and Resources: since the malnutrition is a chronicle problem in Afghanistan so it's important to ensure that adequate funding and resources are allocated specifically for nutrition interventions to meet the needs of vulnerable populations effectively.

Challenges

- Late Inclusion of MPCA Intervention: The Multi-Purpose Cash Assistance (MPCA) intervention was introduced at a later stage, making it difficult to conduct Post-Distribution Monitoring (PDM) effectively.

National Society Strengthening

Budget: CHF 24,229
Targeted Persons: 180
Assisted Persons: 252
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of NS staff trained in CMAM	45	74
# of Volunteers mobilized to participate in program interventions	135	178
# of Lessons Learned Workshops conducted	1	0

Narrative description of achievements

ARCS successfully conducted comprehensive training sessions focused on basic disclosure on violence and safeguarding, as well as Psychological First Aid (PFA), benefiting approximately 25 female staff members in Kandahar and Paktika. Additionally, ARCS provided specialized IMAM training for 14 female nutrition staff in Kandahar.

Additionally, training based on needs of staff in the Malnutrition part key capacity-building activities were successfully implemented across Kandahar and Paktika provinces,

- A total of 25 National Society (NS) staff received basic orientation on violence, safeguarding, and Psychological First Aid (PFA), achieving 100% of the target in both Kandahar and Paktika.
- In Kandahar, 14 NS nutrition staff were successfully trained on Integrated Management of Acute Malnutrition (IMAM), covering key components such as OTP, TSFP, IYCF, and inpatient management of SAM.

Additionally, 34 female participants in Kandahar were trained on MYCIN, meeting the planned target and contributing to enhanced

knowledge and skills in maternal and child health. These achievements reflect strong coordination and commitment at the field level to enhance the capacity of staff and volunteers in delivering essential health and protection services.

Lessons Learnt

Not avialable

Challenges

Not avialable

Financial Report

DREF Operation

FINAL FINANCIAL REPORT

Selected Parameters	
Reporting Timefr: 2024/10-2025/10	Operatio MDRAF017
Budget Timefram 2024/10-2025/8	Budget APPROVED

Prepared on 30/Nov/2025

All figures are in Swiss Francs (CHF)

MDRAF017 - Afghanistan - Malnutrition

Operating Timeframe: 18 Oct 2024 to 31 Aug 2025

I. Summary

Opening Balance	**0**
Funds & Other Income	**500,834**
DREF Response Pillar	500,834
Expenditure	**-501,091**
Closing Balance	**-257**

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			**0**
PO02 - Livelihoods			**0**
PO03 - Multi-purpose Cash			**0**
PO04 - Health	438,905	501,091	**-62,187**
PO05 - Water, Sanitation & Hygiene	3,195		**3,195**
PO06 - Protection, Gender and Inclusion	18,638		**18,638**
PO07 - Education			**0**
PO08 - Migration			**0**
PO09 - Risk Reduction, Climate Adaptation and Recovery			**0**
PO10 - Community Engagement and Accountability	3,728		**3,728**
PO11 - Environmental Sustainability			**0**
Planned Operations Total	**464,465**	**501,091**	**-36,627**
EA01 - Coordination and Partnerships			**0**
EA02 - Secretariat Services	12,141	0	**12,141**
EA03 - National Society Strengthening	24,229		**24,229**
Enabling Approaches Total	**36,370**	**0**	**36,370**
Grand Total	**500,834**	**501,091**	**-257**

Internal

[Click here for the complete financial report]

Please explain variances (if any)

The “Cash Assistance” component/budget line was not included in the original budget but was introduced subsequently after the selected RUTF/RUSF supplier quoted lower than initially estimated. This component was added to ensure full utilization of the savings while remaining aligned with the DREF objectives. With this the budget for Health sector was lowered to CHF 310,914 and the MPCA component added with CHF 127,962.

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Click here for reference