

# THE CRISIS WITHIN CRISES IN AFGHANISTAN:

When a Political  
Crisis Causes  
COVID-19  
Vaccination Efforts  
to Wane

ABDUL WALI RASTA

VACCINE EQUITY, TRANSPARENCY, AND ACCOUNTABILITY IN ASIA:  
Realities and Dilemmas

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# PART I: INTRODUCTION

## 1.1. State and trends of COVID-19 and vaccination in Afghanistan

In late 2019 and early 2020, Afghanistan found itself in the middle of a triple crisis. First, the security situation deteriorated as the Taliban gained more control on the ground (Smith, 2020), and the country was hanging between the Taliban and the Afghan National Security Forces. Second, the disputed 2019 presidential election between two rivals, Dr. Abdullah and Ashraf Ghani, led to a political stalemate (Belquis Ahmadi & Palwasha L. Kakar, 2020)<sup>1</sup>. Third was the COVID-19 outbreak in Afghanistan, which has a fragile healthcare system (Khudadad et al., 2021), and which continues to rank among the countries with the worst access to health globally (WHO, 2020). The country confronted COVID-19 amidst a slew of crises. These crises — political unrest, intensified violence by the Taliban, and the emergence of COVID-19 — exposed new vulnerabilities and further crippled a state that was already partially paralyzed.

On 24 February 2020, the Ministry of Public Health (MoPH) announced the first positive case of COVID-19 (MoPH, 2020), a 35-year-old man who had returned to Afghanistan's Herat province from neighboring Iran. Herat became the epicenter of the virus, which then quickly spread to the neighboring provinces in March. On 22 March 2020, the MoPH confirmed the first fatality related to the novel coronavirus, a 40-year-old man from northern Balkh province (Saif, 2020). The number of cases and deaths then escalated in all 34 provinces. According to the MoPH's DHIS2 data portal (see Table 1)<sup>2</sup>, from the first case in February 2020 until November 2022, 206,158 people were infected with COVID-19, there were 7,834 registered deaths from the disease, and 183,873 people recovered, based on 116,0017 samples taken in 34 provinces.

<sup>1</sup> On 28 September 2019, Afghanistan held its fourth nationwide presidential election since the overthrow of the Taliban in 2001. The preliminary results were announced in December 2019 and declared Ashraf Ghani as the winner. Ghani's main rival, Abdullah, rejected the election results and stated that the results had been engineered, and said he would form his own government. Afghanistan's Independent Election Commission (IEC) announced the final certified results on 18 February 2020, with Ashraf Ghani as the winner. Abdullah again rejected the results and claimed that he was the rightful winner of the election. On 9 March 2020, both Ghani and Abdullah declared themselves president and were sworn in, and both pledged to form an 'inclusive government'. The inauguration of two rival presidents paralyzed post-election Afghanistan at a critical juncture — a time when the US had signed a peace agreement with the Taliban with an assurance that negotiations between the Taliban and the Afghan government would start by 10 March 2020. The dispute set Afghanistan up for a difficult political showdown at a critical time. Shortly thereafter, US Secretary of State Mike Pompeo travelled to Kabul to mediate between Ghani and Abdullah, but he was unable to convince them to put their differences aside. Eventually, after much domestic and international pressure, Ghani and Abdullah signed another power-sharing agreement that would accommodate the interests of both presidential teams.

<sup>2</sup> DHIS2 is an open source, web-based platform most commonly used as a health management information system (HMIS). Today, DHIS2 is the world's largest HMIS platform, in use by 73 low and middle-income countries. Approximately 2.4 billion people live in countries where DHIS2 is used. Including NGO-based programs, DHIS2 is in use in more than 100 countries. <https://dhis2.org/>.

**Table 1: Reported number of tests, cases, deaths, and recovered in Afghanistan, by province (February 2020 - November 2022)**

SN	Province	Samples tested	Confirmed cases	Deaths	Recovered Cases
1	Kabul	477,801	40,957	2,485	38,266
2	Nangarhar	71,300	17,056	538	13,907
3	Herat	67,483	20,224	767	18,823
4	Kandahar	65,007	11,756	257	11,045
5	Balkh	59,883	9,091	583	8,275
6	Kunduz	27,495	6,028	226	5,644
7	Takhar	23,752	6,690	233	6,201
8	Baghlan	23,313	4,978	99	4,802
9	Parwan	21,974	5,531	51	4,798
10	Wardak	21,605	6,527	217	6,192
11	Nimroz	19,849	3,498	108	3,282
12	Badakhshan	19,521	4,888	88	4,671
13	Ghazni	18,313	5,691	163	4,622
14	Helmand	18,069	4,333	166	3,713
15	Kunar	15,769	3,548	108	3,084
16	Bamyan	15,682	4,319	52	4,222
17	Kapisa	15,525	4,897	89	4,202
18	Logar	14,646	3,795	96	3,238
19	Laghman	14,400	4,140	190	3,948
20	Panjsher	14,187	3,920	49	3,478
21	Paktya	14,088	3,924	209	3,650
22	Faryab	13,895	2,301	145	1,802
23	Dykundi	13,558	3,691	68	2,910
24	Zabul	12,221	3,330	80	2,313
25	Ghor	10,768	3,994	60	3,473
26	Urozgan	10,595	1,281	20	776
27	Badghis	10,464	2,497	32	1,870
28	Farah	9,759	3,049	169	1,712
29	Jawzjan	8,432	1,952	51	2,018

30	Samangan	7,164	1,835	73	1,726
31	Sar-e-Pul	6,560	1,415	34	1,206
32	Paktika	6,107	1,996	54	1,631
33	Khost	5,992	2,230	266	1,623
34	Nooristan	4,840	796	8	750
	Total	1,160,017	206,158	7,834	183,873

Source: MoPH, DHIS2 data portal

While the number of cases varied by province, Kabul, with more than four million people (Worlddata, n.d.), remains the most affected, with 40,957 confirmed cases as of November 2022, followed by 20,224 in Herat, 17,056 in Nangarhar, and 11,752 in Kandahar. Provinces such as Kunduz, Takhar, Baghlan, Parwan, and Wardak had 6,000-9,000 confirmed positive cases, while other provinces had fewer than 2,000 confirmed cases.

According to UN and World Bank data, Afghanistan's total population was approximately 40 million in 2021, with 47% below 15 years of age (MoPH, 2021). The highest proportion of recorded COVID-related deaths were in the 60-69 age group (30%), 70-79 age group (21%), and 50-59 age group (20%). Of the total recorded COVID-19 deaths, 65% were male, and 35% female. However, according to the UN Office for the Coordination of Humanitarian Affairs (OCHA) and WHO, confirmed COVID-19 cases and deaths are likely to have been under-reported, due to limited public health resources and testing capacity, as well as the absence of a national death register (OCHA, WHO, 2021).

Despite the political and security crises, the previous government of Afghanistan<sup>3</sup> made valiant efforts to contain the spread of COVID-19. It imposed cross-border screenings and testing as the first intervention to identify and quarantine Afghan returnees from Iran, which hosted more than two million Afghan refugees and migrant workers (Salmani et al., 2020). During the COVID-19 outbreak, tens of thousands of migrant workers crossed the border from Iran to Afghanistan, with Herat along their transit route to their provinces. However, the measures imposed were ineffective in controlling the transmission and spread of the virus in the country due to low testing capacity as compared to the number of returnees. Furthermore, in March 2020, the Afghan government developed and introduced the National Emergency Response Plan for COVID-19<sup>4</sup>, in collaboration with the WHO, which aimed to tackle the pandemic; it also called for all educational institutions to be shut down, and restricted public gatherings and movements in major cities. Unfortunately, many Afghan citizens

<sup>3</sup> The Islamic Republic of Afghanistan (former government of Afghanistan) was established following the US-led invasion of Afghanistan in 2001 which toppled the Taliban regime. On 15 August 2021, after US troops withdrew, The Taliban swept back into power and the Islamic Republic of Afghanistan ended on the same day.

simply did not take the threat of the virus seriously; they frequented packed markets, ate in crowded restaurants, and ignored restrictions and guidance (Basij Rasikh et al., 2020).

In an attempt to further confront and stop the spread of COVID-19, the government advised case detection and isolation as critical interventions. As part of its COVID-19 early response, the MoPH dedicated one hospital in Kabul, with around 1,541 beds, for the treatment of COVID-19 patients (Basij Rasikh et al., 2020). By March 2020, there were 300 ICU beds available nationwide for severe cases to be quarantined under the isolation ward protocol; mild and moderate cases were to be quarantined at home. Despite the increasing cases, Afghanistan had one of the lowest national testing capacities in the region for COVID-19 (Basij Rasikh et al., 2020).

As a low-income country, Afghanistan has struggled to acquire enough vaccines to fully vaccinate its population. It has thus largely relied humanitarian aid and on the COVAX facility<sup>5</sup>, which aimed to provide low- and middle-income countries with vaccines to vaccinate 20% of their populations (Tagoe et al., 2021).

Afghanistan received its first shipment of 500,000 doses of the AstraZeneca COVID-19 vaccine from India on 7 February 2021, as part of the Indian government's assistance (Al Jazeera, 2021), and began to administer the vaccines on 23 February 2021. The 500,000 doses donated from India were initially administered to security force members, health workers, and journalists (Staff, 2021).

On 8 March 2021, Afghanistan received 468,000 doses of the Covishield vaccine from the Serum Institute of India, under the COVAX program, making it the first country in Central Asia to receive a vaccine via COVAX (UNICEF, 2021a). On 9 July 2021, more than 1.4 million doses of the Johnson & Johnson vaccine arrived in Afghanistan, donated by the US through the COVAX facility's dose-sharing scheme (UNICEF, 2021). On 30 July 2021, the Swedish government donated 124,800 doses of AstraZeneca vaccines (GAVI, 2021), the first shipment of three million doses it pledged. On 1 January 2022, India supplied a batch of humanitarian assistance consisting of 500,000 doses of the Covaxin vaccine to Afghanistan (Laskar, 2022). On 8 August 2021, France delivered around 144,000 doses of AstraZeneca to the MoPH in Kabul (SubheKabul, 2021).

In addition to the vaccines supplied by COVAX, India, Sweden, France, and the US, the government of Afghanistan acquired COVID-19 vaccines from China. The Chinese-

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<sup>4</sup> To tackle the pandemic, the Government of Afghanistan developed the National Emergency Response Plan for COVID-19 (NERPC) in March 2020, to follow eight COVID-19 related pillars in coordination with relevant ministries and other agencies. The NERPC incorporated the UNICEF and WHO preparedness and response plan to COVID-19 with the aim to address the developing demands of COVID-19.

<sup>5</sup> COVAX is the vaccines pillar of the Access to COVID-19 Tools (ACT) Accelerator. The ACT Accelerator is a ground-breaking global collaboration to accelerate the development, production, and equitable access to COVID-19 tests, treatments, and vaccines. COVAX is co-led by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi, and the World Health Organization (WHO), alongside key delivery partner UNICEF.

made vaccine (Sinopharm) was critical in resolving Afghanistan's scarcity of vaccines, coming at a time when the country had paused its vaccination program due to a lack of vaccines. China's timely contribution of Sinopharm vaccines resumed the vaccination program in June 2021. In June 2021, China delivered the first batch of the vaccines to Afghanistan, which contained around 700,000 doses (CTGN, 2021). The second shipment, containing 800,000 doses of the vaccine, arrived in Kabul on 8 December 2021 (Asifzada, 2021), where the Chinese ambassador handed them over to the Taliban deputy health minister. A day later, around 200,000 more vaccines were delivered to Kabul as part of China's pledged humanitarian support for Afghanistan (The Killid Group, 2021). Since the 15 August 2021 political change in Afghanistan, China has announced that it would donate three million doses of vaccines, and other medical supplies, to Afghanistan (Sheng, 2021).

After the US and NATO forces withdrew from Afghanistan in August 2021, which led to the return of the Taliban, China filled the vacuum to exploit the country's natural resources and to maintain its security interests. On 9 September 2021, a month after the Taliban takeover of Kabul, Chinese Foreign Minister Wang Yi announced that his country was offering at least USD31 million worth of emergency aid, including COVID-19 vaccines, to Afghanistan (Al Jazeera, 2021). According to Xinhua state news agency, China's foreign minister said that Afghanistan was "standing at the crossroads" as it faced humanitarian crises including the COVID-19 pandemic (Xinhua, 2021). Meanwhile, the Taliban declared that China will be its "main partner" in rebuilding the war-torn country.

Afghanistan has mainly administered three vaccines: Covishield, Sinopharm, and Johnson & Johnson. According to WHO data, as of February 2023, 15 million vaccine doses had been administered in Afghanistan, with 13.4 million people having received at least one dose (34.5%) and 12.7 million considered fully vaccinated (32.6%) (WHO, 2023). Afghanistan's vaccination rate has remained low compared to other Asian countries, despite having additional doses available. Based on the DHIS2 data portal, as of November 2022 the country had 4,619,352 doses of vaccines available, including 991,797 doses of Covishield, 2,803,686 doses of Johnson & Johnson, and 823,869 doses of Sinopharm.

## 1.2. Research methodology

This report is the result of research examining the government of Afghanistan's response to the COVID-19 pandemic. The study focuses on Afghanistan's COVID-19 vaccination plan, especially on vaccine allocation, access to information on vaccines, and vaccine equity in the national vaccination plan, as well as transparency in the implementation of the national plan. In order to better understand the COVID-19 vaccination program, it is also important to look into the distribution and procurement of COVID-19 vaccines in Afghanistan.

In this study, primary data were collected through key informant interviews with different groups of stakeholders inside and outside the government. Secondary data

were collected through a desk review of the available plan, policies, strategies, and documents on COVID-19, as well as media sources.

To collect the primary data, a list of potential key informants was identified, and semi-structured interviews were conducted with 16 key informants in November 2022, using either in person or hybrid format.

**Table 2: List of interviewees for this study**

No.	Sector	Organization/ department	Interview modality	Interview date
1	Ministry of Public Health (MoPH)	National EPI (expanded program of immunization)	In person	13 Nov 2022
2		Department of Provincial Health Coordination	In person	8 Nov 2022
3		Department Procurement	In person	16 Nov 2022
4		COVID-19 Department Policy and Planning	In person	12 Nov 2022
5	Hospitals/ vaccination centers	City Hospital	In person	7 Nov 2022
6		Afghan Japan Hospital	In person	5 Nov 2022
7		Jamhuriat Hospital	In person	5 Nov 2022
8	Non-governmental organizations (NGOs)	Bu Ali Rehabilitation & Aid Network (BARAN)	In person	14 Nov 2022
9		Management Science for Health (MSH) Afghanistan	In person	17 Nov 2022
10		Aga Khan Health Services (AKHS-A)	In person	9 Nov 2022
11		BRAC-Afghanistan	In person	23 Nov 2022
12		Integrity Watch Afghanistan	Hybrid	21 Nov 2022
13		Bakhter Development Network (BDN)	In person	10 Nov 2022
14	Media	Radio Talwezon Afghanistan (RTA)	In person	5 Nov 2022
15		Ariana TV	In person	17 Nov 2022
16		Tolo TV	In person	15 Nov 2022

A set of questionnaires was originally developed in English, but due to local language barriers, the questionnaire was translated into Dari/Farsi. The key themes included in this study were identified in cooperation with Innovation for Change – East Asia. The author translated the data into English from Dari/Farsi, and then analyzed the data using thematic analysis, coded in qualitative analysis software Nvivo. The coded and analyzed data were manually reviewed for better results.

The main limitation of this research was the lack of knowledge of the key informants, due to administrative changes after the Taliban takeover and inadequate access to information. In cases where data sources were successfully accessed, with some exceptions, there was widespread unwillingness by the interviewees to engage or answer the researcher's questions. The main reason for this lack of willingness was due, in part, to the interviewees' lack of knowledge about the existence of available information and their fear of the Taliban punishing them for revealing the truth. In addition, some interviewees refused to allow the interview to be recorded.

## PART II: ON INFORMATION ACCESSIBILITY

Information accessibility is of huge importance in mitigating COVID-19. Timely communication and publicly sharing of accurate information build citizens' trust in public institutions and allow the government to effectively respond to the deadly virus. Access to information also prevents corruption and allows the public to hold government agencies accountable.

During the COVID-19 vaccination rollout in Afghanistan, and into the Taliban administration, the WHO was a primary source of information. In the previous administration in Afghanistan, the MoPH was the primary source other than the WHO, providing regularly updated information on its webpage.<sup>6</sup> This information was accessible in various forms, such as pre-published reports, press conferences, updated information about COVID-19 vaccination through media and social media releases, and radio broadcasting. However, after the taking over on 15 August 2021, the Taliban rarely shared any information on vaccination, either with the media or publicly.

The MoPH under the Taliban administration has been reluctant to share information with the media and public about the pandemic, and when it does, there is generally a significant discrepancy between its reports and data from other sources (Soroush and Ruttig, 2022). According to an April 2022 report by Afghanistan Analyst Network (AAN), "when it comes to informing the public via the media, the Taliban now only share data via voice messages or video clips to a WhatsApp group for journalists once a week, if that". The last time the MoPH under the Taliban updated the media on COVID-19 status and vaccination in any way was on 1 April 2022, when MoPH spokesman Javed Hazhir sent a video clip to journalists and posted it on his Facebook.

Informants for this study from within the media and NGOs stated that they do not have access to COVID-19 information. On the contrary, only designated members of the MoPH's DHIS2 staff and the WHO have access to the COVID-19 database in the DHIS2 data portal (BRAC, personal communication, 2022). A private hospital in Kabul consulted for this research stated that the MoPH under the Taliban administration does not disseminate or share any information related to COVID-19 vaccination (City Hospital-Kabul, personal communication, 23 November 2022). Public hospitals in Kabul stated, "We had access to COVID-19 and vaccination-related information in the previous administration, but since the August 2021 regime change, access to information on vaccines has been limited", even to MoPH partner NGOs.

The Afghanistan COVID-19 Emergency Response and Health Systems Preparedness Project was prepared under the World Bank's Environment and Social Framework

(ESF).<sup>7</sup> As per World Bank Environmental and Social Standard 10 (Stakeholder Engagement and Information Disclosure), implementing agencies should "provide stakeholders with timely, relevant, understandable, and accessible information, and consult with them in a culturally appropriate manner, which is free of manipulation, interference, coercion, discrimination, and intimidation". The case of information accessibility and sharing is different under the Taliban administration, which does not follow the previously developed policies; this can be connected to the new appointments and replacement of the previous administration's staff.

The previous Afghan government claimed that the MoPH and the Ministry of Communication and Technology Affairs jointly developed a mobile application providing updates on COVID-19, saying, "This application was created in collaboration with the Ministry of Telecommunications and Information Technology" (TOLONews, 2020). However, as of November 2022, the web address ([www.corona.asan.gov.af](http://www.corona.asan.gov.af)) was not accessible.

The MoPH ran public awareness through health centers and mobile healthcare staff, but it also raised awareness through mosques and religious leaders in cooperation with the Ministry of Haj and Religious Affairs. Additionally, civil society, including the media, used to play a significant role in awareness-raising and COVID-19 information dissemination, but since the political change the enabling environment for CSOs has shrunk. That leaves the media no longer a reliable source of information on COVID-19.

On the other hand, information on Chinese-donated vaccines to Afghanistan gained media attention. A survey by Hart (2022) published in China Power summarized that, "In 84 countries, government officials of varying seniority participated in handover ceremonies to show gratitude for deliveries of Chinese vaccines". In Afghanistan, three shipments of Chinese-made vaccines were received by Afghan ministers for public health. According to the survey in China Power, 0.9% of Afghanistan's population was covered by the Chinese vaccine based on finalized agreements as of 7 September 2021. After September 2021, China donated around one million doses of Sinopharm vaccines to Afghanistan.

China and Afghanistan have maintained good bilateral relations since 1955 (Reuters, 2011), and the Chinese government announced its support for Afghanistan at the time of the COVID-19 outbreak. On 16 July 2021, in a telephone call between president Xi Jinping and former Afghan president Ashraf Ghani, Xi stated that China was ready to continue providing support and assistance for Afghanistan's fight against the pandemic ([au.china-embassy](http://au.china-embassy), 2021). At the early stage of vaccine production, China

promised that it would deliver its COVID-19 vaccines to low- and middle-income countries in Asia and Africa, including Afghanistan. Chinese vaccine donations to Afghanistan coincided with US troops' withdrawal in 2021. Following the US withdrawal from Afghanistan and its suspension of foreign aid to the country, China was the first country to pledge emergency humanitarian aid, worth USD31 million, to Afghanistan (Y. Sheng, 2021). In addition, on 20 August 2022, China's Xinhua state news agency reported that China was among the first countries to help Afghans after an earthquake affecting eastern provinces of Afghanistan and pledged RMB50 million (about USD7.5 million) in emergency humanitarian aid (Xinhua, 2022).

The US and its NATO allies withdrew from Afghanistan in August 2021 and left a power vacuum that was filled by China. The withdrawal provided an opportunity for China to expand its influence in Afghanistan, which was in dire need of aid, by sending medical aid and vaccines, while 75% of public spending in Afghanistan was subsidized by international aid provider IRC (2023). Recently, China opened a bilateral working group with the Taliban on humanitarian assistance and economic rebuilding in December 2021 (The Diplomat, 2022). According to an article in the Diplomat released in July 2022, Beijing has delivered a dozen batches of humanitarian aid to the Taliban, with the latest aid delivered by Chinese military jets to Afghanistan. There is no doubt that China's vaccine diplomacy is aimed to secure China's economic and security interests in Afghanistan.

## PART III: ON ENSURING EQUITY

Afghanistan developed a National Deployment and Vaccination Plan (NDVP) in 2021, referred to as the National Plan for Covid-19 Vaccination in Afghanistan (NPCV-A), in line with WHO and UNICEF guidelines and following recommendations of the WHO's Strategic Advisory Group of Experts on Immunization (SAGE). The NPCV-A is the product of a joint group led by the MoPH and members of the National Technical Committee on COVID-19 (NTC). The working group includes technical and humanitarian partners and health experts (MoPH, 2021). As mentioned in the NPCV-A, the plan comports with all SAGE guidelines in prioritizing vaccine access for all and safeguarding against the exclusion of marginalized and vulnerable groups (MoPH, 2021).

The government and policy makers were responsible for not just acquiring vaccines, but also distributing them equitably among the country's population. Fair, equitable, and inclusive distribution of vaccines required capacity and ability, but Afghanistan has been dealing with many constraints, including a fragile healthcare system, a lack of infrastructure, and a lack of human resource capacity. Apart from these, an additional challenge that may have hindered or compromised Afghanistan's COVID-19 vaccination plan is the lack of general consensus on prioritized and vulnerable groups, due to unavailability of detailed and reliable data.

According to the NPCV-A, the following target groups were ultimately identified, in order of priority, reflecting Afghanistan's context and SAGE policies and strategies for vaccine development and allocation.

**Table 3: Prioritized target groups for vaccination**

No.	Sector
1	Health workers (MoPH, NGOs, and private health sector), including community health workers
2	Teachers in schools and universities (public and private)
3	Security personnel
4	Prisoners
5	People with comorbidities (e.g. heart diseases, TB, diabetes)
6	People over 50 years old



7	Nomadic population (ages 30-50)
8	People living in IDP camps (ages 30-50)
9	Returnees from neighboring countries (Iran and Pakistan) over the age of 30
10	Government and private employees working with crowds of people aged 18 years or above (e.g. Passport department)
11	People living in urban slums of big cities; emergency use for people age 18 and over

Source: MoPH- Afghanistan

As practiced in other countries, Afghanistan prioritized healthcare staff to be vaccinated first. Afghanistan's vaccination allocation plan was built on "the principle of equitable access and fair allocation of COVID-19 health products developed for the Access to COVID-19 Tools (ACT) Accelerator Covid-19 Vaccines Global Facility (COVAX)" (MoPH, 2021).

**Table 4: Prioritization of target groups for 20% of the population**

Vaccine shipment	Target population	Number	% of total population	Tentative arrival of shipment	Justification for group prioritization (from SAGE recommendation)
First shipment	All health workers (MoPH, NGOs, and private sector), including community health workers	128,000	0.33	Mar 2021	No care homes to first target very older people. Health workers are at high risk of disease.
	Teachers in schools and universities (public and private)	400,000	1.03		Weak infrastructure for mobile and internet services. It is not possible to set up a virtual education system. Vaccinating the teachers leads to opening schools for children.

Second shipment	Security Personnel	400,000	1.03	May 2021	Big number live in shared rooms (indoor) in military bases.
	Prisoners and residents of women's shelters	33,000	0.08		Similar conditions to those of security personnel.
	People with comorbidities (e.g. heart diseases, TB, diabetes)	130,000	0.33		Co-morbidity puts individuals at high risk.
	People over 50 years	2,334,000	6.00	Jul 2021	At high risk by default.
Third shipment	Nomadic population (all men and women ages 30-50)	300,000	0.77		Nomads are a population on the move increasing their risk of contracting the virus.
	People living in IDP camps ages 30-50	300,000	0.77		Living either in camps or miserable situation.

Fourth shipment	Returnees from neighboring countries (Iran and Pakistan) over 30 years	400,000	1.03	Sept 2021	Risk of virus circulation and transmission of the virus to others.
	Government and private employees working with groups of people ages 18+ (e.g. passport department)	100,000	0.26		Some departments or institutions handle a large number of clients on a daily basis (e.g. passport department has over 2,000 clients/day.)
Fifth shipment	People 18+ living in urban slums of big cities, and emergency uses	3,258,000	8.38	Oct-Nov 2021	Poor hygiene practices, poor living conditions, living in shared facilities, poor living situations. Emergency use means any eligible group who is not known/noticed now but will be identified during implementation
<b>TOTAL</b>		<b>7,680,000</b>	<b>20.01</b>		

Source: MoPH- Afghanistan

There are some discrepancies between Afghanistan's priority groups for vaccination and the international scheme for COVID-19 vaccination. According to Afghanistan's vaccination plan, health workers and teachers are prioritized first and second, followed by security personnel, prisoners, people with comorbidities, people over the age of 50, nomadic people, and more. But the international allocation scheme for pandemic COVID-19 vaccines targets essential workers first, which extends beyond healthcare workers. The international scheme says: "Essential workers might include, but are not limited to, workers in the food industry and domestic transportation, police and military staff who maintain public safety, and workers who maintain electricity, water, fuel, information, and financial infrastructures" (Wang et al., 2020). The international scheme also targets people who might experience irreversible and devastating harm from COVID-19 (that is, admission to hospital, admission to critical care, and death).

Target populations include people older than 65 years, and those with high-risk health conditions. Finally, the international vaccine allocation scheme focuses on reducing SARS-CoV-2 transmission, meaning that high transmission groups should be targeted. Target populations include adults and children involved in economic or educational activities who experience a higher risk of economic or educational harm from not working or going to school (Wang et al., 2020). Afghanistan's vaccination plan prioritized prisoners and nomadic people, and included them in the first essential workers' group, justifying the latter group by saying "Nomads are a population on the move increasing their risk of contracting the virus".

According to the NPCV-A (Tables 3, 4), the target groups identified for the first stage (20% of the population, based on the assumption of planned COVAX provision of vaccine doses) were meant to be vaccinated by the end of 2021. The remaining population was to receive vaccines based on the availability of vaccines outside COVAX, with people with disabilities and those older than 18 but not included in the above table identified as target groups for the additional vaccination. According to Human Rights Watch report 2020, Afghanistan has one of the largest populations per capita of persons with disabilities in the world (HRW, 2020). The first-ever government survey on disability in Afghanistan concluded that a family member in approximately one in five households (or roughly 1.2 million people) has a "severe disability", and a family member in nearly two in five households (or roughly 2.4 million people) has some type of disability (Shinwari, et al., 2020). According to Shakespeare et al. (2021), people with disabilities globally have been affected by COVID-19 on multiple levels, including by facing many barriers to inclusion in the COVID-19 response. In Afghanistan, the spread of COVID-19 caused greater inequality between people with disabilities and other citizens, and it caused people with disabilities to face multiple forms of discrimination, access constraints, social barriers, and lack of access to vaccines.

The NPCV-A prioritized the target groups (Table 3) to be vaccinated in the first stage by the end of 2021. However, this study shows that the vaccination program ran according to the plan only for a short period. According to the NPCV-A, around 7,780,000 people (20% of the population) should have received vaccines by the end of 2021; however, only 4,856,713 people (12.1%) had received at least one dose by the end of 2021. Many factors caused this mismanagement, such as interference and influence of authorities, corruption, issues with vaccine delivery and transportation, vaccine hesitancy, political change, and the incompetence of the Taliban administration.

Additionally, government personnel and people with relationships within healthcare bodies received vaccinations first. According to the DHIS2 data portal, people in major cities rushed to get vaccines in July 2021, but the rate dropped after the political changes in August 2021.

Afghanistan has also faced challenges related to COVID-19 vaccine hesitancy, worsened by a low literacy rate (37.27%) and the suspicious mindset of Afghan people. Despite available information, education, and communication, materials were developed from the Islamic perspective during the prior administration (including

a fatwa regarding COVID-19 preventive measures), and measures to address vaccine hesitancy were carried out by the Ministry of Religious Affairs and the WHO. Furthermore, materials were prepared for people who are illiterate or lack access to the Internet. According to a study conducted in late 2021 (Nemat et al., 2021), less than two-thirds of the Afghan public was willing to take the COVID-19 vaccine, and a significant portion had reservations about taking it. The negative perceptions of those unwilling to take the vaccine may also have influenced others and posed a challenge to implementing the COVID-19 vaccination program targeting the eligible population. In interviews with Aga Khan Health Services in Afghanistan (AKHS), Bu Ali Rehabilitation & Aid Network (BARAN), and Bakhtar Development Network (BDN), respondents said that people in Afghanistan hesitated to take vaccines, believing that the vaccines have negative side effects and might result in disabilities (AKHS, BARAN, BDN, interview, 2022).

Vaccine hesitancy was also driven by misinformation (Nemat et al, 2012). Initially, misinformation circulated by word of mouth within the Afghan community, with people saying things like “COVID-19 vaccine causes blood clotting and will kill a human within one year”, “vaccines will make men and women infertile and then kill them”, and “COVID-19 is a human-made virus made to reduce the Muslim population” (RTA, interview, 2022). Low levels of confidence, illiteracy, religious beliefs, and mistrust of the government have fueled vaccine skepticism in Afghanistan. According to Nemat (2021), many Afghans still perceive COVID-19 as a hoax or as exaggerated, instead of as a serious public health threat. To counter disinformation, the Afghan government ran public awareness programs by engaging with existing public health and community-based networks, media, local NGOs, schools, local governments, and other sectors such as health service providers and business and private sector actors, while emphasizing the use of two-way channels to detect and counter misinformation.

## PART IV: ON ENSURING SELF-RELIANCE, TRANSPARENCY, AND ACCOUNTABILITY

At the beginning of the COVID-19 outbreak in late 2019 and during its fast spread around the world in 2020, high-income countries rushed to manufacture vaccines for immunization against the virus. In February 2021, most high-income countries started to vaccinate their populations, but low-income countries like Afghanistan — where a protracted conflict has made the economy and healthcare system fragile — were not able to afford COVID-19 vaccines. While Afghanistan has struggled to manage vaccines through COVAX and aid from friendly countries, its health system has already suffered from conflict and political instability, and it has failed to develop a successful response.

Besides challenges in obtaining vaccines, the country’s vaccination program has had shortfalls in funding the vaccination program; problems with vaccine distribution, monitoring, logistics, and delivery; and a lack of coordination and communication with the public and local civil society organizations.

Afghanistan’s healthcare system heavily depends on international partners and INGOs, and the government in Afghanistan contributes only approximately 5% of the country’s public health services budget (Wardak et al., 2021). According to an MoPH estimate (Ministry of Finance, 2021), USD319 million was needed to cover 60% of the population. Based on the National Statistics and Information Authority’s (NSIA) estimation, around 47% of the Afghan population is under the age of 15. By vaccinating the eligible 60% of the population (with the UN total population project estimating Afghanistan’s total population at 39 million as of February 2021), Afghanistan excluded from vaccination people under the age of 15, which accounts for approximately 40% of the population.

The USD319 million estimate included vaccine costs, operational costs, cold chain, training, and capacity building. According to the MoPH (Ministry of Finance, 2021), international partners provide financial support for the NPCV-A. In brief, COVAX committed to financing COVID-19 vaccine doses for 20% of the population, with an estimated cost of USD84 million. Meanwhile, the World Bank committed to supporting Afghanistan’s COVID-19 vaccination program through technical assistance, vaccine delivery, equipment, and payment for vaccinators, totaling an estimated USD63 million; the Afghanistan Reconstruction Trust Fund (ARTF), a multi-donor trust fund administered by the World Bank, provides USD50 million as co-financing for the project. Additionally, Afghanistan received USD50 million from the Asian Development Bank’s Asia-Pacific Vaccine Access Facility (APVAX) (Asian Development Bank, 2021), aiming to cover: (1) procuring and delivering COVID-19 vaccines to the target groups; and (2) strengthening the capacity of the MoPH to procure and deliver the vaccines. That said, Afghanistan needs USD72 million more to fully implement the vaccination program.

When it comes to data collection, surveillance, and monitoring the NPCV-A, Afghanistan has adopted the three following strategies:

- Utilization of the MoPH DHIS2 platform to collect data and disseminate the results during the COVID-19 vaccine introduction;
- A Smart Paper Technology (SPT) system, to collect real-time data from health facilities; and
- Utilization of the existing Regional/Provincial EPI Management Team (REMT/PEMT) and Partner Supervisors: while receiving health facility data through the DHIS2, the MoPH also utilizes the provincial EPI management teams (PEMTs), Basic Package of Health Services (BPHS) implementing NGOs, and partners (i.e. UNICEF, the WHO, etc.) to monitor the implementation of the COVID-19 vaccine introduction.

The above methods have been used as data monitoring infrastructure to ensure the target population is vaccinated and the vaccine implementation progresses as planned. Nevertheless, the vaccination data has never been shared publicly since the Taliban takeover.

Lastly, the NPVC-A addresses the subject of public and CSO engagement and involvement in the vaccination program as follows: “The roles of stakeholders can include (but are not limited to) planning, funding, formulating strategies, directing the policy, facilitating the implementation, providing technical and operational assistance, increasing the demand, helping the health workers during vaccination, negotiating with non-government actors for access, advocating for political commitment, protecting the health workers during conflict (if it occurs), designing the guidelines and protocols, coordinating the activities, monitoring and evaluation, capacity building, administering the vaccine to target groups, reporting, and so on”. According to the NPCV-A, the role of NGOs in monitoring is highlighted as major, but only implementing NGOs. CSOs working with, or functioning as part of, NGOs are not mentioned. The public’s stipulated role in initiating is minor, while its role in planning, executing, and monitoring is considered major; however, this is contradicted by the findings of this study.

## PART V: CONCLUSION

Years of protracted conflict, political instability, and the 15 August 2021 regime change in Afghanistan have further weakened its already fragile healthcare system’s ability to develop COVID-19 countermeasures and implement its COVID-19 program. Despite the last two decades of international aid flow into the country, the MoPH has only had piecemeal development in health service delivery.

The scarcity of necessary tools to confront and respond to COVID-19 and deploy vaccines have been missing in Afghan healthcare institutions, such as funding, sufficiently trained medical personnel, and processes for administration and distribution of vaccines. At the same time, vaccine hesitancy, an ‘infodemic’, and poor access to health information are among the other factors that hurt Afghanistan’s response.

Since the COVID-19 outbreak, there have been certain challenges within the healthcare system — particularly access to health information. This challenge escalated when the Taliban came into power on 15 August 2021. Under the Taliban, the MoPH has been reticent to inform the media and general public about the pandemic and vaccination efforts despite the growth in COVID-19 cases. Since early 2022, the Taliban has stopped providing information to the public on vaccination efforts. The general public’s understanding of COVID-19 and readiness to take measures has been hampered by pervasive, widespread poverty and illiteracy, and many Afghans have simply been absorbed with other daily hardships.

Afghanistan’s COVID-19 vaccination program has been challenging; there has been low vaccination coverage in the country. A total of 34.5% of the Afghan population has received at least a single vaccine dose — one of the lowest national vaccination rates in the world.

The Taliban administration does not seem to have a clear plan to fight the pandemic. Therefore, these are the recommendations based on the findings of this study:

- INGOs, healthcare workers, and other stakeholders should stay alert and combine their efforts to rescue an already plagued nation. Most hospitals designated for COVID-19 have stopped their operations due to insufficient funds.
- The MoPH should continue its awareness campaigns to keep the most vulnerable groups safe and protected.
- The MoPH must strengthen the level of collaboration and coordination with media and religious and community leaders to encourage people to get vaccinated.

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## ABOUT THE RESEARCHER

Abdul Wali Rasta has worked in different capacities with several organizations in Afghanistan and Central Asia, including in the security sector, research think tanks, national and international organizations, and academic institutions. He is equipped with theoretical as well as practical knowledge and experience in research, public policy development, analysis, and training. His main focus areas are promoting democratic development, human rights, and civic space with particular interest in advocacy for minority rights. Wali served as the Deputy Director of Porsesh Research & Studies Organization (PRSO), a local human rights policy research think-tank in Kabul, Afghanistan, where he advocated for the rights of Afghan non-Muslim minorities. Wali received his B.A in Social Sciences from India. He completed a post-graduate diploma in Military and Defense Studies from HNMG University, India. Wali earned his Master's Degree in Public and Municipal Administration from KIMEP University, Kazakhstan.

