WHO-EM/EHA/057/E

Report on the

WHO/UNICEF joint meeting on interim priorities for the health sector in Afghanistan

Doha, Qatar
29–31 March 2022

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

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CONTENTS

1. CONTEXT

Since 1978, Afghanistan has experienced largely internal violent conflict with the involvement of foreign troops including the Soviet Union (1979–1989) and the United States (2001–2021). In August 2021, Taliban forces seized power across the country and declared the Islamic Emirate of Afghanistan. The de facto regime established a new government that to date is not internationally recognized.

As a consequence of the war, Afghanistan's health care system has progressively declined, relying heavily on support from the international community to provide and sustain lifesaving care for the Afghan people.

In 2003, a basic package of health services (BPHS) was rolled out as part of the health sector's effort to reach all Afghans. The mode of implementation was via contracts with nongovernmental organizations in 31 provinces and national engagement in the three remaining provinces (Panwar, Pashir and Kapisa). Financial and technical support for these contracts was split across the European Union, World Bank and USAID. Subsequently, an essential package of hospital services (EPHS) was contracted through nongovernmental organizations in support of 16 provincial hospitals, with other tertiary hospitals directly supported by the Afghan Ministry of Public Health.

From 2013, donors progressively channelled funds for the basic and essential packages through the Afghanistan Reconstruction Trust Fund managed by the World Bank, granting the Ministry oversight of the nongovernmental organizations. Initially referred to as System Enhancement for Health Action in Transition (SEHAT), it was renamed Sehatmandi in 2018. An independent third party was contracted to monitor implementation of the Basic and Essential Packages.

Despite its reliance on international funding, the BPHS/EPHS system is considered to have significantly improved a number of key health indicators in Afghanistan. Over the past two decades, maternal mortality declined by 60%, child mortality declined by 57% and life expectancy increased by 14%. In the same period, the number of functioning health facilities increased five-fold and the proportion of health facilities with female health care providers quadrupled to approximately 87%. Vaccination against diphtheria and associated illness (DPT3/pentavalent) has risen by 110%.

With support from WHO and international partners, the Ministry of Public Health has significantly enhanced its governance functions and developed both the National Health Policy 2021–2030 and National Health Strategy 2021–2025, both of which have been in force since early 2021.

2. MEETING RATIONALE

Following the resumption of power by the Taliban authorities in mid-August 2021, development funding, including for health, was suspended, abruptly halting Sehatmandi implementation. This soon turned into a full collapse of a health system already severely impacted by the ongoing humanitarian crisis, the COVID-19 pandemic, concurrent disease outbreaks, climate events and a weakened economy.

To prevent a rollback of health gains and ensure sustained health care service delivery, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) stepped in to temporarily bridge the funding gap, working through the United Nations Development Programme (UNDP) and nongovernmental organization partners to deliver care. Thereafter, WHO and UNICEF secured funding from the United Nations Central Emergency Response Fund (CERF) to contract national and international nongovernmental organizations to continue support to 2331 Sehatmandi health facilities for an initial period of three months. Follow-on funding from the Afghanistan Reconstruction Trust Fund allowed the continuation of services until the end of June 2022. Moving forward, it is expected that major donors will provide another funding channel to continue support for a subsequent 18–24 months. It remains unclear how other projects that complemented essential service capacities not covered under the BPHS/EPHS – and that also rely on development funding – will be affected.

Against this background, major international and national health partners agreed to meet and take stock of the current status of the health system in Afghanistan, including developmental and humanitarian aspects. Such an analysis would form the basis for defining short- to medium-term strategic priorities that could further stabilize and restore health care service delivery, support the health system, and prevent and control future health emergencies (see the Concept note, Annex 1). The meeting would also serve as an opportunity to advance constructive engagement with the de facto health authorities and ensure accountability to the Afghan population.

3. MEETING OBJECTIVES

The objectives of the meeting were to:

- review gaps in health and nutrition service delivery (including availability, accessibility, utilization and quality) and identify options for addressing them;
- review progress and persistent gaps in humanitarian response and emergency risk management (including COVID-19, disease outbreaks and acute malnutrition) and identify options for addressing them;
- identify elements of the health system requiring prioritized support and short-term solutions:
- health management information system (HMIS)
  - health workforce
  - supply chain management
  - governance and coordination
  - health financing
  - community health platforms and community-based health service delivery;
- agree on approaches to support implementation of the Afghanistan National Emergency Action Plan for Polio Eradication and to leverage polio assets in support of other humanitarian and development needs;
- agree on approaches for constructive engagement with the de facto authorities and for strengthened accountability to the Afghan population; and
- agree on general strategic directions to support the health sector, including monitoring of the effectiveness of international support.

4. THEMATIC WORKING GROUPS

Ahead of the meeting, 12 thematic working groups (TWGs) were established under the following areas: humanitarian response; COVID-19 and other disease outbreaks; service delivery; community health platforms; nutrition and food security; maternal and child health; polio; HMIS and surveillance; supply chain management; health workforce; governance and coordination; and health financing.

The TWGs consisted of WHO and UNICEF staff at country, regional and global levels; nongovernmental organization representatives; and a range of international experts. WHO and UNICEF engaged Ministry of Public Health counterparts to solicit their inputs for TWG activities. Each TWG produced a standardized working paper consisting of a situational analysis for its respective thematic area, current challenges and constraints, opportunities, challenges, risks and mitigation, critical priorities and next steps. Each draft was reviewed by a number of experts from WHO, UNICEF and academic partners, revised accordingly, and summarized as a PowerPoint presentation to facilitate deep-dive discussions during the meeting. Final versions of all technical working papers were circulated to meeting participants beforehand by email.

The meeting was held over three days in Doha (Meeting programme, Annex 2), hosted by Qatar's Ministry of Public Health. Over 80 participants were present (List of participants, Annex 3), with a smaller number attending virtually, including nongovernmental organization representatives in Kabul, Afghanistan.

5. OPENING SESSION

The meeting was officially opened by Dr Salih Al Marri, Qatar's Assistant Minister for Health Affairs, followed by remarks from high-level speakers including WHO Director-General Dr Tedros Adhanom Ghebreyesus, UNICEF Executive Director Catherine Russell, WHO Regional Director for the Eastern Mediterranean Dr Ahmed Salim Al-Mandhari and UNICEF Regional Director for South Asia George Laryea-Adjei; all of whom noted the dire situation in Afghanistan and stressed the importance of girls' education and the role of female health workers. Afghanistan's Minister of Public Health, Dr Qalander Ibaad, outlined the reforms needed to lay the necessary groundwork for an independent and resilient health care system in Afghanistan and noted that authorities are prepared to collaborate with national and international health partners to achieve this.

6. TWG OUTPUTS

Following presentations on working papers related to each of the 12 TWG thematic areas, participants engaged in intensive dialogue. Key points arising from the discussions are summarized according to thematic area below.

TWG Area 1: Humanitarian needs and response

Led by the WHO Afghanistan Health Cluster Coordinator, the TWG identified a number of challenges in the health sector humanitarian response including: critical shortages of health workforce and "brain drain"; financing challenges including short-term donor funding; and multiple concurrent public health crises straining response capacities.

In parallel, opportunities exist and can be built upon, such as political will from the Ministry of Public Health to ensure a conducive environment for service delivery, improved access to previously inaccessible areas with the presence of actors in 34 provinces, increased donor commitment and strong partner coordination mechanisms.

Interim priorities proposed by the TWG for discussion included improving the quality of care following guidelines adapted to fragile and conflict-affected settings; expanding access to underserved populations; strengthening partnerships, especially those that support localization of the response; supporting community-led initiatives and strengthening the resilience of vulnerable communities; improving the reliability and predictability of donor funding by making allocations and disbursements at the beginning of the year and for longer periods; multisectoral approaches and coordination between health, nutrition, and water, sanitation and hygiene (WASH) clusters; and shifting to more sustainable approaches and interventions.

Discussions highlighted the persisting fragmentation of the health care system, the limitations of the health workforce and the lack of adequate access to health in rural areas. Of special note is that mental health is emerging as a priority for the humanitarian response. Mental health services need to be extended to the primary care level and included in all health workforce development. First aid trauma services should be integrated into BPHS health facilities and social protection measures put in place.

Recommendations and actions for the health humanitarian response were agreed as follows:

Recommendations	
1. Expand and increase access to underserved populations	• Undertake mapping of underserved areas for the provision of essential health care and manage opportunities for referral under the new Health Emergency Response (HER) project – announced by the World Bank as a successor to Sehatmandi – and other service delivery platforms addressing basic humanitarian needs
2. Improve quality of care using existing WHO guidelines for fragile, conflict-affected and vulnerable (FCV) settings and national guidelines	• Establish a quality of care working group under the Health Cluster, to be linked with other quality of care initiatives, such as those that are part of the HER project sponsored by the World Bank
3. Place community needs at the centre of any humanitarian response in order to build trust and strengthen preparedness for future shocks	• Focus on strengthening the resilience of communities (especially vulnerable groups, including women and girls)
4. Promote and strengthen a multisectoral health response with relevant sectors/clusters, such as WASH, nutrition, food security and social protection	• Scale up and adapt health responses to increased food security risks
5. Strengthen capacity to prevent, prepare for, mitigate and respond to humanitarian crises	• Conduct a multi-hazard risk assessment • Strengthen early warning systems • Establish stockpiles • Support emergency operations centres (EOCs) • Build the capacity of local communities and civil society organizations to respond to crises

Application of key principles to humanitarian health action:

- strengthen coordination among united nations agencies and partners
- promote localization and ownership of the response efforts
- ensure predictable funding to facilitate operational planning, particularly with respect to bridging humanitarian and development components
- explore opportunities where possible to operationalize the humanitarian-development-peace nexus (HDPN).

TWG Area 2: COVID-19 and other disease outbreaks

Afghanistan is facing multiple concurrent disease outbreaks, including the COVID-19 pandemic, measles, acute watery diarrhoea/cholera, dengue and malaria. Common challenges across the responses to these outbreaks include:

- financial difficulties to fund surveillance and response;
- shortage of skilled staff and high turnover;
- limited access to remote areas due to geographic, transportation and security challenges;
- lack of community trust;
- inadequate coordination among partners; and
- delays in approving vaccination campaigns and difficulties in maintaining routine immunization and other key health programmes with high coverage rates.

With regard to the COVID-19 response, there has been limited in-country capacity for detection and treatment, slow uptake of vaccination, and a surveillance and response approach that has functioned as a parallel entity rather than being integrated into routine systems.

Recommendations from the group focused on 10 priority actions: human resources and protection for health workers; data management and reporting; early detection and surveillance capacity; transparency and accountability; hospital review and planning capacity; quality of care for case management; supply chain management; monitoring the performance of nongovernmental organizations and hospitals; public awareness and promotion; and preparedness and response to outbreaks and other hazards.

Discussions touched on challenges in access; the potential expansion of preparedness efforts to so-called “white areas” previously not covered; improving active surveillance; protection of health workers; and data quality and alignment between United Nations partners, civil society and the HMIS to inform outbreak response.

Participants agreed on the following recommendations by priority area to improve outbreak response capacity:

Recommendations	
1. Human resources	• Map and document priority gaps, especially in relation to control of COVID-19 and other infectious disease risks
	• Ensure protection of health care workers, including through consistent provision of PPE and improved infection prevention and control governance and processes

2. Data management and reporting	• Strengthen the routine HMIS at facility and community levels, phasing in digitalized reporting mechanisms; collect/report sex- and age-disaggregated data wherever possible
	• Standardize indicators for COVID-19 and other outbreak management (test positivity rate; vaccination coverage; case fatality rate); ensure timely analysis and data dissemination, including through epidemiological bulletins, sitreps and dashboards
	• Progressively expand reporting from both public and private health care facilities and laboratories
	• Strengthen the Disease Early Warning System (DEWS) based on both passive and active surveillance, including event-based surveillance
	• Improve outbreak investigation and early control efforts through progressive expansion of the number of rapid response teams
	• Continue the expansion and strengthening of laboratory capacity at national and provincial levels; introduce genomic sequencing capacity
	• Strengthen collaboration with the animal health sector to enable identification of zoonotic diseases with potential for spillover to humans
3. Clinical care, hospital review and planning capacity	• Phase in the integration of COVID-19 care into the services provided by relevant secondary and tertiary care facilities
	• Undertake a review of existing hospital bed capacity, needs and gaps in the context of the COVID-19 pandemic
	• Undertake a specific review of oxygen needs, supplies and gas, using the WHO oxygen platform or the UNICEF Oxygen System Planning Tool (OSPT) (https://www.unicef.org/innovation/oxygen-system-planning-tool); and develop a costed plan to address priority gaps
	• In the longer term, improve the capacity of hospitals to undertake their own needs assessment, including estimation of beds, medical supplies, staffing, etc.
4. Risk communication and community engagement (RCCE)	• Strengthen emergency communication, risk communications and community engagement capacities, including through improved social listening mechanisms
5. Outbreak preparedness and response	• Establish an integrated outbreak preparedness plan for emerging infectious diseases, including risk assessment and integrated surveillance across both animal health and human health sectors

TWG Area 3: Service delivery

The service delivery structure in Afghanistan suffers from fragmentation of service delivery models; insufficient, fragmented and unpredictable funding; lack of local/district health system structures; and service packages that have been designed based on an outdated burden of disease profile. While there have been some improvements in coverage and health status, stark inequities persist. An integrated package of essential health services (IPEHS) was drafted to replace the BPHS and EPHS but has not been implemented.

Despite the instability of the current context, some opportunities exist. A sharp reduction in violence has improved population mobility and access, although challenges remain for female health staff and patients, and some security risks remain. New and enhanced coordination mechanisms may facilitate integration of services in common policy and delivery models. District hospitals could be strengthened to form the nucleus of local health systems, based on

a primary health care approach. Further developments in eHealth and other technologies could be integrated to strengthen service provision.

Proposed priorities from the TWG centred around stabilizing and expanding the model of care, institutionalizing a localized/district health system based on a primary health care approach and integrating the core service delivery components with urban health, expanding access to white areas, community health workers (CHWs), mobile health and nutrition teams, humanitarian health providers, and integrating vertical programmes and nutrition services. Quality of care and accountability were further identified as priority areas of focus.

Discussions emphasized the need to review the model of care, revisit the proposed IPEHS and transition from the BPHS/EPHS to a more integrated model of service delivery, strengthen the district health system, develop costing of needs to inform investment and planning, focus on quality of care, ensure financial protection mechanisms and establish a predictable common funding framework. Inputs from service providers convened in Kabul brought attention to the poor state of physical infrastructure. Many health facilities require extensive maintenance or reconstruction, and many primary health care facilities operate from private houses or rented premises, which is unsustainable. While mobile teams are amplifying reach and coverage in hard-to-reach areas, they are not a sustainable approach as they are largely funded under emergency and short-term mechanisms. As the package of services is revised, the essential medicines list must be updated accordingly. Public-private partnerships may provide further opportunities for scaling up health service delivery in urban slums and rural and hard-to-reach areas.

On service delivery, the following priority recommendations and actions were agreed:

Recommendations	
1. Stabilize and sustain the achievements of Sehatmandi through continuity of the BPHS and EPHS, including under the HER project	
2. Expand service coverage in the geographic areas currently not under Sehatmandi/HER	• Utilize mobile health and nutrition team (MHNTs) in white areas/sparsely populated districts when there is no alternative through fixed service delivery platforms, including community-based services, while exploring more sustainable options such as infrastructure expansion, public-private partnerships, and longer-term and more stable funding for mobile or outreach approaches
	• Establish referral pathways between service delivery platforms funded by HER and other sources, family health houses (FHHs) and MHNTs
3. Structure the public sector delivery system around organized local (district) health systems	• Harmonize facility and community health interventions; establish the district hospital as the first referral point
	• Strengthen health partner coordination and planning at provincial level, in collaboration with the Provincial Public Health Department (PPHD)
	• Integrate urban health, white areas, CHW, MHNT, FHHs, humanitarian health providers and vertical health programmes (Gavi, Global Fund) into the delivery system
4. Maintain ongoing investments outside BPHS/EPHS contracting	• Maintain priority projects whose continuity is critical for support to the BPHS/EPHS, including those supported by Gavi and Global Fund
	• Identify and support hospitals and other service delivery platforms such as MHNTs and FHHs that are critical to address gaps in BPHS/EPHS capacity and coverage
	• Integrate COVID-19 care into regular health facilities

5. Seek donor and partner support to sustain and expand referral hospital functionality (secondary and tertiary care)	
6. Strengthen and expand processes to promote quality of care (QOC) by building on current initiatives and progressively integrating QOC into all service delivery platforms	• Establish a technical working group, under the Health Development Partners Forum, including to consolidate lessons from existing/previous quality improvement initiatives implemented by partners
	• Prepare integration of "quick win" quality improvement processes at primary health care and hospital levels that can be integrated into contracting after June; include these in performance-based incentives and validation as part of third-party monitoring
7. Explore the possibility of adopting and implementing the IPEHS	
8. Build and keep accountable networks of private providers for strategic purchasing approaches, e.g. in urban slums	
9. Strengthen monitoring, reporting and performance management mechanisms	

TWG Area 4: Community health platforms

Effective, efficient and equitable primary health care requires community-level action that is cost-effective and high-impact as the foundation for the supply of, and demand for, health and well-being. The community health system in Afghanistan is well-integrated into primary health care; CHWs are the first point of contact in the primary health care referral chain, and the Community-based Health Care (CBHC) Department in the Ministry of Public Health is responsible for community health implementation.

However, the CBHC programme suffers from waning political support and leadership, inadequate funding, insufficient capacity-building and supervision of CHWs, weak referral linkages and inadequate supplies. Further, social norms have negatively impacted access to and utilization of services for women, including at the community level.

Opportunities to expand and improve the CBHC programme include enthusiasm from the current Ministry of Public Health for effective and efficient approaches to improve health status; urban and nomadic CBHC programmes in place since 2010; the introduction of a community health indicator into the pay-for-performance (P4P) framework; and increasing access to communities as the security situation improves.

The TWG recommended immediate priorities (spanning the next six months) including: joint review and planning, rapid assessment and costing of the CBHC programme; improving the supply of essential medicines to CHWs; instituting reimbursement of CHWs for expenses incurred; and facilitating supervision and in-service capacity-building of CHWs. Medium-term priorities (spanning 6–36 months) were proposed to institutionalize sustainable financial incentives for CHWs; review the catchment population size and distribution of CHWs; revise roles and tasks to align with changing epidemiological needs; and strengthen linkages between the CBHC programme and a) primary health care facilities and b) other community-based platforms. Establishment and scale-up of community accountability mechanisms is also essential to improve the quality of services. This includes enhancing the capacity of health shuras (councils) to be involved in planning and monitoring of health services, and to establish community feedback mechanisms.

Participants deliberated between maintaining CHWs primarily in rural and hard-to-reach areas versus considering a need for an urban community-based health care approach. Gaps in the information system were raised, such as a need to map the existing community health posts for a comprehensive view of current reach and where expansion is required, and the need to establish a master database of CHWs at the national level. A need to strengthen and expand community-based accountability mechanisms was also raised, noting the Citizen's Charter and the Community Scorecard as examples which could be revived.

Consensus was reached on the following priority recommendations for the community-based health care programme:

Recommendations
1. Re-engage with community leaders and members: undertake community dialogue, including with religious leaders and new provincial health authorities to promote the importance of CBHC
2. Promote awareness and utilization of CHW-provided services and complement with other investments at community level to strengthen the quality of service delivery
3. Re-establish and improve CHW access to essential medicines and supplies, especially those recommended for high-impact interventions
4. Provide prompt and adequate reimbursement to CHWs for expenses they incur in the performance of their duties, e.g. transport expenses for accompanying patients to higher levels of care, delivering samples to health facilities for testing and attending supervisory meetings
5. Strengthen supportive supervision for CHWs and improve the mobility of community health supervisors (CHS)
6. Restore and expand the capacity of CHWs to deliver quality services, based on a revised service package of high-impact interventions in line with epidemiology and need; priority topics would likely include: rational use of drugs; integrated community case management of childhood illnesses and community-based management of malnutrition; and reproductive health
7. Expand the MHNT programme to reach populations for which there are no established health posts and/or CHWs
8. Mid- to longer-term priorities (6–36 months): • revitalize the CBHC programme and position it as a core component of the country's primary health care, and revisit the financial and non-financial incentives for CHWs; and • strengthen linkages between CHWs and BPHS facilities along with other community health networks; and • revise CHW job descriptions to ensure a focus on high-impact interventions and consider expanding responsibilities based on a life-course approach
9. A new and revitalized CBHC programme should focus on: • scaling up coverage, addressing equity gaps and increasing access to high-impact interventions; • enhancing quality of service provision; • increasing demand and socio-behavioral change through robust and meaningful engagement of communities; • ensuring comprehensive and sustainable investment whilst enhancing system efficiencies and accountability; and • ensuring all health actors work with communities to build trust, engage in the design and implementation of the CHW programme and integrate them into the health workforce.

TWG Area 5: Reproductive, maternal, newborn, child and adolescent health

Despite significant progress in access to reproductive, maternal, newborn, child and adolescent health (RMNCAH) services and improved RMNCAH outcomes in the past 20 years, nearly half of all births still take place at home, and there is limited access to 24/7 care. Maternal and newborn health guidelines and services are fragmented; for those that exist, the level of qualifications among service providers remains low and quality of care standards are poorly implemented. Adolescent health is not adequately reflected in national guidelines and frameworks. The private sector is not well regulated, and accountability frameworks remain weak.

In this context, opportunities to strengthen RMNCAH include a multisectoral humanitarian response plan that prioritizes reaching the most vulnerable women, children and adolescents; integrating health with nutrition programming; and expanding collaboration with WASH and education sectors.

Discussions among panellists and participants raised issues around data, noting that while a significant amount of reliable data is available for child health, data on maternal health is less available, and maternal mortality data is particularly controversial. Despite the progress noted in maternal and newborn health outcomes, stillbirth rates have not improved, and significant gaps remain in quality of care. The national newborn action plan requires revision. Further, social protection mechanisms for women and children are inadequate, and out-of-pocket costs for transportation and service fees are prohibitive for many families. There is further need to address the social determinants of maternal and newborn health status and outcomes.

Based on the discussions, the following proposed interim priority recommendations and actions for RMNCAH were made to sustain provision of essential lifesaving services alongside the humanitarian response:

Recommendations	
1. Sustain provision of essential lifesaving RMNCAH services across all health service programmes, including humanitarian response, BPHS, EPHS and community-based health care	• Strengthen both basic and comprehensive emergency obstetric and neonatal care
	• Strengthen adolescent health services; reach out to those both in school and out-of-school through relevant programmes and services, including nutrition, education, and WASH
	• Sustain and expand RMNCAH service delivery through the CBHC programme
	• Strengthen school health service provision: anaemia prevention, deworming, nutritional supplementation and health information
2. Strengthen policy, guidelines and implementation strategies for essential RMNCAH service provision	• Ensure strong technical coordination with the Ministry of Public Health to develop implementation strategies
	• Consider the need for specific strategies/policies in the areas of newborn care, adolescent health, community-based RMNCAH services and communications
	• Engage/collaborate with the private sector on RMNCAH policy/guideline development and implementation
3. Explore options for integrating a social protection component into RMNCAH services, e.g. on transportation costs for pregnant women	
4. Identify and address provincial and sub-provincial variations and inequities in RMNCAH programming	
5. Strengthen RMNCAH partnerships, including with the private sector, civil society and professional associations	

TWG Area 6: Nutrition

Within the nutrition sector, broad policies and strategies are in place, and nutrition is already included as a core component of the BPHS and EPHS. Community-level services are expanding. Access to prevention programmes such as food supplementation and cash assistance are scaling up. UNICEF, World Food Programme (WFP) and WHO have developed an urban nutrition strategy. In contrast to some other programmes discussed during the meeting, nutrition supplies are generally funded and available, and the nutrition information system is functioning well.

However, people in Afghanistan are facing a severe food insecurity and malnutrition crisis, due to drought, the financial crisis and increased food and fuel prices, with significantly increased acute malnutrition rates. There is a notable gap between detection and admission of cases. Gaps remain in urban nutrition services, with overcrowding in hospitals and missed opportunities for growth monitoring. While child nutrition is generally well addressed, maternal nutrition remains neglected. There is an overreliance on BPHS service providers, whose capacity is already stretched, to also scale up nutrition programs. While monitoring is strong, evaluation is currently weak. Environmental factors such as drought remain prevalent, and prevention programmes are much less developed than treatment.

Immediate priority recommendations for the nutrition sector were identified as follows:

Recommendations
1. Scale up access to essential nutrition actions and timely referral, including through primary care facilities, CHWs, MHNTs, FHHs, urban nutrition platforms and stabilization centres for severe acute malnutrition
2. Scale up and adapt essential health services to address increased malnutrition and health risks, including integrated management of childhood illness, screening and treatment of anaemia in pregnant and lactating women, increased risks for neonates with low birthweight, malnutrition in HIV and TB patients, etc.
3. Strengthen nutrition information, including expansion of nutritional surveillance and conduct of standardized monitoring and assessment of relief and transition (SMART) surveys at provincial and national levels
4. Generate demand for nutrition services through social and behaviour change communication campaigns
5. Strengthen intercluster/intersectoral coordination, especially among health, nutrition, WASH and food security clusters
6. Explore options for strengthening, expanding and integrating school nutrition services
7. Expand prevention programmes, including food supplementation programmes and cash assistance, targeting maternal and child nutrition, as well as the high financial barriers for accessing essential health and nutrition services due to loss of livelihood and income during the food security crisis
8. Continue advocacy for resources, including exploring options for including treatment costs in BPHS/EPHS costing and financing

TWG Area 7: Polio

Wild poliovirus cases are at a historic low. While endemic areas remain in the eastern and southern regions of Afghanistan, only four cases were reported throughout the country in 2021. Vaccine-derived poliovirus cases were recorded in 2021 and 2022, but the outbreak is considered to be under control. Previous challenges around the inaccessibility of vulnerable areas for vaccination campaigns have been addressed through continuous dialogue, establishing permanent transit teams in these areas, and integrating polio vaccination with routine EPI

services. Cross-border vaccination campaigns and campaigns targeting nomadic communities have addressed challenges related to population movements. Targeted community engagement strategies and activities are combatting clusters of refusals and hesitancy in endemic areas.

Since August 2021, four nationwide polio campaigns have already been conducted, with five more campaigns (three national, two subnational) planned for the remainder of 2022. House-to-house and mosque-to-mosque strategies are being used to reach previously inaccessible children. The polio surveillance system has continued to function uninterrupted throughout the turmoil, and environmental surveillance has expanded. The Emergency Operations Centre for Polio Eradication has been restructured for better performance. However, security threats to frontline workers persist. Several have been killed or injured in 2021 and 2022.

Polio eradication represents a global public good, and the rest of the world is waiting on Afghanistan and Pakistan to deliver on their commitments to end polio. Afghanistan and Pakistan must achieve this agenda together, otherwise each will continue to present a risk to the other. In order to achieve this, the health and humanitarian response communities need to ensure a safe environment for frontline workers, and we need to leverage the capacity of polio workers to reach every family. The best opportunity lies in strengthening the overall EPI programme.

Interim priority recommendations for polio eradication were agreed as follows:

Recommendations
1. Fully implement the National Emergency Action Plan for 2022
2. Ensure sustained high vaccination coverage to interrupt remaining poliovirus transmission and to prevent vaccine-derived outbreaks
3. Maintain and strengthen preparedness capacities for rapid response to new cases and outbreaks, including a clearly designated and trained rapid response cadre
4. Develop further in-country capacity for the Afghanistan Polio Information Management System, including to facilitate fast-track data compilation
5. Develop further in-country laboratory capacity for poliovirus detection and classification of acute flaccid paralysis (AFP) cases
6. Continue sentinel surveillance
7. Continue to expand the integration of other essential health services into polio control activities. Many opportunities exist for integrating polio and nutrition services, and including mobile health units for underserved pockets

TWG Area 8: Health management information system (HMIS) and surveillance

Afghanistan has a myriad of data, monitoring and information management systems. Monthly health facility data is aggregated into an HMIS (DHIS2), priority diseases are monitored through a national disease surveillance and response mechanism (DEWS), health service delivery is monitored by a third-party monitoring agency, and population-based surveys have been conducted regularly over the past several years (Demographic and Health Survey 2015, Afghanistan Household Survey 2015 and 2018). The HMIS is paper-based at facility level and digitized at provincial level. The surveillance system consists of 519 sentinel sites monitoring 17 diseases, and event-based monitoring has recently been introduced.

However, many challenges and gaps pervade the health information system. The last national census was conducted in 1997; therefore, denominators for calculating population target groups and achievements are unreliable. The surveillance system is not digitized and the private sector is not included in the HMIS. While significant amounts of data are available, and have been improving in quality and reliability over the past several years, the potential to support evidence-based decision-making has not been optimized. Maternal mortality estimates are based on modeling, and thus are not considered reliable.

Throughout the transition period following August 2021, HMIS and surveillance systems have been largely sustained, although reporting from sentinel sites has dropped. A national demographic and health survey planned for 2020–2021 was cancelled. Development of a civil registration system, including mortality tracking, has been interrupted. The balanced scorecard approach has been interrupted – the Ministry of Public Health and partners will need to determine whether it is worth reviving.

Discussions during the meeting raised the additional challenge that the HMIS does not include some indicators that are important to the current epidemiological profile, such as noncommunicable diseases – thus trends in these conditions are not available to inform decision-making. Participants further highlighted that available data is not effectively translated into action, especially at decentralized levels (district and facility). Further, there is no likely solution to the "denominator" issue of lack of current and accurate population estimates, as a new national census is unlikely in the near future.

Based on the discussions, the following priority recommendations were identified:

Recommendations
1. Invest in and continue to strengthen the existing HMIS, leveraging its capacities to support monitoring and evaluation of health system performance
2. Develop and implement a strategy for integrated disease surveillance in coordination with the Health Information Management Department of the Ministry of Public Health
3. Expand and strengthen event-based surveillance in coordination with the Health Information Management Department
4. Deploy the updated Health Resource Availability and Mapping System (HeRAMS) and seek complementarities with other systems that assess or monitor functionality of health facilities, to better monitor health facility and health workforce capacity and gaps, and include all types of providers, funding sources and owners
5. Agree on adapted third-party monitoring, with appropriate tools that are fit for purpose in the current context
6. Medium- to longer-term priorities: • explore options for digitization of the HMIS • implement a population-based Afghanistan health survey • establish a sample registration system to facilitate improved maternal mortality ratio (MMR) estimates

TWG Area 9: Supply chain management

The role of the Ministry of Public Health in procurement and supply chain management (PSCM) primarily consists of setting standards and guidelines, including establishing an essential medicines list (EML), lists of medicines for BPHS and EPHS, and guidelines for quantification, procurement and distribution. In the current system, nongovernmental organization service

providers are responsible for sourcing medicines, supplies and medical products for the BPHS and EPHS, with United Nations agencies playing a key role in procurement and distribution of medicines and supplies for national programmes and emergency response. The National Medicine and Health Products Regulatory Authority, later renamed the Afghan Food and Drug Administration (AFDA), was established in 2016 and expanded quality control laboratories in key provinces. However, there is no centralized pharmaceutical management information system (PMIS), resulting in inaccurate quantification, insufficient human and physical capacity at central and regional medical stores, and insufficient in-service training for pharmacy staff.

While the Ministry of Public Health provides guidelines and standards, there is an absence of endorsed PSCM rules and regulations. Standards documents are not regularly updated, thus stakeholders develop and implement their own criteria where there are gaps or outdated information in the official guidance. Use of medicines suffers from irrational prescribing and dispensing. As with other areas of the health sector, there is inadequate engagement with, and regulation of, the private sector.

Service providers joining via satellite from Kabul highlighted PSCM challenges from their on-the-ground experience, including transportation difficulties, unstable market prices, unclear durations of funding and lack of storage space. They called for adherence to the EML, the need for an automated PSCM, development of a PMIS to inform demand-based supply, and improved quality control mechanisms for BPHS medicines. They also highlighted the need for guidelines to improve rational use of medicines and end-user engagement.

Discussion highlighted the need to reduce reliance on global shipping; to explore non-traditional supply sources such as India and China; and to develop regional and local supply chains rather than relying on global supply chains. There have been concerns regarding BPHS and EPHS contracts, including insufficient budget for medicines. Under the P4P system in particular, partners have not had the up-front capital needed for offshore procurement, nor access to hard currency. Additionally, some supplies are not included in the BPHS costing but are part of the BPHS package and essential medicines list, such as nutrition supplies. There is limited capacity at central public health laboratories for quality control. In the longer term, there is a need to introduce or increase pharmacy education programmes in-country, strengthen the AFDA and consider local pharmaceutical production.

Based on these discussions, the following priority recommendations were agreed:

Recommendations
1. Develop an interim supply chain master plan to provide an overall framework for priority interventions, covering: • updated policies for product selection • forecasting and quantification, consolidating fragmented data on demand and utilization • selective pooled procurement through UNICEF's Supply Division • warehousing and storage improvements • national human resource capacity for supply chain management • mechanisms for monitoring and supervision
2. Introduce and strengthen the logistics management information system and associated SOPs to improve the collection, analysis and use of essential logistics data

3. Leverage complementary financing approaches for supply chain management, including: • domestic budget allocation for health commodities • private sector engagement, pricing and quality • donor funding
4. Strengthen the role of authorities in accountability and regulation of supply chain management

TWG Area 10: Health workforce

While there is a critical shortage of health workforce in Afghanistan, it is also acknowledged that there are imbalances in the distribution of the workforce that is available, and low absorption capacity, with many qualified health workers unemployed. Incentives have been established to attract health workers to rural and remote areas. However, there is no national health workforce strategic plan and information/data on the health workforce is unreliable, hampering planning and monitoring efforts.

In the transitional period, the salaries of health workers have been assured through donor funding, and female health workers continue to be allowed to report to work, although they face substantial security risks in doing so. There has been some brain drain, primarily among managerial staff. In the long term, restrictions on female education risk blocking the pipeline of future health workers.

Discussions highlighted the need for continuing professional development to ensure quality of care, and to base planning and assessment of the health workforce on the country's educational capacity.

Recommendations for the interim period include:

Recommendations
1. Conduct a rapid health workforce assessment to inform short- to medium-term workforce analysis, planning and deployment
2. Build on the assessment by reviewing facility-based staffing standards and norms to guide the immediate planning and deployment of health workers in line with priority, gender-sensitive service delivery gaps
3. Facilitate key stakeholder dialogue to develop a sustainable mechanism for the employment and remuneration of government health workers and to operate and maintain facilities as an immediate priority, including the provision of interim funding arrangements for health worker payments
4. Review the responsibilities and scope of practice of health workers at primary and secondary care facilities
5. Prioritize the development of cadres of female health workers, including physicians, nurses, midwives and laboratory staff
6. Strengthen the community health workforce – including capacity-building, incentive packages and logistics support – as an integrated part of the health system (see above under TWG 4: Community health platforms)
7. Prioritize the protection of health workers, including polio staff, and provide access to mental health and psychosocial support services at designated facilities/centres
8. Build mechanisms for continuous professional development (CPD) using a range of channels and approaches, as an integral part of contracts
9. Strengthen the capacity of national and provincial health management workforce, informed by identified gaps (medium- to longer-term)
10. Strengthen and empower the Afghanistan Medical Council and the Afghanistan Nursing and Midwifery Council (medium- to longer-term)

TWG Area 11: Governance and coordination

There is a well-established system of coordination bodies, committees and mechanisms in the health sector in Afghanistan, although these do not always reach consensus on important decisions. Additionally, these mechanisms are predominantly functional at the national level, with some devolved to the provincial level, but without substantial representation at the district level or below. Further, they are quite fragmented and vertical; coordination could be managed more efficiently and effectively if some of these bodies were integrated horizontally.

The National Health Policy 2021–2030 and National Health Strategy (2021–2025) were developed and endorsed in early 2021. Once the contracting-out mechanism was adopted for the BPHS and EPHS, the role of the Ministry of Public Health evolved to one of stewardship. This role has been undermined to some extent since August 2021, with many departments in the Ministry shutting down when project-based donor funding was suspended. However, some capacity remains with retention of technical staff, and the Ministry has continued its regulatory and quality control function for the import of medical supplies.

New aid architecture

Since the meeting in Doha, and before publication of this report, a new aid architecture for international partners in Afghanistan has been established. A key element of this new structure is the establishment of strategic thematic working groups (STWGs) for a number of relevant sectors, including health. The Health STWG (H-STWG) is chaired by WHO, the World Bank and USAID. Its tasks include the development of a mid-term, three-year health strategy: the Health Sector Transitional Strategy (HSTS) 2023–2025. Both operational coordination for humanitarian assistance and basic human needs are under the STWGs.

This means that some of the priorities from the meeting would have by now already materialized. In general, it is expected that the results of the meeting, with the listed priorities for the 12 thematic areas, will feed into the HSTS during its development.

Discussions highlighted that communities must have an integral role in health system governance. Health shuras present an opportunity for this, and must be strengthened and included, while considering the possible risks to ensure gender perspectives and equity.

Based on the discussions, the following recommendations for governance and coordination priorities were agreed upon:

Recommendations
1. Commit to and develop inclusive health system governance mechanisms that include all relevant stakeholders (health authorities at national/subnational levels, United Nations agencies, donors and national/international nongovernmental organizations) while ensuring predictable dialogue with health authorities to report on health programming based on United Nations-defined principles of engagement
2. Consider establishing a transitional health partner forum (THPF) to simplify and harmonize coordination among international partners by adjusting the scope and terms of reference of the Health Development Partners Forum
3. Strengthen the mechanism for consistent and constructive dialogue with the Ministry of Public Health based on principles of engagement of the United Nations; use this forum to agree on health priorities and to report on the progress of health programming to the Ministry
4. Link and leverage the Health Cluster and the new TPHF to engage all relevant partners in policy dialogue and health sector planning. Under the new aid architecture, all humanitarian clusters are linked with and report to the new STWGs, ensuring the nexus between humanitarian assistance and basic human needs

5. Develop an interim national health plan/strategy informed by the priorities outlined in this report, the stated priorities of the de facto authorities, the existing National Health Policy and National Health Strategy and other relevant inputs
6. Ensure mechanisms are in place to demonstrate accountability to the population, health officials, donors and other relevant stakeholders

TWG Area 12: Health financing

The Afghan health system is heavily dependent on external funding and out-of-pocket expenditure due to very limited fiscal space and the low priority given to health in the government budget. A large portion of external resources is managed through resource pooling, channelled through the Afghanistan Reconstruction Trust Fund, although some vertical funding for individual projects and programmes continues to flow (particularly for EPI and RMNCAH).

Since the launch of the Sehatmandi project for BPHS and EPHS service delivery, purchasing of services has followed a P4P model. This was intended to ensure the responsiveness of BPHS and EPHS service providers and to incentivize expansion of services. While it has been successful in increasing provision of targeted services, the model has faced a number of challenges, including under-bidding, lower-than-expected and delayed payments, resulting funding shortages and demotivation of service providers. P4P has incentivized quantity of service provision but has not sufficiently focused on improving quality. During the immediate aftermath of the transition after August 2021, the P4P model was suspended, with the BPHS and EPHS supported by UNICEF and WHO using input-based budgeting to support stability and predictability.

Participants noted that this is an opportune time to review the P4P model and assess its suitability to the current context. The previous model (under Sehatmandi) was very dynamic and complex, with significant technical support granted to the Ministry of Public Health to operationalize the system. A simpler and adaptive model could be tailored to meet the current needs. The variety of contexts throughout the country may also require an adaptive model that does not force “one-size-fits-all” solutions.

The recent economic crisis has impacted banking transactions, interrupting payment of health worker salaries and imports of medical products. It has further resulted in a decreased capacity for households to make out-of-pocket payments for health, impacting one of the most significant income streams for the health sector. There is an urgent need to address financial barriers to accessing health services. Service providers must ensure that incoming funding results in reduced charges for health care users.

While Afghanistan remains a priority for donors, resources are limited and maximizing value for money is vital. Authorities need to establish a clear vision for health and continue pooling funds to make the most efficient use of available resources. There was a clear call from major donors at the meeting to consider the most cost-effective way to provide needed coverage of services. It was also acknowledged that the most cost-effective and impactful interventions will begin with prevention and require a balanced mix of primary, secondary and tertiary services, with a well-functioning referral system.

Donors also emphasized that while significant funding is in the pipeline, the overall fiscal space is not expected to grow significantly. Thus, it is important to prioritize investments and to avoid investing in programmes that do not have scale-up potential. Stakeholders should take a "one plan, one budget" approach to coordinate investments and avoid duplication. The health financing strategy will also need to take into account the private sector, explore pooling of public and private resources to expand reach, and account for both humanitarian and development resources.

Recommendations stemming from discussions are listed below by priority area.

Recommendations	
1. Revenue raising	• Undertake a costing of requirements to deliver health services and to maintain key health system functions: - Base the costing on updated population, health workforce and health facility data - Include investments in essential public health functions and one-off capital investments and routine maintenance
	• Estimate the funding envelope for the medium-term based on mapping of key donor investments and in-kind support through the Global Fund, Gavi, etc.
	• Undertake an assessment of funded/unfunded services by province and type of service
	• Advocate with de facto health authorities regarding their contribution to health expenditure, particularly in areas with no direct like to personal health care, e.g. management areas such as HMIS and public health functions
2. Pooling	• Create/modify a pooled mechanism that is open to all willing donors; this mechanism should become the nucleus of a strategic purchasing fund
	• Intervene directly to reduce out-of-pocket expenses (OOP) by lowering prices of medicines and diagnostics, and increasing efficiency, for example through pooled procurement; set targets for OOP
	• Use a common and transparent framework to decide funding according to potential effectiveness and efficiency; ensure that funding is comprehensive and predictable
3. Purchasing	• Ensure that the design of the pay for performance (P4P) mechanism is kept as simple as possible; a common understanding should be established among purchasers, providers and monitors of what is purchased, how it is assessed and how financing is managed
	• Undertake a mapping of funding and in-kind contributions for all provinces and from all sources; establish common criteria to prevent gross inequalities among provinces
	• Include other donors and partners in the design of the future HER project to overcome existing shortcomings and design a way forward that considers changes in the context; this process can build upon the outcomes of the initial meeting in Dubai
	• Ensure that the HER project P4P mechanism and lump sum are sufficient to cover the cost of routine operations, with adequate upfront funding for initial procurement and predictable payment schedules for salaries, based on "floor funding" and extra funding to be awarded if performance of agreed indicators exceeds a given threshold. Explore options for increasing efficiency such as greater economies of scale in supply chain management, centralizing and standardizing in-service training and continuous professional development, standardizing the approach to quality improvement, etc.
	• Ensure that third-party monitoring verification is light and focuses on solution-finding; rather than introducing its own tools, it should primarily validate HMIS outputs and adherence to quality standards
4. Protection	• Improve efficiency through economies of scale in the supply chain and by centralizing workforce development
	• Set targets to reduce OOP and enhance financial protection, focusing on the most vulnerable

7. CONCLUSION

Discussions on the various thematic areas repeatedly raised some common points. Among the most prominent were the need to:

- improve data quality and robust information systems in order to ensure use of available data for evidence-based decision making;
- focus on quality of care and improving quality in service provision through existing (supported) health facilities and services;
- ensure multisectoral integration between health, nutrition, WASH, education and social protection sectors;
- strengthen management capacity at national and provincial levels, expanding to district level, for effective implementation of agreed plans;
- work with communities to build trust and ensure accountability at the level of service providers and beneficiaries;
- recognize that the CHW programme presents an opportunity for scaling up a wide range of services through an integrated platform, but to be cautious about overloading and diluting it; CHWs in the longer term should be part of health cadres; and
- review and revise the model of care, as there is a need for a district health system model based on a primary health care approach.

While several priorities were identified for each of the thematic areas and in the revised working papers of the TWGs, it is clear that not all priorities can be addressed in the immediate future. These priorities need to be refined, consensus built and action plans developed based on the most urgent needs for the next 18 to 24 months.

Decisions on the way forward must be guided by Afghan voices: the Ministry of Public Health, provincial public health departments, local implementers and communities, in consultation with technical experts from national and international organizations. While the meeting succeeded in setting out key priorities and recommendations, it was not able to draw definitive conclusions or establish action plans. Thus, a key next step is to reconvene the discussion in Afghanistan, with national and local stakeholders playing a more active role in decision-making.

The refined interim priorities are intended to guide the investments and plans of partners and donors for the short- and medium-term (18–24 months). These priorities will become the reference point for monitoring the effectiveness of international support and will help to promote the joint accountability of all actors and transparency towards the Ministry of Public Health.

However, these priorities are not meant to constitute a national strategic plan, although they may be used to engage with the Ministry for harmonized support to the health sector. Under the new aid architecture, the interim priorities will be used by the H-STWG to develop a health sector transitional strategy.

The criteria used to guide the refinement of identified priorities are as follows:

1. Activities that directly contribute to saving lives over the coming 6–12 months, under these thematic areas: humanitarian response and humanitarian health services; detecting and responding to epidemics; and addressing food insecurity.
2. Activities that enhance stabilization of service delivery capacity across the country in terms of funding, service organization and packages of services to be delivered.
3. Activities that address pre-existing shortcomings in the health system foundations and/or programmes, and that if not addressed will continue to affect service delivery negatively.
4. Consider available funding in a dynamic manner, i.e. avoid new initiatives unlikely to be funded, as the fiscal space is unlikely to increase during the period under consideration.
5. Avoid addressing problems that have existed for more than five to 10 years as resolution may not be achieved within the short- to medium-term, considering the current status of the health system and the humanitarian crisis.

Suggested refined priorities
1. Sustain and strengthen the collective humanitarian and emergency health response • Address ongoing disease outbreaks, displacement and malnutrition • Strengthen preparedness for future outbreaks and health emergencies
2. Increase coverage of essential health services not covered by BPHS and EPHS • Expand into underserved white areas • Ensure the availability of tertiary care
3. Strengthen community engagement, community-level service delivery approaches and the accountability of the health system to the population it serves
4. Improve the quality of health services • Establish working groups under Health Cluster and HER coordination structures • Strengthen monitoring and evaluation of humanitarian health response and provision of BPHS and EPHS
5. Remain vigilant regarding COVID-19, including continued expansion of vaccination coverage
6. Commit political will and resources to achieving polio eradication
7. Develop the model of care and the outline of the future health system, starting with evidence, strategies and plans needed
8. Establish strong coordination and collaboration among all humanitarian and development stakeholders

8. NEXT STEPS

At the close of the meeting, participants determined the following set of action points as next steps:

1. Ensure the active participation of stakeholders on the ground by bringing the conversation back to Kabul.
2. Re-convene TWGs on at least one or two occasions within the next weeks to refine and provide final recommendations:
   – adjust priorities based on meeting deliberations over the last three days with regard to emphasized priorities, areas of consensus and new proposals that emerged;
   – refine the priorities by identifying basic non-negotiables versus the activities that can be deferred;
   – make recommendations more detailed and context-specific;

- turn the “what” into the “how”;
- categorize priorities based on short-term (6 months), medium-term (12–18 months), and longer-term (24–36 months) periods; and
- consider the funding implications, available resources and likely fiscal space, as well as the potential inclusion of experts for costing where funding needs are not clear.

3. With Afghan health authorities and health and multisectoral partners, WHO and UNICEF will consolidate the results and use the final document as an actionable tool to guide coordination for:
   - resource mobilization
   - implementation
   - policy and strategy dialogue, specifically:
     - establishing a regular dialogue with the Ministry of Public Health at national and subnational levels; and
     - WHO and USAID, as co-chairs, reviewing the scope and terms of reference of the Health Development Partners Forum (this will now be done under the new H-STWG, that has the World Bank as a third co-chair.); the interim priorities agreed during this meeting will inform the HSTS.
4. The World Bank will convene technical working groups and invite key stakeholders to review and, where appropriate, improve the process and technical aspects of the former Sehatmandi, for the development of the new HER project.
5. Share accountability by reviewing progress after 3-, 6- and 12-month windows, together with the Ministry of Public Health, United Nations partners, civil society organizations and community stakeholders.

ANNEX 1

CONCEPT NOTE

Introduction

Afghanistan is in the midst of massive development and humanitarian crises with major public health implications. Following the recent assumption of power by the Taliban authorities in August 2021, the functioning of the health system has declined sharply and humanitarian needs have soared, placing the substantial gains in health outcomes over the past 20 years at severe risk. These challenges are occurring in the setting of a de facto regime that is not currently recognized internationally, a rapidly worsening economic crisis, staggering levels of poverty, potentially catastrophic levels of food insecurity, an increase in acute malnutrition coupled with an increase in disease outbreaks, especially measles, acute watery diarrhoea and resurgent polio, amid a persistent COVID-19 pandemic. Ironically, at the same time there is an unprecedented opportunity to eradicate polio within the country. The recently released Afghanistan Humanitarian Response Plan (HRP) and United Nations Transitional Engagement Framework for Afghanistan (TEF) outline urgent areas for short-term and medium-term assistance support. In this complex and rapidly evolving environment, it is timely and urgent to undertake a comprehensive review of health sector priorities for an interim (18–24 month) period.

Background

Over the past two decades impressive progress has been made in key health indicators across Afghanistan. The maternal mortality ratio has declined by 60%, child mortality has declined by 57%, and life expectancy has increased by 14%. Over the same period, the number of functioning health facilities has increased five-fold and the proportion of health facilities with a female health care provider almost four-fold to 87%. Vaccination coverage for DPT3/penta5 has increased by 110%. Much of this progress can be attributed to the Sehatmandi project which supports 2331 health facilities through performance-based contracts across the country and has been described as the "backbone of the national health system."

A pause in funding by international donors in August 2021 severely threatened the continuity of the basic and essential packages of health services (BPHS and EPHS) provided through Sehatmandi. Fortunately, sequential and temporary contributions from a combination of donors – most recently the Afghanistan Reconstruction Trust Fund (ARTF) – has permitted the continuation of services until at least June 2022. Thereafter, it is expected that major donors will provide another funding channel to support the Sehatmandi facilities for a subsequent 12–24 months.

Nonetheless, it is estimated that there are over 3800 health facilities across Afghanistan, of which Sehatmandi covers only 61%. Gaps in primary, secondary and tertiary care services therefore persist, including in some of the most remote and vulnerable communities. These include the 39 government-supported hospitals that currently have limited support. Communities in so-called white areas where Sehatmandi is not present rely on a combination of nongovernmental organization- and government-run facilities and mobile clinics, for which financing is not assured.

Humanitarian needs are enormous and increasing. A combination of economic instability, severe drought, harsh winter, major food insecurity, rising malnutrition, forced displacement, the COVID-19 pandemic, other concurrent disease outbreaks (such as cholera, measles and dengue), and violent trauma (landmines, attacks by ISIS-K) have conspired to create one of the largest and most rapidly evolving humanitarian crises on the planet. As noted in the HRP, 24.4 million people will need humanitarian assistance in 2022 – a dramatic 260% increase over the past two years. Over 18.1 million people are estimated to need humanitarian health services and Health Cluster partners will aim to reach at least 14.7 million. Over 23 million people are in acute food insecurity (IPC3+) and 4.7 million people face malnutrition, including 1.1 million children at risk of severe acute malnutrition.

The COVID-19 pandemic in Afghanistan has not been as explosive as in many other countries to date, but previous waves claimed almost 7500 lives and the threats posed by new variants such as Omicron could rapidly overwhelm the already weakened health system. Only 10% of the population is fully vaccinated against COVID-19, well below the global target of 40% for the end of 2021, requiring concerted efforts to get on track for the ambitious mid-2022 target of 70%. Afghanistan is also prone to multiple other disease outbreaks, requiring the strengthening of disease control efforts.

The rapid economic deterioration in Afghanistan is severely exacerbating humanitarian needs. The pause in development funding (previously the source of 75% of public expenditures) and freezing of Afghan assets overseas has led to a lack of liquidity and a rapid decline of the Afghani currency. Gross Domestic Product has contracted by an estimated 40%, with a significant increase in unemployment and the associated risk of up to 97% of Afghans becoming impoverished by mid-2022. A cash shortage means Afghans are running out of money while prices of basic items, from food to medicine among others, are skyrocketing; this will further impact the already high financial barriers for access to health, especially considering that out-of-pocket (OOP) spending accounts for 73% of total health expenditure.

Beyond service delivery, other key elements of the health system are lacking the sustained support that they had previously. The government-run health management information system (HMIS), including disease surveillance, functions effectively and is a vital asset; failure to support it would have serious consequences. The health workforce has suffered serious losses in recent months due to emigration and brain drain – including many female health workers – and thousands did not receive their salaries for up to seven months. Options to retain, support and renew the pipeline of doctors, nurses, midwives and other health workers must be explored, with a special emphasis on female staff. Mechanisms to ensure a reliable supply and logistics for essential medicines, equipment and consumables must also be established. Financing of the health sector will continue to come primarily from out-of-pocket expenses and international donors, but interim options need further analysis.

Governance and coordination present special challenges, including in the health sector. The new de facto Taliban regime is currently not recognized as the legitimate authority by the international community at large, and subsequently all development funding through government structures has been paused. The Afghanistan Partnership Framework and the Afghanistan National Peace and Development Framework II 2021 to 2025 have both been

suspended. Donors are establishing alternate funding channels through United Nations agencies and nongovernmental organizations for their development funding.

Nonetheless, the de facto authorities have made appointments across government and security structures at national and subnational levels. Coordination and consultation with de facto Ministry of Public Health officials at these levels is vital to ensure ongoing access and an enabling operating environment. Regular meetings are held with key United Nations and other agencies, but formal coordination mechanisms between the de facto authorities and international partners have not been established. Coordination within the health sector is now largely through the humanitarian Health Cluster which has expanded to include the "Sehatmandi nongovernmental organizations" but does not include Taliban authorities.

The de facto authorities have begun raising revenues but continue to face significant capacity deficits, in part due to the continuing outflow of former government officials and their lack of preparation for the complexities of governing a country that has modernized significantly over the past 20 years. They have not yet allocated a similar government contribution to the total health budget as done by the former regime, putting at risk the functioning of the hospitals they manage and of the Ministry of Public Health's institutions.

While the number of security incidents and civilian casualties in Afghanistan have dropped sharply since the Taliban declared the end of their military offensive on 6 September, landmines persist, and attacks claimed by or attributed to ISIL-K have increased in number and geographic scope. These include a deadly attack on a hospital in Kabul in November that left 20 dead. The de facto authorities have prioritized operations against ISIL-K.

One of the more positive developments in the health sector is that only four wild polio cases were documented in Afghanistan during 2021, although there were 43 cases due to a vaccine-derived cVDPV2 outbreak. Following negotiations with the de facto authorities nationwide, polio campaigns resumed after a three-year pause, reaching 8.5 million children including 2.4 million who were previously inaccessible. Recent progress has increased optimism about wild polio virus eradication in the near term, guided by the 2021 Afghanistan National Emergency Action Plan for Polio Eradication.

In this challenging operating environment, it is important for health partners to define short- to medium-term strategic directions and priorities that will further stabilize and restore service delivery, protect the population from health emergencies, and support the foundations of the health system. At the same time, it will be necessary to advance constructive engagement with the de facto health authorities and ensure accountability to the Afghan population.

Meeting goal

To establish a joint stakeholder agreement on health sector priorities and strategies for Afghanistan for the next 18–24 months.

Objectives

1. Review gaps in health and nutrition service delivery (availability, accessibility, utilization, quality) and identify options for addressing them.
2. Review progress and persistent gaps in humanitarian response and emergency risk management (including COVID-19, disease outbreaks, acute malnutrition) and identify options for addressing them.
3. Identify elements of health system requiring prioritized support and short-term solutions:
4. HMIS
   - Health workforce
   - Supply chain management
   - Governance and coordination
   - Health financing
   - Community health platforms, community-based health service delivery.
5. Agree on approaches to support implementation of the Afghanistan National Emergency Action Plan for Polio Eradication and to leverage polio assets in support of other humanitarian and development needs.
6. Agree on approaches for constructive engagement with de facto authorities and for strengthened accountability to the Afghan population.
7. Agree on general strategic directions to support the health sector, including monitoring of the effectiveness of international support.

Planning and structure of the meeting

The meeting will be designed to support the development of a joint stakeholder strategic plan to support the Afghan health sector for the next 18–24 months.

8. Pre-meeting planning: a Steering Committee will be established to lead the preparatory and follow-up work of the meeting.
   - Composition: Co-chaired by WHO and UNICEF with membership from United Nations, nongovernmental organizations, donors, academia, and knowledgeable external consultants.
   - Roles:
     - Contribute to finalization of the draft agenda, format and participants of the meeting.
     - Conduct deep dive analysis into the thematic areas (service delivery, including immunization; humanitarian response; COVID-19, other outbreaks and disease control; nutrition; governance and coordination; HMIS; pharmaceuticals and supply chain management; human resources; financing) and produce related presentations, background papers and talking points.
     - Consult with Taliban health authorities on thematic issues and planning.
     - Participate actively as presenters, moderators, rapporteurs.
     - Manage the follow-up of the meeting (see below).

9. Proposed structure
   - Days 1–2: Setting the scene
     - Context: Overview of context in Afghanistan (political, economic, development, humanitarian) and latest developments affecting the health sector.
     - Thematic areas: Situation, challenges, opportunities and way forward for each thematic area.
     - Financing and donors: Summary of financing of the sector, including current donor support and plans.
     - Participants will be invited to discuss the key observations, lessons learnt on what has been done well, what could have been done better, and identify options for course corrections.
     - Deep dives on issues that require further exploration.
   - Days 2–3
     - Combination of plenary and group work. Participants will be invited to work collaboratively to make recommendations on strengthening current approaches and activities, addressing gaps, mobilizing resources and monitoring progress.
     - Wrap-up and agreed next steps.
10. Proposed participants
    - From WHO: Regional Director, WHO Representative to Afghanistan, Director of Programme Management, Director of Business Operations, Director of the regional Health Emergencies programme, and staff from the Afghanistan country office, Regional Office for the Eastern Mediterranean and WHO headquarters.
    - United Nations agencies: WHO, UNICEF, UNDP, UNFPA, UNHCR, WFP, IOM.
    - Donors: World Bank, USAID, European Union, Asian Development Bank, Islamic Development Bank, Global Fund, Gavi, other bilateral and multilateral donors.
    - Nongovernmental organizations: national and international.
    - Red Cross and Red Crescent movement.
    - Academia: University of Geneva, Royal Tropical Institute of Amsterdam, Johns Hopkins University, London School of Hygiene and Tropical Medicine.
    - External consultants with expertise in thematic areas.
11. Post-meeting follow-up
    - Steering Committee to support development of an interim health sector plan for Afghanistan (18–24 months) and associated monitoring plan, based on the deliberations of the meeting.
    - Monitoring to be managed through established coordination platforms, e.g. Health Partners Development Forum.

ANNEX 2

MEETING PROGRAMME

Day 1: Tuesday, 29 March 2022

OPENING SESSION

09:00–9:45	Welcome and introductory remarks	**Facilitator:** *Dr Salih Al Marri* (Qatar Ministry of Public Health)
	• Welcome remarks from Qatar Ministry of Public Health	**Speaker:** *Dr Salih Al Marri*
	• WHO/UNICEF principals' remarks	WHO Director-General: *Dr Tedros Adhanom Ghebreyesus* UNICEF Executive Director: *Dr Catherine Russell*
	• Opening remarks by WHO/UNICEF Regional Directors	WHO Regional Director: *Dr Ahmed Al-Mandhari* UNICEF Regional Director: *George Laryea-Adjei*
	• Afghanistan Ministry of Public Health remarks	Afghanistan (Ministry of Public Health): *Dr Qalander Ibaad*
09:45–10:15	Meeting objectives and health context overview	**Presenters:** *Dr Luo Dapeng* (WHO) *Dr Mohamed Ag Ayoya* and *Dr Fouzia Shafique* (UNICEF)
10:15–10:45	Ministry perspective of the health situation in Afghanistan	**Presenter:** Afghanistan Ministry of Public Health presenter **Facilitators:** *Dr Ibrahima Socé Fall* (WHO) *Dr Aboubacar Kampo* (UNICEF)

SESSION ONE: HUMANITARIAN RESPONSE AND EMERGENCY RISK MANAGEMENT

11:15–12:15	Review progress and challenges in humanitarian response and emergency risk management. Thematic presentations on:	**Presenters:** *Dr Jamshed Tanoli* (WHO) *Dr Alaa Abouzeid* (WHO) **Facilitators:**
	• Humanitarian needs and response	*Dr Colleen Hardy* (CDC) *Anna Cilliers* (MSF)
01:15–02:15	COVID-19 and other disease outbreaks	

SESSION TWO: HEALTH SERVICE DELIVERY STRATEGIES

02:15–05:15	Deep-dive sessions on thematic topics: • Service delivery • Community health platforms	**Presenters:** *Dr Xavier Modol* (WHO) *Dr Maureen Momanyi* (UNICEF) **Facilitators:** *Dr Paata Chikvaidze* (WHO) *Dr Moazzem Hossain* (UNICEF) *Dr Minqad U Rahman Roadwal* (ICRC)
	Commentaries on service delivery by partners	**Speakers:** *Dr Claudia Hudspeth* (AKHS) *Dr Mohiuddin Khan* (IOM)
05:15–05:30	Wrap-up	**Facilitators:** *Dr Richard Brennan* (WHO) *Dr Fouzia Shafique* (UNICEF)

Day 2: Wednesday, 30 March 2022

09:00–09:15	Session plan for Day 2	**Facilitators:** *Dr Walid Osman* (Qatar Ministry of Public Health) *Dr Muhammad Naseem* (HealthNet)

SESSION THREE: HIGH-PRIORITY INTERVENTIONS

09:15– 11:45	Deep-dive sessions on thematic topics: • Nutrition and food security • Maternal and child health • Polio	**Presenters:** *Melanie Galvin* (UNICEF) *Dr Asheber Gaym* (UNICEF) *Dr Nek Wali Shah Momin* **Facilitators:** *Dr Maha El-Adawy* (WHO) *Zivai Murira* (UNICEF) *Christopher Nyamandi* (Save the Children) *Dr Hamed Jafari* (WHO)
	Commentaries on polio	**Facilitators:** *Dr Irfan Akbar* (WHO) *Dr Shamsher Khan* (UNICEF) *Michael Galway* (BMGF)

SESSION FOUR: HEALTH SYSTEM COMPONENTS I

2:00– 4:00	Deep-dive sessions on thematic topics: HMIS and surveillance Supply chain Health workforce	**Presenters:** *Dr Egbert Sondorp* (WHO) *Phyllis Ocran* (UNICEF) *Dr Fethiye Gulin Gedik* (WHO) **Facilitator:***Dr Walid Osman* (Qatar Ministry of Public Health)
04:15– 05:00	Wrap-up	**Facilitator:***Dr Karl Blanchet* **Rapporteurs:** *Dr Andre Griekspoor* (WHO) *Meredith Dyson* (UNICEF) *Dr Xavier Modol* (WHO) *Dr Egbert Sondorp* (KIT) *Dr Ibne Amin Khalid* (Ministry of Public Health Afghanistan)

Day 3: Thursday, 31 March 2022

09:00–09:15	Recap of Day 2	**Facilitator:** *Dr Karl Blanchet*

SESSION FIVE: HEALTH SYSTEM COMPONENTS II

09:15– 11:30	Thematic presentations on • Health financing • Governance and coordination Commentaries on health financing *Dr Claudia Hudspeth (AKHS)* *Dr Sophie Witter* *Dr Xavier Modol*	**Presenters:** *Dr Awad Mataria* (WHO) *Dr Ali Ardalan* *Meredith Dyson* (UNICEF) *Dr Andre Griekspoor* (WHO) **Facilitators:** *Hadia Samaha* (World Bank) *Randolph Augustin* (USAID)

SESSION SIX: WRAP-UP SESSION

11:45– 01:45	Strategic discussion: • Review interim priorities for the health sector in Afghanistan • Strategic directions to support the health sector, including monitoring of the effectiveness of international support • Next steps/way forward	**Presenters:** *Dr Andre Griekspoor* (WHO) *Dr Moazzem Hossain* (UNICEF) **Facilitators:** *Dr Rana Hajjeh* (WHO) *Dr Aboubacar Kampo* (UNICEF)
03:00– 04:00	Closing remarks	**Presenters:** *George Laryea-Adjei* (UNICEF) *Dr Ahmed Al-Mandhari* (WHO) Ministry of Public Health Afghanistan Ministry of Public Health Qatar

ANNEX 3

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