Migration MPTF

JOINT PROGRAMME DOCUMENT

PROJECT INFORMATION	
Joint Programme Title:	Managing Health Risks linked to Migration in Afghanistan: Operationalization of International Health Regulations
Country(ies)/ Region (or indicate if a global initiative):	Afghanistan
Convening UN Organization:	IOM
PUNO(s):	WHO
Implementing Partners	Ministry of Public Health (MoPH), Provincial Public Health Directorate (PPHD), Ministry of Interior (MoI), Afghan Border Police (ABP), Afghan Civil Aviation Authority (ACAA), Ministry of Return and Reintegration (MoRR), Directorates of Return and Reintegration (DoRR) and select civil society organizations
Migration MPTF Thematic Area *(select one and delete others)*	Thematic Area 2: Protecting the human rights, safety and wellbeing of migrants, including through addressing drivers and mitigating situations of vulnerability in migration
Primary GCM objectives	**Obj 7**: Address and reduce vulnerabilities in migration; **Obj 12**: Strengthen certainty and predictability in migration procedures for appropriate screening, assessment and referral
Relevant SDG Target	**SDG 3, target d:** Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks; **SDG 10, target 7:** Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies
Expected Project Commencement Date Period of Implementation (in months):	Expected start date: To be determined alongside the Migration MPTF, potentially 1 August 2021 – 31 July 2023 (for a period of 24 months)
Requested Budget	USD 2.9 million (IOM: USD 1.52m; WHO: USD 1.38m), For gender and women's empowerment initiatives: $511,030 (32% of programmatic budget)
Project Description	This joint project aims to reduce the transmission of communicable diseases across the borders of Afghanistan through the improved implementation of International Health Regulations (IHR). Building on the technical and thematic areas of expertise of the World Health Organization (WHO) and the International Organization for Migration (IOM), it will take a multi-faceted approach to i) build a comprehensive

	knowledge base and support legal and policy frameworks on IHR, ii) conduct capacity building and infrastructure upgrading at PoEs, iii) strengthen community-level surveillance systems and awareness and iv) ensure cross-border cooperation and interlinkages with Pakistan and Iran. This project will be implemented within and informed by the context of the COVID-19 pandemic, but will provide critical support to prevent, detect and respond to the numerous infectious diseases detected in Afghanistan, with a particular frequency in migrant populations, including tuberculosis, malaria, cholera, Crimean-Congo hemorrhagic fever, arboviral diseases (dengue, chikungunya), leishmaniasis and hepatitis B, among others.

Marker Questions	
Human Rights Marker Score	A
Gender Marker Score	B
Child Sensitivity Marker Score	C

SIGNATURE PAGE

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PUNOs (PUNO)	
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Chair of the Migration MPTF Steering Committee
Name
Date
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JOINT PROGRAMME PROPOSAL NARRATIVE

1. Migration Context and Rationale

Migration, mobility dynamics and health outcomes in Afghanistan

Forty years of conflict has shaped Afghanistan into a country defined by large scale displacement, migration and return. This encompasses internal displacement driven by conflict and natural disasters, as well as mass out-migration into Iran, Pakistan and beyond, and consequent return flows. The associated mobility dynamics are complex and dynamic, shifting in volume and frequency based on a range of internal and external drivers. They include a high volume of both formal and informal cross-border trade, cyclical labour migration and trans-national communities that operate via porous border crossings on the Afghan-Pakistani and Afghan-Iranian frontiers. To illustrate scale, from 1 January to 22 March 2021, over 6,622,000 million border crossings into Afghanistan were logged from Iran and Pakistan.[1]

In 2020, driven by the impacts of the COVID-19 pandemic, cross border movements spiked. This has continued and intensified in 2021, with more than double the rate of undocumented migrants returning in the first three months than as the same period in 2019 and 2020.[2] Alongside the uncertain outcomes of the ongoing peace process, the expecting continuity of the de-stabilizing impacts of COVID-19 is expected to continue to drive further waves of increased cross-border movement. Accompanying the pandemic and these mobility dynamics has been a renewed attention to *long-standing gaps in communicable disease detection, prevention and response measures in Afghanistan, particularly at Points of Entry (PoEs), and the extent to which mobile populations and communities in mobility pathways are at a heightened risk of disease exposure and transmission*. A systematic review of Afghan migrants in the Islamic Republic of Iran revealed that 29 percent of migrants are suffering from infectious diseases, including tuberculosis (TB), multi-drug resistant TB, malaria, cholera, Crimean-Congo hemorrhagic fever, arboviral diseases (dengue, chikungunya), hepatitis B, and are prone to other emerging and re-emerging diseases.[3] In 2019, in coordination with the Afghan Civil Aviation Authority (ACAA), IOM health screening for forced returnees from Turkey at the Hamid Karzai International Airport (HKIA) in Kabul showed that around 37 per cent of the deportees were suffering from scabies.[4]

While migration and mobility are increasingly recognized as determinants of disease exposure risk[5], the volume, rapidity and ease of today's travel and necessity of trans-national trade also pose challenges to cross-border disease control. As such, Afghanistan's under-resourced health and border management systems along major mobility pathways and in border areas require innovative, systemic and multisectoral public health strategies for communicable disease prevention, detection and response. In Afghanistan, a country in which health infrastructure remains limited and many communities report access to health care remains a major challenge,[6] ensuring robust detection and preventative measures are in place plays

1 See IOM Afghanistan's COVID-19 Cross-Border Migrant Inflows dashboard: https://afghanistan.iom.int/IOM-COVID-19-Response#District%20of%20Return%20in%20Afghanistan , accessed 23 March 2021.

2 Ibid.

3 Pourhossein B, Irani AD, Mostafavi E. Major infectious diseases affecting the Afghan immigrant population of Iran: a systematic review and meta-analysis. Epidemiol Health. 2015;37:e2015002. Published 2015 Jan 7. doi:10.4178/epih/e2015002.

4 Health database of IOM's Refugee Return and Reintegration (RRR) programme, IOM October 2019.

5 WHA Res. 61.17, Health of Migrants, 2008

6 On average, the closest accessible healthcare facility per household is 23 kilometers away, with only 23 per cent of survey participants stating they had access to health care facilities within their settlement. See: Afghanistan – Baseline Mobility

a critical role in improving public health outcomes, both for migrants and the overall population. This is particularly true for women, who may face limitations in accessing healthcare due to a lack of access to female doctors. Recognizing the specific needs and vulnerabilities of female migrants and returnees is dually important in a context where 4.2% of the overall flow of returns from Iran and Pakistan were single females in the first nine months of 2020.

Status of IHR implementation in Afghanistan

In 2009, the Government of the Islamic Republic of Afghanistan (GoIRA) endorsed the International Health Regulations (IHR, 2005), an international legally binding agreement of 196 State Parties[7] with the purpose and scope "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade".[8] Under IIHR state parties are asked to develop core public health capacities, including legislation and policy, coordination, surveillance, response, preparedness, risk communication, human resources and laboratory capacities at points of entry (PoE) and for IHR related biological, chemical, radiological or nuclear hazards.

In Afghanistan, WHO is providing technical support on the required capacities under IHR for infectious, chemical and radiological events at PoEs at national and sub-national levels, however these capacities have been mostly mobilized during Public Health Emergencies of International Concern (PHEICs, i.e. Ebola outbreak, COVID-19). *Overall, the PoE lack necessary infrastructure, trained personnel, operating procedures and mechanisms to adequately and routinely implement IHR.* A 2016 joint external evaluation (JEE) of Afghanistan's IHR core capacities detailed a series of major compliance gaps in Afghanistan's adherence to IHR. While the JEE showed strong cooperation and coordination with security authorities (80%), real time surveillance system (75%), zoonotic diseases (67%) and vaccine access and delivery (50%), all other areas did not even meet 50% of required capacities. Annual self-assessments also show PoEs meeting an average of only 9% of all IHR capacity requirements.[9]

Therefore, in order to enhance the management of cross-border flows and improve public health outcomes, particularly for migrant populations, and in line with on-going efforts and needs recognized by the Ministry of Public Health (MoPH), **IOM and WHO propose a two-year joint programme to strengthen the implementation of International Health Regulations (IHR) in Afghanistan, focusing specifically on key Points of Entry (PoE) and communities of high return. This will provide a useful tool for bridging public health and border management engagements, which have remained mostly siloed in Afghanistan, strengthening mechanisms to curb disease transmission and improve health outcomes of migrants and affected communities**. Particular attention will be given to ensuring that staffing and programme design takes into consideration the needs of women migrants and community members, and the possible impediments they face in participating in programme activities and accessing information and services.

Assessment Summary Results (January – June 2020), IOM Displacement Tracking Matrix (DTM) Report, October 2020, available at https://displacement.iom.int/reports/afghanistan-%E2%80%94-baseline-mobility-assessment-summary-results-january%E2%80%94june-2020, accessed on 10 March 2021.

[7] Including 194 member states of WHO

[8] WHO, 2016, International Health Regulations (2005), https://www.who.int/publications/i/item/9789241580496

[9] International Health Regulations (2005) Monitoring Framework - Country profiles [Internet].; 2017 [cited Sep 27, 2020]. Available from: https://www.who.int/Global Health Observatory.

The programme has been designed in response to needs identified by WHO and IOM, alongside public health and border management partners, through prior assessments, direct operational experiences in disease surveillance and mobility tracking, as well as close engagements with border communities and migrants. It is also centrally informed by prior experience by IOM in implementing health and humanitarian border management programmes in the Ebola virus responses in West and Central Africa (See Appendix 2). The project will be shaped through assessments at the on-set of the project and continuously shaped and informed by stakeholder inputs through inclusive management and feedback systems. As with the rapid roll out of COVID-19 prevention and response measures in 2020, community leaders, civil society and community members will play a key role in ensuring local dynamics and capacities are reflected and buy-in is achieved in support of these efforts.

Given the scale of this programme and migration dynamics in Afghanistan, this project is targeting five key Points of Entry in Afghanistan, focusing on the borders with Iran and Pakistan. Currently, there are three designated PoE (Hamid Karzai International Airport in Kabul, Torkham Ground Crossing with Pakistan in Nangarhar Province and Islam Qala Ground Crossing in Herat Province) targeted to develop required capacities for implementation of IHR. Due to its criticality as a transit point for goods, livestock, and some 40,000 persons per day on average, Spin Boldak Ground Crossing on the Pakistan border in Kandahar Province, will also be included under the parameters of this project. In addition, the Melak Ground Crossing in Nimroz Province, which is a key crossing point with Iran for returns of incarcerated individuals and migrant workers, which are populations with notable disease exposure risks, will also be targeted for support within this project. These four land points (shown below in Image 1) are considered the highest volume points of entry from Iran and Pakistan while the Hamid Karzai International Airport in Kabul is considered the key PoE for international arrivals by air.

Complementarity and Additionality.

This joint programme takes a complementary, multi-level approach to engage stakeholders, build capacities and raise awareness related to IHR and communicable disease prevention at the national, provincial, PoE, community and individual level. In doing so, the programme is taking a novel, and much-needed approach to strengthening IHR in Afghanistan, ensuring both institutions and people are centered in programme design and implementation.

WHO has been working with MOPH on developing IHR core capacities, including for PoE, in Afghanistan since 2009, while IOM has been working in supporting migration health in border communities and at PoE in various iterations since the 90s. During COVID-19 response, the need for enhanced capacities at the PoEs was underscored, with government authorities and partners working to develop the required capacities in the PoE to minimize the impact of COVID-19 interference on travel and trade. In support of this WHO has been supporting MoPH on developing technical guidelines for screening travelers, education messages and materials to travelers and IOM has been supporting the PPHDs at provincial level for the deployment of Rapid Response Teams (RRTs) and screening teams at PoEs. These actions have been complementary and allowed the agencies and MoPH to complement each other and fill the gaps that arose specifically during COVID-19 response.

The programme will build upon these and other on-going efforts from WHO, IOM and partners to support Afghanistan to better understand, develop and institutionalize the prevention, detection, preparedness and response capacities needed at PoEs and mobility corridors. While a national health policy exists, no

component fully covers the gamut of IHR implementation.[10] To apply effective control measures at all PoE given the lessons learned of COVID-19 response, national legislative mandates and policies are essential for ensuring the development and sustainability of timely detection and response mechanisms. This includes policies for risk assessment, inspection, investigation, response, and quarantine of suspected cases/ill travelers. The development and roll-out of related SOPs, including for training of border officials, responding to various situations of concern at PoE and undertaking cross-border engagement and information sharing, is also key for ensuring capacity development and sustainability. Assessments undertaken under this programme will build from existing works, filling in key information gaps to inform the rest of the programme, as well as efforts outside the parameters of this project, i.e. capacities for the examination of livestock for zoonotic diseases.

Experiences from IOM, WHO and partners in directly implementing support at PoEs and in communities, as well as across borders, will likewise be leveraged upon. For example, at the Airport in Kabul IOM has a medical team which conducts post-arrival medical screenings for all undocumented Afghan returnees from Europe and Turkey. As a result, the organization is familiar with the common ailments faced by these populations, alongside the strengths and weaknesses of the public health related infrastructure at the airport. In addition, during the roll out of COVID-19 symptoms screening at the PoEs in Afghanistan, many challenges emerged, including a lack of supplies, staffing and formal coordination mechanisms between appropriate PoE authorities and relevant public health staff. Such lessons provide useful material for informing assessments and capacity building efforts under this project. In addition, through efforts on COVID-19 surveillance, the management of transit and reception centers under the Cross Border Return and Reintegration (CBRR) programme[11] at all four target PoEs and border management interventions at key land PoE and border areas, IOM has a ground-level, operational understanding of the current physical infrastructure and capacities for disease surveillance, detection and isolation of suspected cases at PoE in Afghanistan. Notably, there are efforts at Torkham and Islam Qala to finalize the construction of infrastructure for the use of the Afghan Border Police to roll out the Migration Information & Data Analysis System (MIDAS), which provides a platform for the registration of undocumented migrants, and strengthen their overall capacities. This provides a useful starting point to investing in up-grading and undertaking novel construction works to bring the PoE in line with IHR compliance. During COVID-19, a health module was created for the MIDAS system, which while currently rudimentary, could be looked at for synergies with the wider disease surveillance and notification system that is supported by WHO under their IHR support to MoPH.

Further, while strong efforts have been made by the Health Promotion Department and the Public Relations Department of the MoPH in the area of Risk Communication and Community Engagement (RCCE), the country lacks a communication strategy, operating procedures, a multisectoral platform for coordination (beyond COVID-19), focal points or trained risk communicators[12]. Protection Monitoring conducted by IOM between November 2020 and January 2021 also indicated a sharp increase in the returnee population reporting lack of awareness of COVID-19 (up from 11% to 29% in the previous quarter) and the need for additional RCCE efforts, especially targeted at returnees and migrant

[10] Ibid

[11] For more information, see https://afghanistan.iom.int/cross-border-return-and-reintegration

[12] WHO, 2016, Joint External Evaluation of IHR Core Capacities of the Islamic Republic of Afghanistan, https://www.who.int/ihr/publications/WHO-WHE-CPI-REP-2017.43/en/

populations.[13] This programme will offer a critical platform for strengthening and ensuring the continuity of these critical efforts, extended past COVID-19 specific efforts.

In addition, this programme will benefit from the detailed, and regularly updated information on mobility dynamics and areas of return gathered by IOM's Displacement Tracking Matrix (DTM) team. Through Flow Monitoring at Torkham, Spin Boldak, Melak and Islam Qala—the main PoE from Iran and Pakistan—the DTM team is able to map out where migrants departed from in Pakistan and Iran and their intended districts of destination in Afghanistan (shown below in Image 1 and as part of Appendix 1). These districts of high return, as well as notable locations (i.e. gas stations), settlements and towns along transit routes, referred to as "mobility corridors" throughout this proposal, can therefore be pinpointed as having an elevated risk of communicable disease exposure and transmission.

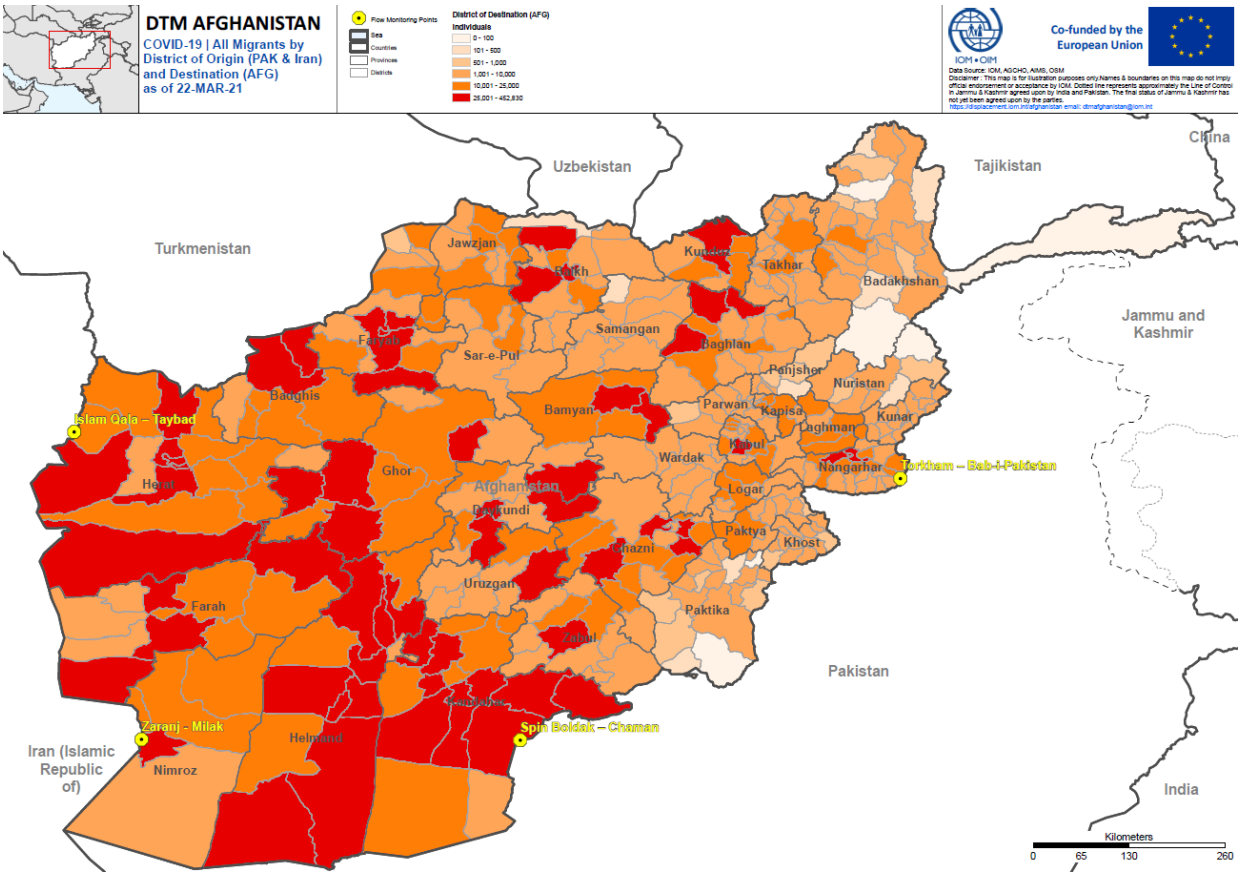

Image 1: Districts of high return for migrants returning/entering from Iran and Pakistan in Afghanistan

Using the regularly updated information, starting in 2020, through close coordination with the Ministry of Public Health (MoPH) and IOM's Migration Health Unit, the DTM team have been engaging with key health representatives and change agents in areas of high return and potentially high incidence of COVID-19 in Herat, Kabul, Kandahar, Mazar-e-Sharif, Jalalabad and Spin Boldak on COVID-19 RCCE. This programme will build off these to roll out RCCE and PMM exercises that cover a wide range of disease transmission, equipping institutions and at risk communities to recognize localized, mobility related public

[13] https://afghanistan.iom.int/sites/default/files/Reports/covid-19_protection_monitoring_report_iom_20210222.pdf

health gaps and inform the development of community level, event-based surveillance and notification systems that link into the national surveillance system. In addition, these RCCE activities have included targeted engagements with women, from which lessons will be integrated into this programme.

Currently, IOM is implementing a regional project TB screening and response project across Iran, Pakistan and Afghanistan. The steering committee meets annually with participation key stakeholders, including UN agencies and Ministries of Health for the three countries. Under this project, a harmonized approach to treatment guidelines have been developed for referral cases. More recently, a regional referral software application is under development for sharing patient data for referral cases where the data will be available across borders. Furthermore, there is active cross-border engagement amongst health officials from Afghanistan and Pakistan on Polio in Torkham and Spin Boldak which has been used for information sharing during the COVID-19 response. This programme offers an opportunity to expand upon these efforts, to explore how cross-border cooperation on mobility and public health in this sub-region can be explored more holistically, in line with IHR.

Linkages to relevant national strategic priorities:

The intervention aims to reduce the transmission of communicable diseases across the borders of Afghanistan through improved implementation of the IHR. To this end, significant consultation between international and national actors in Afghanistan, and within the UN in-country, have been ongoing since 2019. These consultations have solidified under UNHCR and IOM leadership on pillar 5 – Points of Entry – in the WHO-lead COVID-19 response plan. This programme also supports the National Actional Plan for Health Security (NAPHS, 2019-2022), based on the results of the JEE of IHR Core Capacities of the Islamic Republic of Afghanistan, completed in 2016. It is also based on ongoing consultation with the Provincial Public Health Directorate (PPHD), Afghanistan Border Police (ABP) officials and provincial Directorates of Refugees and Reintegration (DoRRs). At the central level, consultations have been held with the Ministry of Refugees and Repatriations (MoRR) and the General Directorate of Monitoring, Evaluation and Health Information System, the IHR National Focal Point (NFP) in the MoPH about how best to address the issues identified. During the consultations and the country priorities under NAPHS for PoEs, the **relevant officials indicated a strong commitment to develop IHR core capacities, particularly at the PoEs.** This programme is designed to capitalize upon this renewed and timely commitment in support of sustainable impact, actively involving key stakeholders at the PoE including MoPH/IHR NFP, Provincial Public Health Directorate (PPHD), Afghanistan Border Police (ABP), Civil Aviation Authority (ACAA), Ministry of Refugees and Repatriations (MoRR), civil society and communities around the border at all stages of the intervention.

At the UN level, within the "One UN for Afghanistan" [14] plan there is a specific Outcome dedicated to health systems strengthening (4.1), with a particular mention of health regulations. The UN in Afghanistan is currently in the process of developing its new United Nations Sustainable Development Cooperation Framework, which is likewise expected to make a specific mention of this area of intervention.

Alignment to the GCM, SDGs and Relevant Frameworks:

This intervention is in line with key priorities of the Global Compact on Migration and Sustainable Development Goals (SDG). By ensuring there are strengthened measures for screening, assessing and referring suspected cases/ill travelers at border points and in communities characterized by high levels of

[14] Adopted in 2018, this document serves as a UN-specific add on to the Afghanistan National Peace and Development Framework (ANPDF), drafted at the request of the President's office. https://afghanistan.un.org/sites/default/files/2020-08/One-UN-for-Afghanistan-03042018.pdf

mobility (GCM Obj 12), IOM and WHO will meaningfully contribute to addressing and reducing a significant driver of individual and community-level vulnerabilities associated with migration (GCM Obj 7). The COVID-19 pandemic has underscored the importance of ensuring universal capacities to implement early warning, risk reduction and management of national and global health risks (SDG 3, target d). In doing so, this project centrally contributes to the overall target of facilitating orderly, safe, regular and responsible migration and mobility of people, by ensuring migration can be undertaken without undue health risks to both mobile populations and the wider population (SDG 10, target 7). This program is also in line with and informed by the pillars from WHO's World Health Assembly Resolution on the Health of Migrants (2008) and its subsequent Global Consultation on the Health of Migrants (2010).[15]

At the national level, the immediacy of COVID-19 has added urgency to the need for action on strengthening IHR, with the MoPH requesting support for the implementation of the NAPHS (2019-2022), and the Provincial Public Health Directorates (PPHD) in four border provinces also requesting assistance[16]. The implementation of IHR is in line with the National Health Strategy (2016-2020) sub result 6.4, related to timely responses to disease outbreaks and public health emergencies of international concern (PHEICs).

2. Results Framework and Theory of Change

Results Framework:

The project will *contribute to a reduction in the transmission of communicable diseases across the borders of Afghanistan.* This will be achieved through *improved implementation of International Health Regulations in Afghanistan* through four key areas of intervention, which as describe below are complementary and build on each other.

Outcome 1: Government and civil society actors in Afghanistan effectively plan and inform interventions to strengthen International Health Regulations (IHR) capacities at PoEs and target communities in Afghanistan.

Output 1.1: A combined assessment of the implementation of IHR for key PoE is available to guide contingency planning. In quarter one, a joint PoE assessment team, including WHO, IOM, UNHCR, MoPH, ABP and Customs officials, will assess the implementation of IHR at the three existing, IHR mandated PoE, the International Airport in Kabul, Torkham crossing with Pakistan in Nangarhar Province and Islam Qala crossing with Iran in Herat as well as the Spin Boldak crossing with Pakistan in Kandahar and Melak with Iran in Nimroz. Using tools from WHO on IHR adapted to the local context[17], this will include an examination of existing guidelines/SOPs This assessment will include particular considerations/modules to account for and analyse the different experiences various populations may face at PoE, inclusive of age, gender and disability. This will include access to information, treatment by staff at the border and gaps in service provision.

The findings of the assessment will be used to support the implementation of other outputs and create a baseline for future assessments. In addition, under this output, an operational **public health contingency**

[15] https://www.who.int/migrants/publications/mh-way-forward_consultation-report.pdf

[16] Request letter to IOM from Nimroz PPHD, dated 2 February, 2020

[17] International Health Regulations (2005): Assessment tool for core capacity requirements at designated airports, ports and ground crossings. https://www.who.int/ihr/publications/PoE/en/

plan for timely detection and response to public health events at the PoEs will be developed, based on the findings of the assessments and ensuring that it meets the need of different populations, including specific considerations for the needs of women and children. ***WHO lead; IOM support***

Output 1.2: Government and civil society actors have access to IHR-related legislative assessments and recommendations in support of policy and legal frameworks. The project will assess the legislative and policy framework to identify key gaps to support advocacy, consultation and drafting for policies and procedures on risk assessment, inspection, investigation, response and quarantine of suspected cases/ill travelers. Necessary legal amendments to the National Public Health Law, Civil Aviation Law, 2012, Regulation for Aviation Security Directorate, 2015, Afghanistan Custom Law, 2005, and Civil Aviation Regulations in Afghanistan, 2015, based on IHR (2005) requirements, will be supported by a national committee of legal advisors and public health officers. The assessment will also examine whether particularly vulnerable groups present at PoEs, including single women, children, disabled individuals and women-headed households, are sufficiently included under the aforementioned legal laws/regulations and advocate for greater attention where needed. Specific and recommendations will be provided to address the gaps based on these findings. The extension of IHR regulations to cover additional high-volume points of entry will be a priority. Advocacy efforts, including workshops and ad hoc meetings, will be undertaken in support of spreading information on the findings of the assessments and recommendations, as well as in pushing the proposed legal amendments forward for adoption. ***WHO lead; IOM support***

Outcome 2: Key target land and air PoE more effectively implement IHR (Islam Qala, Melak, Torkham and Spin Boldak land crossings and Hamid Karzai Airport in Kabul)

Output 2.1 A comprehensive capacity building plan for government (MoPH and ABP) and civil society actors is developed and rolled out. This will include training for PoE-related staff on risk assessment, inspection of conveyance, vector surveillance and control, personal protective equipment, screening, early detection, reporting, tracing, investigation and response, sample collection for suspected cases, waste management at PoE and disinfection, decontamination, disinfection, and deration. The development of the overall plan and training tools will be undertaken based on the training needs assessment through tailored WHO training tools for the required capacities under IHR at the PoEs. Given cultural sensitivities relating to women and gender dynamics in Afghanistan, the participation and nomination of women border staff will be ensured for all trainings to meet the needs of women crossing the targeted PoE. This will help ensure there are an adequate number of trained female staff to undertake the inspection of women's baggage, interviews, required investigations and tracing for public health events. All staff will also participate in gender modules that will be embedded in the training.

Given high levels of staff turnover at the border, it is expected that trainings will need to be conducted on a regular, 6-month basis. Similarly, simulation exercises will be run every six months. A designated training coordinator will be hired. During supervisory visits, additional on-the job training and coaching will be undertaken to enhance their efficacy and support further capacity building. The programme is targeting the training of a total of 150 officials, with at least 30% women. ***WHO lead on tool development and engagement with MoPH; IOM lead on roll-out of tools/trainings and engagement with ABP and Customs Authority***

Output 2.2 Infrastructure at Point of Entry (PoE) is better equipped to handle interviews, the isolation of suspected cases and expanded health and surveillance services. While this Output will be centrally informed by a joint assessment undertaken by IOM and WHO engineers and IHR experts, broadly speaking infrastructure upgrading and novel construction will aim to improve the availability at the targeted PoE of primary health care services and access to potable water, handwashing, public washrooms, and waste management facilities. The infrastructure upgrade will ensure availability of separate space for men and women. Currently, the PoEs lack proper facilities for interviews and isolation of suspected cases. Likewise, the current clinics require upgrades to provide the necessary services to all travellers crossing the PoEs, especially women, children and other persons with particular needs.

The project's core engineer and support staff will work closely with the WHO and MoPH IHR experts to design plans for all targeted PoE, however it is envisaged that specifically **Torkham and Islam Qala will be upgraded to be in line with IHR**. IOM is currently undertaking construction at the Torkham and Islam Qala border crossings, in partnership with the ABP, which lays a solid baseline of infrastructure for upgrading to further improve compliance with IHR.

For all five targeted PoEs, full designs and recommendations will be made on infrastructure-related up-keep and/or upgrades that would be required to bring them into further compliance with IHR, which would expand past the timeframe and budget of this project. This is due to the significant resources that would be required to fully undertake fully IHR-compliant construction at Spin Boldak and Melak, which are beyond the parameters of this project. However, this will provide a useful basis for further outreach to the government and donors to undertake these works. Local PoE-level ABP and health officials will be closely coordinated with during the assessment and design phase to ensure they understand the utility and importance of these plans and commit to supporting their implementation and upkeep.

During the assessment phase, the feasibility for minor works at Spin Boldak and Melak will be considered, within the parameters of the budget and in line with the baseline infrastructure needs for other activities, such as those under Outcome 3 on surveillance and referrals systems. ***IOM lead; WHO support***

Outcome 3: Community and PoE-based surveillance systems, reporting mechanisms and awareness raising efforts support effective and timely responses to the presence of communicable disease.

Output 3.1: Public health emergency surveillance systems are integrated and/or strengthened at the International Airport and key land crossings, as well as in key mobility corridors. Building off the results of the assessment conducted under Outcome 1 on PoE capacities, this output will include both systems - level and community-based interventions. This includes the development of SOPs for COVID-19 and other public health event reporting, registration and referral mechanisms, the integration of a PoE surveillance/health information management system within the indicator-based component of the national surveillance system and the strengthening of vector surveillance at PoE. At Torkham and Islam Qala, where IOM has been supporting the implementation of the Migration Information and Data Analysis System (MIDAS), which is currently used to register undocumented returnees, the project will explore potential complementarities between the medical module within MIDAS, which was developed in response to COVID-19, and the surveillance system.

Zero-point clinics and reception centers for migrants, including those run under IOM's CBRR programme in all four target PoE and provinces will be designated as sentinel sites for surveillance, in coordination with and as agreed upon with MoPH. The zero-point clinic will ensure provision of the needed services at

the PoEs for women. Under this output, a designated health official will be supported for each of the target PoEs, to support in detection, report, investigation and response to disease/events/outbreaks at PoE, with their salary and support costs covered for the duration of the project (up to two years). They will report to the surveillance coordinator/officer within the relevant PPHD and oversee the surveillance teams. The public health official at the PoE will also support training of border officials and community around borders for their active engagement in public health surveillance. They will be provided with tablets for online data entry/updates and mobile phones for communication with surveillance team members. Ambulance transfer services to appropriate medical facilities from PoE will also be supported as part of the referral mechanism. The screening team will be supported to screen, identify and interview suspected cases and 30% of the team will be women to screen and interview women for providing gender sensitive services.

Simultaneously, the project will further reinforce surveillance systems through **Population Mobility Mapping (PMM) exercises,** engaging stakeholders at provincial, district, and settlement levels to create a shared understanding amongst stakeholders on mobility dynamics and the associated potential transmission risks for a range of communicable diseases.[18] This will expand past PMM's that were conducted specifically on COVID-19 risks and enable communities to better recognize where a range of key public health gaps exist, specifically in relation to mobility dynamics, taking into account the experiences of specific sub-sets of the population, including women, youth and people with specific needs (PSNs) who will be among the key informants for the interview.

The results of the PMMs will critically feed into the development of community level, event-based surveillance, referral and alert systems, linking into and strengthening the existing national system, which was previously established by the MoPH with the support of WHO, with PoE and border community components being developed and strengthened. In particular, the community key informants of PMM, notably including women, will be trained and integrated in even-based surveillance of MoPH to report the events of concern of the population to the system. The participatory approach taken will ensure that the implementation of IHR in Afghanistan builds upon the strengths of existing information channels and methods for handling public health challenges at the community level, rather than attempting to put in place structures that will lack sustainability or buy-in. This will maximize sustainability, as the lessons learned and capacities developed will have wider applicability for systems strengthening and coherence. The PMMs will also inform targeted strengthening of local health systems to reduce the risk of transmission and contain potential and ongoing outbreaks.[19]

Under this project, **2 PMM exercises will be conducted per year, per target PoE and surrounding priority districts, as well as in one targeted priority district of high return, excluding Kabul and the International Airport (20 in total)**. The latter will serve as a pilot of this approach, with wider applicability across other districts of high return. The specific districts will be selected during the programme's first quarter, accounting for updates in dynamics and access from time of writing. Appendix 1 illustrates the mapping and analysis conducted by IOM's DTM that will help inform these decisions. ***IOM lead; WHO support, particularly on SOP/document development and links with national surveillance systems***

[18] For information on IOM's approach to PMM, see https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/mhd_infosheet_population_mobility_mapping_intro_2017.pdf

[19] IOM, 2016, Health, Border & Mobility Management: IOM's Framework for Empowering Governments and Communities to Prevent, Detect and Respond to Health Threats along the Mobility Continuum.

Output 3.2 Risk Communication and Community Engagement (RCCE) is available on health risks and border control at PoE and in border communities proximate to key border crossing. Leveraging the PMM efforts and existing RCCE materials and programming, engaged community leaders in border communities will discuss the transmission of communicable disease and the importance of border management controls, including communication mechanisms for early warning. In particular, IOM will engage its existing networks under the DTM programme, which span 12,600 communities across all districts nationwide, to ensure RCCE materials are rolled out and that the materials and methods for communicating with target populations are appropriate and effective for the local contexts. This will include taking into account gender, age and ability dynamics and reviewing whether previous approaches have been effective. During the two-year period of the project, IOM and WHO will undertake monitoring of RCCE messaging information retention and efficacy, strengthening materials and messages when possible. While there has been substantial push for RCCE roll-out during COVID-19, less has been done to robustly measure the impact, rather than just immediate intake of RCCE messaging.

As with COVID-19 specific RCCE efforts, outreach and messaging will be undertaken in a culturally and gender-sensitive manner. This will include separate sessions for women to ensure they have direct access to information

Under this output, there will also be a strengthened effort from WHO, in coordination with the MoPH, to advocate for and ensure strong and consistent messaging is being centrally produced, vetted and shared with PoE authorities and staff are trained on RCCE messages. ***IOM lead on implementation/roll out; WHO lead on materials, messages and guidelines development***

Outcome 4: Strengthened cross-border cooperation enhances early detection and response capacities at PoE and target communities

Output 4.1: Coordination and communication mechanisms exist at PoE for reliable early detection and response, including cross-border agreements.
In line with the defined IHR core capacities on communication[20], this project will build links between domestic and cross-border stakeholders to create sustainable relationships that support functional early warning and response systems at PoE.[21] This will include the formation of a joint technical working group for cross border collaboration at the national level and the formation of multi-sectoral PoE coordination committees at PoE and provincial levels. The PoE level committees will consist of key health and border officials at the PoE and will meet quarterly, whereas the provincial level committees, detailed under the Joint Management section as "Provincial Reference Groups", will be comprised of a wider range of stakeholders, including civil society and health shura, and will meet every 4-5 months. The exact schedule will be agreed upon at the first meetings.

Together, IOM and WHO will also organize a national workshop to discuss and agree upon national level guidance on cross-border collaboration measures and the roll out of the national protocol in Public Health information sharing (developed under output 3.1). This will have wider applicability outside the immediate scope of this project.

[20] International Health Regulations (2005): Assessment tool for core capacity requirements at designated airports, ports and ground crossings. https://www.who.int/ihr/publications/PoE/en/

[21] Due to the political nature of PoE, the cross-border collaboration initiatives need to be led by UN agencies including WHO and IOM in Afghanistan.

At the PoE level, cross-border collaboration events and joint simulation exercises will be held with key partners at least on an annual frequency, or more frequently, as it has often been requested from the Afghanistan side. Depending on COVID-19 or other restrictions, these will either be organized in person or over telecoms. The project will also work towards establishing tailored, agreed upon SOPs, ToRs or protocols with cross-border counterparts at each PoE on routine and emergency communication and alert mechanisms. The nature of these agreements would be more technical with a focus on the public aspects of joint collaboration, avoiding issues that would trigger any conflict between bordering countries. This will be closely monitored and discussed with IOM/WHO counterparts in Pakistan and Iran throughout the project.

This area of programming will build off the existing experiences of IOM, WHO and local authorities in cross-border cooperation on public health matters, as well as lessons from other contexts, including successes from the Ebola response in West Africa and existing collaboration on polio with Pakistan. The active cross-border engagement amongst health officials from Afghanistan and Pakistan on Polio in Torkham and Spin Boldak has been used for information sharing during the COVID-19 response. This collaboration will be expanded to include other public health events of mutual concern. Moreover, there is some informal cross-border collaboration occurring at the PoEs between the District Health Officer of Provincial Public Health Directorate (PPHD) and the PoE health staff of neighboring countries in Islam Qala, Torkham and Spin Boldak, including informal monthly, quarterly meetings conducted on joint collaboration and information sharing. Such collaborations will be augmented and strategized on public health events of mutual concern to increase the joint prevention, detection, preparedness and response capacitates at the PoE. Discussions on cross-border collaboration will be facilitated by IOM, WHO and the Provincial Public Health Directorate (PPHD), engaging IOM and WHO offices in Pakistan and Iran as well.

Moreover, the cross-border collaboration issue is also frequently raised in regional IHR stakeholders meetings. WHO will convene regional meetings to bring together the IHR NFPs of Afghanistan, Pakistan and Iran for information exchange and initiation of cross-border collaboration as highlighted in NAPHS (2019-2023). ***IOM lead; WHO support***

Theory of change:

IF (i) the capacities and needs of PoE are understood **AND** (ii) a comprehensive policy framework is informed to guide and advocate for IHR implementation, **AND IF** (iii) stakeholders are trained and have the resources to implement and maintain IHR at PoE, **AND** (iv) operational surveillance systems are able to timely identify and report public health emergencies and events, **AND** (v) border communities are aware of public health risks and early warning mechanisms, **AND IF** (vi) coordination and communication mechanisms and agreements exist to facilitate joint action, **THEN** the Republic of Afghanistan and supporting civil society will be able to reduce the cross-border transmission of communicable disease and respond to public health emergencies quickly and effectively **BECAUSE** (i) implementation needs are well understood by stakeholders, (ii) implementation of IHR is legally , institutionally and operationally supported, (iii) the capacities exist to implement IHR, (iv) there is early warning of public health emergencies, (v) border communities take pro-IHR actions during public health emergencies, and (vi) coordinated internal and cross-border action is taken.

Assumptions: (ia) COVID-19 restriction on international travel allow for field assessments, (ib) conflict levels do not increase, preventing access to PoE, (iia) government commitment remains sufficient for policy action (including after peace talks integration), (iib) turnover in administration allows for continuity in advocacy and policy action, (iiia) staff turnover is sufficiently minimal to maintain

capacity, (iiib) materials are available for construction and purchase, (iva) MoPH and ABP resources exist to sustain staffing, (va) access to communities is maintained, (vb) conflict does not trigger displacement in capacitated communities, and (via) political relationships between partners remain supportive of cross-border agreements.

3. Project Implementation Strategy

Joint Programme Implementation Strategy:

This two-year joint programme will capitalize upon and build synergies between the unique areas of expertise and added values of WHO and IOM, taking a new approach to effectively strengthen IHR implementation and public health outcomes for migrants and migrant affected communities. It will kick off with a meeting of the joint steering committee (defined below). This is designed to solidify key government and stakeholder buy-in at all levels, as well as to collect key inputs in support of final project implementation details at national and provincial levels. This includes specifying locations for PMM exercises and integrating additional interested and relevant stakeholders into the project, additional to those already identified. In this first quarter, **multi-sectoral PoE coordination committees** will be formed in each priority province and at the Kabul airport level, including key border and public health officials present at the PoE. Other management bodies, listed under the Joint Programme Management and Coordination section below, will likewise be formed during this period.

The PoE assessment under Outcome 1 and infrastructure assessment under outcome 3 will be undertaken during the first, and possibly second, quarter of the project depending on possible delays. Findings will guide the subsequent components on capacity building and infrastructure works. During this period other preparatory planning measures will be taken, such as hiring necessary contracted staff (i.e. engineers and RCCE staff), defining key RCCE messages and materials and fully developing the M&E plan. The subsequent quarters will follow the workplan and activity descriptions above, taking into account potential shifts in contextual dynamics that may require adjustments in implementation.

As detailed below, gender considerations will be actively considered and mainstreamed throughout the project by the programme management team, adjusting programming to better account for the experiences of and specific health needs of both women and men at PoE. This includes developing modules within the operational and legal assessments that consider gendered experiences at PoE and look at the extent to which relevant needs are reflected in relevant legal bodies, using the results to advocate for legal/policy amendments. In addition, the project will ensure the availability of gender and culturally sensitive infrastructure and staffing at PoE (the provision of separate spaces and staff) and that RCCE messages are informed by the experiences of women and rolled out using outreach methods that specifically target women (i.e. rolling out information on illnesses women are more susceptible to, women-only information sessions and engaging with shura/community leaders to increase women's participation and access).

While IOM and WHO will visit each PoE on a regular basis, the designated health officials will act as key guides in understanding the daily dynamics at the PoE and if the implementation of certain activities require adjustments. This will include ad hoc monitoring of the up-take of RCCE materials and access to reporting/accountability mechanisms at PoE.

The final quarter will include project closure events with key stakeholders and officials at the provincial and national level, final monitoring and reporting and contracting of and support to the external

evaluator. Potential for follow-on programming, targeting these and other PoE in Afghanistan will likewise be explored more in-depth during this period, pulling from lessons learned under this project.

Visibility products and branding for this project will be included on physical project outputs, including on infrastructure where possible and appropriate. Social media posts will also be published promoting the programme, under the support of the MPTF. The timing and communications plan for this will be developed as preparatory work in close coordination with MPTF staff and communications colleagues in both organizations. Budget has been allocated to visibility products.

While COVID-19 remains a concern in Afghanistan, particularly as a third wave of COVID-19 is hitting the country in May/June, meetings with government officials and key partners are possible, with COVID-19 considerations taken into account or taken fully online. Under related projects, trainings have been adapted to online modalities or creative methods have been rolled out for ensuring COVID-19 prevention measures are taken into account while remaining in-person and engaging. Similar tactics will be taken under this project, depending on the COVID-19 situation. The MPTF will be kept informed of relevant dynamics that arise relating to the pandemic that could impact the programme and mitigation measures put in place.

Geographic selection and targeting
Target Land PoEs:
-Islam Qala, Herat Province-Iran
-Melak, Nimroz Province-Iran
-Torkham, Nangarhar Province-Pakistan
-Spin Boldak, Kandahar Province-Pakistan
Target Air PoE:
-Hamid Karzai International Airport, Kabul Province

In defining project sites, IHR implementation is critical component of mandated PoE, thus Hamid Karzai International Airport in Kabul, Torkham and Islam Qala were natural choices to focus on. In addition, IOM has been supporting the implementation of integrated border management registration systems and infrastructure up-grading at Torkham and Islam Qala, which provide natural synergies for this project. However, as the mandated classification is limited to just these three locations in Afghanistan, IOM and WHO have jointly decided to also target Spin Boldak and Melak ground crossings for support, which are both key border crossing for persons, livestock and goods. Melak also is a notable crossing point for deportations from Iran, including of prisoners, which are populations particularly at risk for exposure and transmission of communicable diseases. This has also been a point of the return for the bodies of diseased individuals, which under IHR requires specific procedures and infrastructures be in place. While there are a total of 20 official PoEs, including land (16) and air (4) PoE in Afghanistan, these specific locations have been selected in order to focus efforts at particularly high volume locations. The outputs from this project will however be able to be used to strengthen the IHR capacities of other PoE in follow-on efforts.

In relation to the community engagement components of this project, these will be informed by existing knowledge of mobility corridors in Afghanistan. Illustrated in Appendix 1, IOM's DTM team has an in-depth understanding of the magnitude and direction of migrant flows as well as community-based needs, which will help inform where PMMs and other engagements at the community level, including RCCE will be most suitable. This includes in districts immediately neighbouring PoE, as well as those more in-land within border provinces and within provinces further in-land, which have notable trans-national

connections.[22] Target locations for print and in-person RCCE efforts will include the PoE, transit centers and communities in key mobility corridors. IOM gained substantial experience under on-going COVID-19 related RCCE and will capitalize upon the knowledge to most effectively share messages finalized by WHO and MoPH.

Coordination

Coordination at the Kabul level, particularly with the MoPH, will be carried out primarily by WHO, which maintains close working relationships with key public health stakeholders and policymakers. This will be bolstered by the relationships IOM has with the central offices of border management entities, such as the Afghan Border Police (ABP), Afghan Civil Aviation Authority (ACAA) and Afghan Customs Department. Conversely, at the provincial level, IOM will lead on coordination at the provincial and local levels, as the organization's existing programming and coordination role at the PoEs and in border provinces, has resulted in standing-relationships with key directorate level officials in the targeted border provinces, as well as frontline ABP and Customs officers, local health actors and government officials, community leaders and civil society. However, WHO, as the UN's leading agency on public health matters, will play a critical role at these levels as well, particularly with health actors.

On the cross-border components, both IOM and WHO have on-going engagements on strengthening coordination between Afghanistan and its neighbours on health tracking and testing, respectively on TB and polio. In addition, on the border and migration management side, the ABP are in contact with their counterparts across both Iranian and Pakistani borders (Islam Qala/Melak and Torkham/Spin Boldak respectively) for coordination on issues such as deportations, which is of particular relevance at the Iranian points. However, these engagements have never been holistically mapped or fully understood at a systems level. Under this programme, the formal and informal channels that have arisen at PoE, as well will be more formally mapped and formalized. IOM and WHO in Afghanistan have close relations with their organization's counterparts in Pakistan and Iran, which will help to facilitate meetings of key officials and undertaking mapping exercises on their sides of the border, where possible.

3b) Cross-Cutting Principles:

This project mainstreams and strives to ensure the full realization of Human Rights, dignity and fundamental freedoms of persons through its implementation. IHR is recognized as the principal international legal framework governing infectious disease control and is centrally designed to promote global health security while respecting human rights imperatives. Compliance with IHR principles encourages national responsiveness to pressing public needs, necessary and proportionate to a legitimate aim, prescribed by law and not imposed arbitrarily; and applied as a last resort using the least restrictive means available.[23] Specifically, this intervention increases the likelihood that ill migrants moving through PoE and mobility corridors will be treated in line with Human Rights principles and commitments, and that ABP and health officials at PoE have the training and tools to do so. In addition, the surveillance systems will ensure that data privacy and protection are maintained and respected.

Ensuring equitable access for all to public health information and services regardless of gender is central to the realization of improved IHR. At the core of this, is ensuring that gender considerations and possible impediments to access and appropriate care are considered across all interventions, from how

[22] This is illustrated in IOM DTM's mapping of mobility patterns during COVID-19 through locations of origin (Iran and Pakistan) and destination (Afghanistan) in Appendix 1. For the most up to date version, visit https://afghanistan.iom.int/IOM-COVID-19-Response.

[23] https://www.hhrjournal.org/2020/08/human-rights-must-be-central-to-the-international-health-regulations/

assessments are designed and rolled out down to the physical infrastructure that is installed at PoE and the training that frontline workers receive. Specifically, under this project, the design and implementation of IHR-related guidelines and SOPs will address the needs of women and girls in a gender-sensitive manner and ensure the participation of women in their consultation and implementation. Assessments under Output 1 will include components on equal access and ensuring tailored services that consider gender, age and disability. This will build on IOM supported transit centre-based mainstreaming of the needs of women and girls, and the needs of unaccompanied migrant children and individuals with disabilities. Additionally, female PoE staff will be prioritized in focused trainings, including in health facilities, with a goal of a 1:3 (female-male) ratio. In addition, training and simulation materials will be designed to ensure gender components are both mainstreamed and covered in targeted examples/modules. This project will also include coordination with and inputs from health shura, community leaders and civil society, to ensure sensitivities and access concerns are being addressed. RCCE efforts in particular will be designed to ensure women are able to directly access and understand key health-related messages and information on access to health care.

In addition, the rollout of the community and PoE level surveillance mechanisms will be designed to ensure women are included within their screening and reporting catchment. In Afghanistan reporting on health outcomes, including for COVID-19, is widely understood to under-represent women, who face limitations in access to medical care/infrastructure. By working closely with health shura and community leaders, this programme can provide an important contribution to ensuring women are included, strengthening the overall accuracy of the surveillance system and contributing to improving overall health outcomes.

4. Partnerships

The project will directly engage the **Ministry of Public Health (MoPH),** the national authority responsible for health issues and national focal point for IHR, and the **Ministry of Interior (MoI)**, the national authority responsible for the control of PoE, specifically through the Afghan Border Police and Customs Authorities. The **Ministry of Refugees and Repatriation (MoRR)** and the **General Directorate of Monitoring, Evaluation and Health Information System** will likewise be key partners. MoRR in particular, oversees the flows of undocumented returnees from Iran and Pakistan and provision of reintegration assistance to these caseloads. Under the leadership of the MoPH, the existing IHR multi-sectoral committee will provide a key platform for building collective understanding, engagement and buy-in of other relevant government stakeholders. This committee is already working on developing the 19 IHR capacities, including PoEs, and will play a role in reviewing and monitoring the progress of the project (members and the role of this body are discussed further below).

In Afghanistan, the provincial level governing bodies for ministries are called “Directorates”, which oversee implementation and the day to day running of relevant public services and programmes. As such, alongside the **Afghan Border Police, Provincial Public Health Directorate (PPHD),** and **Directorates of Refugees and Repatriation (DoRR)** will be key field level partners. This notably includes key ABP and Customs officials overseeing the PoEs, who IOM already has existing partnerships with on technical capacity building on border management.

Based on prior engagements and relevant areas of expertise, IOM and WHO will invite **key civil society partners** to engage with this programme, as well as the **Afghanistan Independent Human Rights Commission**, at national and provincial levels. Targeted civil society actors that are already engaged with IOM and WHO include **Assistance and Development of Afghanistan (AADA), HealthNet Transcultural**

Psychosocial Organisation (HNTPO), MOVE Welfare Organisation, Handicap International, Medical Refresher Courses for Afghans (MRCA), War Child and Human Resource Development Agency (HRDA). Additional civil society partners, particularly at the district and settlement level, which express interest during implementation will also be invited to relevant meetings.

At the community level

While the IHR are normative, the success or failure to implement the IHR, has a direct impact on the health of communities and individual citizens. IOM maintains close engagement with communities and awareness of the individual and community level needs of the population through implementation of the DTM across the country, and specifically at PoE and in communities with high levels of return. This intervention will build upon these networks in the roll out of RCCE and to **engage border communities in community-level, events-based surveillance**, making border communities key partners in IHR implementation. This health-related partnership will involve significant consultation, particularly with health shura, to ensure community concerns and interests are well integrated into project implementation and monitoring, with community-approved structures included to facilitate community feedback as implementation proceeds. IOM and WHO will also ensure that gender dimensions of health outcomes and access to services and reporting mechanisms are integrated.

Regarding cross-border partnerships

Under Outcome 4, strengthening cross-border collaboration and partnerships will be specifically targeted. Currently, ABP, MoRR and and zero-point clinics at the POE convene bilateral exchanges with cross-border counterparts on policy decisions, including public health matters and particularly with counterparts in Pakistan. This was evident during coordinated border closures that were taken to minimize the spread of COVID-19 infection in August – September 2020. There has also been existing cross-border collaboration with Pakistan on Polio. Both countries exchange information on evolving situations and recently decided on synchronization of vaccine schedule for successful eradication of polio. The existing polio collaboration, the strengths and lessons learned provide an opportunity to expand this cooperation beyond polio to all events of mutual concern. There has also been sporadic exchange of information between border officials from Iran and Afghanistan, though not as formalized as on the Pakistan side. This proposed project envisages to build upon and institutionalize these information sharing mechanisms and create systems that encourage sustained cross-border partnerships that focus on mobility and public health.

There have been several regional meetings held by WHO to bring together the **IHR NFPs** in the region to share their experiences and exchange information on IHR implementation. Cross-border collaboration is among one of the key agendas for these IHR stakeholder meetings and will encourage more discussions among countries for collaboration under this project and more broadly. Recently, WHO's regional office in Cairo facilitated a discussion with WHO country offices in Afghanistan, Pakistan and Iran for starting formal cross-border collaboration, specially on COVID-19. Such mechanisms will be continued in collaboration with this project to support the initiation of country discussions among IHR NFPs and relevant counterparts.

5. Innovation and Sustainability

Innovation

This project engages the tested expertise of WHO in strengthening IHR implementation and IOM in Health, Border and Migration Management through novel and strengthened approaches that uniquely combine public health and border management in the context of Afghanistan.

While up until now IHR implementation has been predominately undertaken at a systems and technical level in Afghanistan, this programme offers an innovative mechanism of bridging it downstream to the community level. In doing so, the project is helping the MoPH in building a more holistic approach to IHR that reflects the realities in Afghanistan of disease transmission, information flows and health services and health seeking behaviours at the local level, while linking into the formal surveillance mechanism. As this will be the first time this is undertaken to such a degree in country, lessons learned will be documented and reviewed by staff at programme management meetings, discussed with local counterparts and shared with MoPH IHR counterparts for integration into and finetuning of the wider surveillance system.

Second, while the Government of Afghanistan signed on to IHR in 2009 and has implemented some measures at POE to respond to PHEICs, these efforts have lacked sustainability and cohesion. By uniquely bringing together both border management actors (ABP and customs officials and health actors) under structured and joint capacity building and institutionalizing IHR core capacities and management structures at PoEs, the country will be able to take key steps towards moving past ad hoc measures towards a sustainable, well-prepared and resilient system for early detection, prevention and response to public health events. While this approach will be "piloted" through this project at the target PoE, it is expected that the structures, guidelines and capacity building efforts rolled out under this joint programme will be able to be tailored and rolled out at other PoE.

In addition, while COVID-19 has had many negative impacts in Afghanistan, one positive aspect is that it has pushed forward and underscored the importance of the collection and analysis of data on mobility and trends that could lead to heightened risk of disease transmission across borders (Annex 1 is one example). While this information has up until now been used for COVID-19 specific purposes, this data, which includes the mapping of high return, and therefore of heightened transmission, areas for imported communicable diseases, as well as the outcomes of the PMM exercises with MoPH public health surveillance with the aim of strengthening the overall system.

Finally, one priority that has emerged in Afghanistan, and that has been underscored by WHO, is the need to better understand the efficacy of RCCE efforts. While there was a proliferation of COVID-19 specific efforts, many of these were rolled out under the guise of a rapid response and did not include plans for longer term or overly substantive monitoring and evaluation efforts. While acceptable during a ramped up emergency health response, this project offers the time and parameters to develop more impact oriented M&E efforts for RCCE, which has not been completed for most RCCE for COVID-19. This will allow for real time adjustments in messaging and outreach methods, with applicability beyond this project alone.

Sustainability

Sustainability of impact is at the core of this project's logic. At a systems level, this is done through the alignment with already existing policy and systems, the enforcing of NAPHS implementation lead by the MoPH and the utilization and strengthening of of existing infrastructure at the borders (e.g. border checkpoints, transit centre infrastructure and screening and referral systems that already mainstream protection, gender and address the needs of unaccompanied migrant children (UMCs)).

A designated competent public health authority will be placed at each PoE, with their salaries covered for the duration of this project. As has been discussed and agreed upon with the MoPH, they will continue to support these key positions following project closure, ensuring their positions are written into planning processes and appropriate budgeting. In addition, capacity building efforts, inclusive of tool development

and trainings will be embedded in the MoPH, ABP and other government agencies for future use. The establishment of a stronger policy framework and government consultation structures will allow for strengthened monitoring, assessment and update of IHR requirements in addition to the self-assessment of IHR capacities conducted annually.

Under Output 2.2, the PoE infrastructure plans whose implementation will not be significantly covered under this programme, namely Spin Boldak and Melak, are intended to be used for further engagement with other national and international funding bodies. Given there are not currently large scale infrastructure improvements or works on-going at these PoE, bringing these PoE up to full IHR compliance will require significant investment, but this project provides the opportunity to lay a critical component of the groundwork for this. Being able to illustrate results and impact from this joint programme's full implementation of IHR upgrading at Torkham and Islam Qala will also provide a useful tool for illustrating the impact and importance of investing in bringing PoE up to IHR compliance.

At the community level, the PMM exercises and RCCE engagements are designed to build capacities to self-identify and raise awareness for public health risks and gaps, placing the ownership of this process locally and strengthening existing knowledge sharing networks and response mechanisms. Thus, the promotion of IHR implementation in Afghanistan supported through this project is expected to have a sustainable impact not only at a systems level, but also directly within the capacities of affected communities. It will also help shape plans that can be used to inform and advocate for health systems strengthening interventions, as funds become available through the government or international donors.

As the COVID-19 pandemic has provided a catalyst for interest in this joint area of programming, lessons learned from programme design, border management and health partnerships, and implementation across activities will be collected and well documented throughout the project, analysed by project staff and presented both periodically to the JSC, as well as at the closure of the project. These will be used to further strengthen interventions at the targeted PoE, as well as inform nascent efforts by WHO and the MoPH to strengthen IHR implementation at other PoE in Afghanistan, notably along the borders with central Asian countries. In addition, this will allow for an overall strengthening in understanding the successes and areas for improvement of community level surveillance mechanisms across communities which are at a higher risk of transnational disease transmission. Lessons will also be shared with key IHR, public health and integrated border management experts at the global level to reach a wider audience, some of whom have already expressed interest in this project.

This project also provides a valuable platform for strengthening understanding of the capacities and developing further on the ground collaboration between IOM and WHO in Afghanistan, to the wider benefit of migrant populations, affected communities and partners.

The project also lays the foundation for the extension of IHR to other PoEs and the strengthening and complementing of targeted surveillance and health systems in other communities of high return. In particular, it creates a template for similar cross-border engagements with Central-Asian neighbours, including Tajikistan, Uzbekistan and Turkmenistan. WHO Afghanistan, in coordination with IOM, has begun closer coordination its WHO counterparts in these countries, to map IHR implementation and discuss possible areas of cross-border collaboration and interventions at these PoE. While these engagements are still in the discussion phase, there is the potential to move forward more substantively. WHO would coordinate possible opportunities for lessons sharing and engagement.

6. Project Management and Coordination

PUNOs (PUNOs) and Implementing Partners

This project engages and capitalizes upon the technical expertise, programming experiences and existing national, provincial and local level networks of WHO and IOM in Afghanistan. Together, the two agencies are uniquely situated to successfully implement this programme. While each agency will be leading on designated activities, the two agencies will be working closely throughout programme implementation to ensure the expertise of each are fully utilized.

As the mandated health cluster lead, core partner of the MoPH, custodian of IHR and normative lead on public health matters, **WHO** will be leading on components pertaining to assessments, policy and strategy development, standardizing guidelines and protocols, SOP development and capacity building for health officials and ensuring close coordination with MoPH throughout implementation. In addition, WHO is well placed to lead efforts of legislative assessments and efforts in support of IHR reforms. Further, WHO co-chairs the RCCE working group and is the technical lead on RCCE approaches, in support of the MoPH.

As the mandated migration agency of the UN, **IOM** is the main operational actor present at border crossings and in mobility corridors in Afghanistan and has been recognized by the MoPH for undertaking COVID-19 surveillance and migrant health support during the pandemic. IOM has extensive experience working directly with migrant populations, community leaders and civil society, as well as a proven history of collaboration with border officials, including customs and border police, and the Ministry of Foreign Affairs, particularly on topics related to cross-border movements. This past year, IOM's DTM programming and data collection efforts to map high return/high transmission areas during COVID-19 have involved engaging closely with over 12,600 settlements hosting returnees and IDPs and included reaching 134,499 community leaders and influencers with risk communication on COVID-19. Together with UNHCR, IOM co-chairs the PoE Working Group in country and houses the COVID-19 RCCE working group portal on its website.[24] As agreed upon, **IOM is the convening agency** for this joint programme.

Joint Programme Management and Coordination:

As the convening agency, IOM will coordinate the overall project management, implementation, monitoring and evaluation, and reporting to the MPTF, working closely with WHO at each step.

Under this programme, IOM will hire a dedicated staff member who will oversee the coordination of the day to day running of the programme (with a focus on the training and meeting components). IOM will also provide partial funding to the Migration Health Officer and Migration Management Programme Officer to provide technical guidance and further programme management support. Other support staff costs, including for DTM, are included in the budget. WHO will support the International Health Regulations Officer (50%) to provide technical support to IHR implementation and coordinate with MoPH and IOM for project implementation, monitoring and reporting. Other relevant staff will also provide support as needed.

The follow mechanisms will guide programme management and ensure the input and feedback of all relevant stakeholders:

- Monthly **Programme Management Team (PMT) meetings** will be held amongst key staff in IOM and WHO to discuss project updates on programme progress, challenges and risks. During preparatory work, IOM will consult with WHO and stakeholders to finalise a monitoring and evaluation system to measure project results against indicators. Regular budget monitoring

[24] https://afghanistan.iom.int/IOM-COVID-19-Response-RCCE

reports will be run by IOM and WHO on their respective activities and compiled by IOM to ensure project implementation and spending is on track. These will be shared with the MPTF secretariat per the agreed upon reporting schedule. (See below for more details on monitoring and evaluation)

- The project will also be guided through meetings every six months of a project-specific **joint steering committee (JSC)** under the existing IHR multisectoral committee, led by MoPH. The JSC will include PoE-related representatives of IOM and WHO, the MOPH, the MoI and ABP, Civil Aviation Authority, Custom Department of Ministry of Finance, Ministry of Agriculture, Irrigation and Livestock (MAIL), Ministry of Justice (MoJ), Ministry of Foreign Affairs (MoFA), MoRR, Ministry of Border and Tribal Affairs (MBTA), the Afghanistan National Disaster Management Authority (ANDMA), the National Security Directorate (NSD) and key civil society partners, such as Assistance and Development of Afghanistan (AADA), MOVE Welfare Organisation, HealthNet Transcultural Psychosocial Organisation (HNTPO), Nomad's Representative and the Afghanistan Human Right Commission. The **project will be launched with an initial meeting of the JSC**, to gather inputs from stakeholders at all levels and ensure collective buy-in and understanding of the project's activities and intent.
- At a more local level, there will be quarterly meetings of **provincial reference groups (PRG),** which will bring together key IOM/WHO, government, border officials, community health workers, NGOs, civil society actors and notable community leaders to discuss the programme, give status updates and gather feedback. The organization and first meeting of each PRG will be within the first quarter of the project. Key civil society include provincial level representatives from Assistance and Development of Afghanistan (AADA), HealthNet Transcultural Psychosocial Organisation (HNTPO), MOVE Welfare Organisation, Handicap International, Medical Refresher Courses for Afghans (MRCA), War Child, Human Resource Development Agency (HRDA), Provincial Office of Human Right Commission, Nomad's representative, etc. These will be held in person, with online or call-in options available if stakeholders are not able to be physically present.
- **Migrant and community-level inputs** on programme-relevant issues will be obtained during PMM exercises and RCCE sessions, as well as from surveys at PoE and in mobility corridors. These will build off existing and on-going data exercises and analysis from IOM's DTM programme.
- There will be **operational, multi-sectoral coordination bodies set up at each target PoE** (described under Output 4.1), however these will be less engaged on programme management, but rather on the everyday running of the PoE, synergies between border management and improved health screening and service provision and referrals, and the roll out of IHR related interventions under this programme. These will consist of key PoE officials, including ABP, Customs Officials and the designated health official.

At all levels, IOM and WHO will ensure there are gender and age diverse voices at the table. This will include aiming for at least 40% women (where appropriate) in the JSC and PRG meetings and including relevant, culturally sensitive topics in discussion.

Support provided under this project to the Afghan government to undertake reforms to migration management structures will provide a strong opportunity to put the GCM and new migration considerations on the national agenda, which until now has not gained significant traction. The existing UN Working Group for Return and Reintegration, co-Chaired by IOM, is likely to have its mandate expanded to include broader migration issues, potentially transitioning over time into the UN Migration Network in Afghanistan. This programme will engage with these mechanisms as they develop, as relevant.

Risk Management:

Given the operating context in Afghanistan, risk management and mitigation considerations are central to project management across all UN programmes. As part of joint programme management, key risks and mitigation measures for this programme, such as security concerns, shifts in political buy-in or decay in cross-border political relations, will be discussed and adjusted at monthly Programme Management Team meetings, or on an ad hoc basis, as needed. Bi-annually, the risk matrix will be more formally reviewed.

At the wider UN level, all projects fall privy to the Programme Criticality Assessment (PCA), which determines when certain categories of activities are required to halt deliverables and/or movements to project sites, dependent on security restrictions and the criticality of services they provide. The Programme Criticality (PC) for this programme would be determined during preparatory work immediately prior to the start of the programme and handled by IOM as the convening agency, re-assessing as needed, dependent on shifts in the context. The majority of health related programmes fall under PC level 2 or 1, meaning activities are able to be carried out under a higher level of risk, with appropriate risk mitigation measures in place.

Specific risks to consider include the following, detailed more fully in the annexed Risk Matrix:

- Conflict and political instability around border areas and mobility corridors prevent access to PoE and/or targeted communities
- Restrictions related to COVID-19, or other disease outbreaks, prevent international or domestic travel to conduct field assessments and activities
- Government commitment becomes insufficient for policy action and support of programme efforts decrease substantially, at any level, specifically within MoPH/PPHD and ABP officials
- Turnover in administration disrupts continuity in advocacy and policy action and/or ability to implement
- Government staff turnover rises to a level too significant to maintain capacity and transfer of skills
- Supply chain disruptions prevent purchases and construction
- Conflict or natural disaster triggers significant displacement in capacitated communities
- Political ties with neighboring countries (Pakistan and Iran) weaken, weakening support and trust in cross-border agreements and activities

Joint programme monitoring and evaluation:

The findings of the PoE assessment conducted at the beginning of the project will act as the baseline capacity markers for the project. Overall progress in strengthening IHR capacities at PoE will be monitored and evaluated against these.

To ensure oversight and close monitoring of the project, WHO, IOM and MoPH will conduct joint monitoring visits to the key project sites on a quarterly basis. These will be scheduled to also coincide with the PRG meetings, to ensure the key border officials, community health shuras (CHS), civil society members, and influential community members will be key interlocutors for monitoring and coordination meetings, to discuss and gather feedback on project implementation. Targeted border communities will also be engaged to discuss the project, supported by existing needs related data and the PMM exercises. In addition, regular monitoring and interviews with migrants utilizing border points will be collected, again leveraging significant data already collected at PoE by IOM. Compiled feedback and recommendations will be provided to programme teams, partner ministries and the MPTF secretariat, as relevant.

In order to ensure transparency, gather feedback/complaints and offer further information to migrant populations and communities, this project will explore linking with AWAAZ Afghanistan, a country-wide

call center that is currently used across—predominately humanitarian—programming, hosted under UNOPS.[25] IOM also has independent call centers for several of its programmes, which could be explored as an alternative.

Evaluation
IOM and WHO intend to conduct an internal, mid-term evaluation at the 1-year mark to take stock of implementation status and understand if any form of course correction is needed. This will be scheduled to coincide with project monitoring visits and a JSC meeting. The findings will be presented in JSC meetings and PRG meetings to address the gaps. The details of this will be determined during the M&E Plan design during preparatory work for the programme.

IOM and WHO will jointly contribute towards a joint end-of-programme evaluation, which will be undertaken in the final 3 months of the project. An external consultant or consultancy firm will be contracted based on a developed TOR to undertake the evaluation, addressing relevance, efficiency, effectiveness, impact and sustainability, in line with the normal evaluation requirements of both agencies. The evaluation will take into account inputs from regular reports, monitoring reports, products developed under the project, feedback from communities from PMM exercises and follow-ups, interviews with government officials and civil society counterparts and field visits (as permissible due to security and other potential restrictions).

7. Project Budget and Workplan

Budget
The total budget for this programme is 2,900,000 USD. Programming, and the associated costs have been split between IOM and WHO to account for areas of specialty and in regard for value for money. 3% of the total budget ($85,700) has been allocated to monitoring and evaluation efforts in the programme, including an external final evaluation.

Under Outcome 1, the budget inputs have been informed specifically by WHO, given their thematic and in-country knowledge of this area of programming and associated costs, including travel to and the undertaking of assessments at PoE, as well as the organization of workshops with key stakeholders. Funding to cover IOM portions of engagement in the assessments and activities will come from the WHO lines. Notably, under activity 1.2.2 two national workshops are planned.

Under Outcome 2, Output 1 costs are split as IOM will be handling trainings and activities at the PoE and provincial levels while WHO will cover these at the central level in Kabul. Costs have also been allocated for WHO to develop SOPs and guidelines. WHO will be undertaking simulation exercises for the Airport, while IOM will undertake these at the four land PoEs. Under Output 2, IOM will hire a national engineer to lead the review, design and infrastructure works. WHO will support this through the provision of an engineer for the assessment and design process, particularly for bio-safety infrastructure, quarantine facilities and other technical issues. IOM will cover the infrastructure related costs, while WHO will provide the bulk of equipment provided to outfit the PoE working spaces. Costs for meetings, under this outcome and others, are inclusive of travel, venue, associated security costs (i.e. armoured vehicles, security guards), daily transportation, refreshment and other associated costs. These may be higher than other operational contexts due largely to security costs associated with transportation and venue costs.

For Outcome 3, capacity building efforts, inclusive of the roll out of SOPs and trainings on surveillance systems, will be jointly undertaken by IOM and WHO, with the same breakdown of responsibility as Outcome 2 at the

[25] See the AWAAZ website for more info: https://awaazaf.org/#pll_switcher

provincial/PoE (IOM) and central (WHO) levels. The largest budget item (3.1.3) covers the establishment of PoE surveillance teams/systems for all 5 target PoEs and attached referral capacities. This which reflects the labour intensive nature of this works and the need to ensure the availability of ambulances for referrals as required. The amount is based on IOM and WHO's experiences in this area developed during COVID-19. For RCCE efforts, WHO will receive funding for the development of messages and training of trainers, whereas IOM has budgeted for the rollout at PoE and community levels.

As with the other outcomes, Outcome 4 costs as split with WHO covering national level engagements and IOM at the provincial/PoE level. Who has also costed in travel required for activities at the PoE level.

32% of the programmatic budget ($511,030) is allocated to gender-components and ensuring the participation of women in this project at all levels and promoting equal access to services and information. This includes funding to ensure women's participation in training and hiring as key staff, as well as women-targeted RCCE efforts.

***Workplan**:*

The below workplan has been developed in close collaboration between IOM and WHO. It takes into account the initial assessment and start-up activities that will occur in the first quarter of the project, specifically under Outcome 1 and 2. In addition, it lays out the schedule for periodic activities planned, such as meetings and trainings, throughout the duration of the project as well as activities that are expected as once or twice-off, and those that will occur throughout implementation.

Annex 1: Results Framework

RESULTS	INDICATORS	Data Source and Collection Method	Baseline	Targets	ASSUMPTIONS
Overall Objective Statement: The transmission of communicable diseases across the borders of Afghanistan is reduced through the improved implementation of International Health Regulations					
Outcome 1: Government and civil society actors in Afghanistan effectively plan and inform interventions to strengthen International Health Regulations (IHR) capacities at PoEs and target communities in Afghanistan.	Outcome Indicator 1a: % of officials reporting an increased capacity to support IHR efforts	End of project surveys, interviews with officials	N/A	80%	**Political will of key actors continues in support of engagement on IHR** **Increased access to information and engagement leads to increase in interest in IHR**
	Outcome Indicator 1b: % of officials reporting strengthened IHR efforts as a key priority for Afghanistan	End of project surveys, interviews with officials	N/A	80%	
	Outcome Indicator 1c: # of meetings held on IHR legislation assessments and recommendations	Meeting minutes, photos	0	3	
Output 1.1: A combined assessment of the implementation of IHR for key PoE is available to guide contingency planning.	Output Indicator 1.1a: Availability of PoE assessment reports	Copy of report	0	5 (Hamid Karzai Airport, Islam Qala, Melak, Torkham and Spin Boldak)	**Access is maintained to successfully conduct assessments** **Assessments are in depth and conclusive enough to inform contingency planning**
	Output Indicator 1.1b: Availability of public health contingency plans at targeted PoE	Copy of contingency plan	0	5 (Hamid Karzai Airport, Islam Qala, Melak, Torkham and Spin Boldak)	
List activities under Output 1.1 *1.1.1 Form assessment team and tools for PoE assessment*					

1.1.2 Training of field team, conduct field assessments and de-briefs *1.1.3 Draft the assessment report and organize events to discuss findings and recommendations* *1.1.4 Organize key stakeholder meetings to develop contingency plans*					
Output 1.2 Government and civil society actors have access to IHR-related legislative assessments and recommendations for adapting policy and legal frameworks.	Output Indicator 1.2a: # of legislation committee meetings conducted to review the national legislations, rules/regulations and policies	Project progress report, meeting minutes	0	3	**MoPH policies/plans support implementation of IHR** **MoPH remain committed to implementation of IHR and amending the legislations, law, regulations**
	Output Indicator 1.2b: Availability of legislation review assessment report	Project progress report, copy of the report	0	1	
List activities under Output 1.2 *1.2.1 Form the committee of advisors and public health experts and recruit one legislation expert for 4 months* *1.2.2 Conduct national workshops on the review and formation of legislation, policy and recommendations* *1.2.3 Draft, publish and disseminate the legislation review assessment report and advocate for legal amendments based on the recommendations*					
Outcome 2: Key target land and air PoE more effectively implement IHR (Islam Qala, Melak, Torkham and Spin Boldak land crossings and Hamid Karzai Airport in Kabul)	Outcome Indicator 2a: % of trained officials reporting an increase in ability to implement IHR related duties	Post-training surveys; follow-up surveys	N/A	80%	**POE staff available for capacity building program** **Key government actors support the capacity building development plan** **MoPH designate health officials at PoE**
	Outcome Indicator 2b: # of table top exercises conducted	Project progress report	0	20	
	Outcome Indicator 2c: % of targeted PoE with appropriate facilities for interviews, isolation and medical services	Project progress report, mid-term and final evaluations	0%	100%	

Output 2.1: A comprehensive capacity building plan for government (MoPH and ABP) and civil society actors is developed and rolled out.	Output Indicator 2.1a: Availability of capacity building plan for POE staff	Project progress report	No	Yes	
	Output Indicator 2.1b: # of POE staff trained on rights based approaches to IHR and border management (disaggregated by gender)	Project progress report; training attendance records	0	200 (75 women)	
List activities under Output 2.1 2.1.1 Review training needs component of the POE assessment 2.1.2 Develop SOPs, capacity building plan and training curriculum on rights based IHR implementation at PoEs 2.1.3 Organize trainings for MoPH, ABP and Customs officials 2.1.4 Run tabletop simulation exercise(s) 2.1.5 Print and distribute pocket reference guides 2.1.6 Mentorship activities and follow up to review efficacy of trainings					
Output 2.2 Infrastructure at Point of Entry (PoE) is better equipped to handle interviews, the isolation of suspected cases and expanded health and surveillance services	Output Indicator 2.2a: # of PoE with fully completed infrastructure/upgrading works in line with IHR	Post-construction evaluation, pictures	0	2 (Torkham and Islam Qala)	**Security and political stability remain conducive during implementation**
	Output Indicator 2.2b: # of plans drafted on infrastructure improvements for PoE	Copies of drafted plans	0	5 (Hamid Karzai Airport, Islam Qala, Melak, Torkham and Spin Boldak)	**Rooms/Space available to be dedicated for interview and isolation at PoE**
List activities under Output 2.2 2.2.1 Hire engineer staff to design and oversee construction 2.2.2 Field assessment of infrastructure needs jointly by WHO and IOM Engineers					

2.2.3 Hold meetings to review PoE assessment and agree upon design of construction plans for each PoE 2.2.4 Construction and upgrading of PoE infrastructure 2.2.5 Supporting upgrading of infrastructures in the vicinity of PoEs (transit center clinics) 2.2.6 Procurement of additional office and medical supplies 2.2.7 Procurement of IT Equipment, Software and supplies for PoE 2.2.8 Procurement of PPE					
Outcome 3: Community and PoE-based surveillance systems, reporting mechanisms and awareness raising efforts support effective and timely responses to the presence of communicable disease.	Outcome Indicator 3a: Availability of integrated PoE surveillance system within the national surveillance system	Final evaluation	No	Yes	**Community trust and willing to report COVID-19 and other suspected priority diseases** **Staff available at PoE to report to the national surveillance system** **MoPH committed to support POE surveillance integration**
	Outcome Indicator 3b: % of persons reached by RCCE efforts reporting increased knowledge of public health concerns and prevention measures	Post- surveys	N/A	80%	
	Outcome Indicator 3C: # of events/cases reported by PoE to the surveillance system	Reporting records from surveillance system	0	TBD at the first meeting of JSC	
Output 3.1: Public health emergency surveillance systems are integrated at the International Airport and key land crossings, as well as in key mobility corridors	Output Indicator 3.1a: # of designated health officials present at targeted PoE	Copies of signed contracts, monitoring reports	0	5 (Hamid Karzai Airport, Islam Qala, Melak, Torkham and Spin Boldak)	
	Output Indicator 3.1b: # of PMM exercises conducted	Exercise notes, photos, recommendation documents	0	20 (2 per year for each targeted land PoE + selected district of high return)	

List activities under Output 3.1 3.1.1 Strengthen and tailor SOPs and other guidance within the overall surveillance system 3.1.2 Conduct capacity building workshops on surveillance systems 3.1.3 Establish screening/surveillance system at the PoE with functioning referral management (inclusive of ambulance transport) 3.1.4 Support the placement of a designated health official at each target PoE 3.1.5 Conduct Population Mobility Mapping exercises 3.1.6 IOM-DTM consultant to support PMM assessment 3.1.7 Develop and roll-out community-based mechanism for feeding into overall surveillance system in targeted border communities 3.1.8 Establishing vector surveillance system for PoEs including international TA for developing guidelines/SoPs and trainings and equipment					
Output 3.2: Risk Communication and Community Engagement (RCCE) is available on health risks and border control in border communities proximate to key border crossing.	Output Indicator 3.2a: # of new RCCE materials developed in close coordination with MoPH	Copies of materials	0	10	**Community members trust and adhere to risk communication messages** **IEC materials successfully reach most at-risk populations**
	Output Indicator 3.2b: # of individuals reached with RCCE messages	Project reports, social media monitoring, distribution reports	0	400,000 persons	
List activities under Output 3.2 3.2.1 Through three local workshops and a national workshop, develop and consolidate RCCE messaging and materials, coordinating closely with MoPH and consulting with community committees and PoE officials. 3.2.2 Conduct RCCE ToT at national level 3.2.3 Print/procure IEC materials 3.2.4 Roll out messaging, via billboards, social media 3.2.5 Conduct awareness raising and orientation sessions 3.2.6 Visibility activities of the project					
Outcome 4: Strengthened cross-border cooperation enhances early detection and response capacities at PoE and in target communities	Outcome Indicator 4a: # of PoE with a strengthened communication mechanisms set up to share information on the detection of	Proof of communication on disease detection; existence of online or chat mechanisms for regularly sharing information	N/A	4 (Islam Qala, Melak, Torkham and Spin Boldak)	**Authorities remain open to and have adequate political will for engaging across the**

	cases/clusters of communicable diseases with counterparts across the border				**border with counterparts** **Early notification of disease detection results in actions taken to limit the spread across the border**
	Outcome Indicator 4b: % increase in the frequency of communication with cross-border partners	Reports from key PoE staff; records of phone calls, emails, texts, etc	TBD during PoE assessments	50% increase (per PoE)	
Output 4.1: Coordination and communication mechanisms exist at PoE for reliable early detection and response, including cross-border agreements	Outcome Indicator 4.1a: # of cross-border agreements or SOPs existing for POE collaboration	Copies of agreements or SOPs, other shared documents	0	At least 2 (1-Iran covering Islam Qala and Melak, 1-Pakistan covering Torkham and Spin Boldak)	
	Outcome Indicator 4.2b: # of cross-border coordination meetings held	Meeting minutes and attendance	0	8 (2 per Islam Qala, Melak, Torkham and Spin Boldak)	
List activities under Output 4.1 4.1.1: Form core multi-sectoral airport and land PoE planning and support coordination teams and support regular meetings 4.1.2: Conduct stakeholder mapping of existing cross-border coordination engagements 4.1.3: For each land PoE, develop/tailor a ToR, SOP or protocol for national and international communication links on cross-border engagement and information sharing with cross-border partners 4.1.4 Provide logistical support to the organization of cross border meetings, table top exercises and joint trainings 4.1.5 Joint cross-border trainings with Pakistan and Iran					

Annex 2: Risk Management Plan

Risks	**Risk Level** *(Number: Likelihood times Impact)*	**Likelihood** *Certain: 5 Likely: 4 Possible: 3 Unlikely: 2 Rare: 1*	**Impact** *Essential: 5 Major: 4 Moderate: 3 Minor: 2 Insignificant: 1*	**Mitigation measures**	**Responsible PUNO**
i) Conflict and political instability around border and mobility corridors prevent access to PoE and/or targeted communities	12 - High	4	3	Provide essential services needed at PoE, scale back or shift activities until stability returns	IOM
ii) COVID-19, or other disease outbreaks, prevent international or domestic travel to conduct field assessments and activities	6 - Medium	2	3	Early detection, reporting to surveillance system can ensure timely response to disease/events and thus minimize the cross-border spread of disease; some activities can be adapted to be remote if needed	WHO
iii) Government commitment becomes insufficient for policy action and support of programme efforts decrease substantially	8 - Medium	2	4	Regular coordination meetings at national and provincial levels to discuss progress and consult	IOM/WHO
iv) Turnover in administration disrupts continuity in advocacy and policy action and/or ability to implement	6 - Medium	2	3	If this was to occur, advocacy efforts would be ramped up to re-build government support	IOM/WHO
v) Government staff turnover rises to a level too significant to maintain capacity and transfer of skills	6 - Medium	2	3	Training and capacity building exercises shift to focus more significantly on training of trainers (ToT) and regular trainings	WHO
vi) Supply chain disruptions prevent purchases and construction	6 - Medium	3	2	Regularly monitor supply chains and pro-actively seek out alternative vendors as a pre-caution	IOM
vii) Conflict or natural disaster triggers significant displacement in capacitated communities	6 - Medium	3	2	Members of the capacitated communities can use their knowledge to support the prevention	IOM

				of potential disease outbreaks while displaced	
viii) Political ties with neighboring countries (Pakistan and Iran) weaken, weakening support and trust in cross-border agreements and activities	6 - Medium	3	2	Cross-border interlinkages and coordination will be strengthened at the technical level, which is likely to be able to continue, regardless of heightened political tensions	

Annex 3a: Budget – Results Based Budget

	Outcome/ output/ activity formulation:	IOM	WHO	**TOTAL** (all PUNOs)	Amount reserved for direct action on gender equality:
PROGRAMMATIC BUDGET					
OUTCOME 1: Government and civil society actors in Afghanistan effectively plan and inform interventions to strengthen International Health Regulations (IHR) capacities at PoEs and target communities in Afghanistan					
Output 1.1	**A combined assessment of the implementation of IHR for key PoE is available to guide contingency planning. (WHO)**	**-**	**83,000**	**83,000**	**35,200**
Activity 1.1.1	Form assessment steering committee and develop tools for PoE assessment	-	13,000	13,000	7,200
Activity 1.1.2	Conduct field assessments and de-briefs	-	25,500	25,500	12,000
Activity 1.1.3	Draft the assessment report and organize events to discuss findings and recommendations	-	15,000	15,000	6,000
Activity 1.1.4	Key stakeholder meetings to develop contingency plans		29,500	29,500	10,000
Output 1.2	**Legislative assessments, recommendations and advocacy efforts are provided in support of adapted policy and legal frameworks. (WHO)**	**-**	**43,000**	**43,000**	**9500**
Activity 1.2.1	Form the committee of advisors and public health experts	-	24,000	24,000	5,000
Activity 1.2.2	Conduct national workshops on the review and formation of legislation, policy and recommendations	-	5,000	5,000	2,500
Activity 1.2.3	Draft, publish and disseminate the legislation review assessment report and advocate for legal amendments based on the recommendations	-	14,000	14,000	2,000
Total for Outcome 1 (Outputs 1.1 + 1.2 + 1.3…etc.)		***-***	***126000***	***126,000***	***44700***

OUTCOME 2: Key target land and air PoE more effectively implement IHR (Islam Qala, Melak, Torkham and Spin Boldak land crossings and Hamid Karzai Airport in Kabul)					
Output 2.1	**A comprehensive capacity building plan for government (MoPH and ABP) and civil society actors is developed and rolled out. (WHO, some IOM)**	**16,000**	**118,800**	**134,800**	**54880**
Activity 2.1.1	Hold meeting to review training needs component of the POE assessment	-	7,000	7,000	3,400
Activity 2.1.2	Develop SOPs, capacity building plan and training curriculum on rights based IHR implementation at PoEs	-	19,000	19,000	9,000
Activity 2.1.3	Organize trainings for MoPH, ABP and Customs officials	-	42,000	42,000	12,700
Activity 2.1.4	Run quarterly tabletop simulation exercise(s)	-	40,000	40,000	19,680
Activity 2.1.5	Print and distribute pocket reference guides	16,000	-	16,000	5,100
Activity 2.1.6	Mentorship activities and follow up to review efficacy of trainings		10,800	10,800	5,000
Output 2.2	**Infrastructure at Point of Entry (PoE) is equipped to handle interviews, the isolation of suspected cases and expanded health services. (IOM)**	**163,071**	**27400**	**190,471**	37200
Activity 2.2.1	Hire engineer staff (G5/6) to design and oversee construction	22,400	-	22,400	-
Activity 2.2.2	Field assessment of infrastructure need jointly by WHO and IOM Engineers	-	5,400	5,400	2,200
Activity 2.2.3	Hold meetings to review PoE assessment and agree upon design of construction plans for each PoE	2,640	8,000	10,640	3,000
Activity 2.2.4	Construction and upgrading of PoE infrastructure	60,000	-	60,000	25,000
Activity 2.2.5	Supporting capacity building of intrastructures in viccinity of PoEs	26,031	-	26,031	7,000
Activity 2.2.6	Procurement of additional office and medical supplies	32,000	-	32,000	-
Activity 2.2.7	IT Equipment, Software and supplies - PoE	10,000	14,000	24,000	-
Activity 2.2.8	Procurement of PPE	10,000	-	10,000	-
Total for Outcome 2 (Outputs 2.1 + 2.2 + 2.3…etc.)		***179,071***	***146,200***	***325,271***	***92,080***

OUTCOME 3: Community and PoE-based surveillance systems, reporting mechanisms and awareness raising efforts support effective and timely responses to the presence of communicable disease.					
Output 3.1	**Public health emergency surveillance systems are integrated and/or strengthened at the International Airport and key land crossings, as well as in key mobility corridors. (IOM and WHO)**	541,190	341,400	882590	286750
Activity 3.1.1	Strengthen and tailor SOPs and other guidance within the overall surveillance system	-	17,000	17,000	8,000
Activity 3.1.2	Conduct capacity building workshops on surveillance systems	-	9,500	9,500	5,000
Activity 3.1.3	Establish screening/surveillance system at the PoE with functioning referral management	481,380	-	481,380	160,000
Activity 3.1.4	Support the placement of a designated health official at each target PoE	-	84,000	84,000	25,000
Activity 3.1.5	Conduct Population Mobility Mapping exercises	28,660	-	28,660	8,500
Activity 3.1.6	Consultant - DTM	31,150	-	31,150	-
Activity 3.1.7	Develop and roll-out community-based mechanism for feeding into overall surveillance system in targeted border communities	-	24,000	24,000	10,000
Activity 3.1.8	Establishing vector surveillance system for POEs including international TA for developing guidelines/SoPs and trainings and equipment	-	206,900	206,900	70,250
Output 3.2:	**Risk Communication and Community Engagement (RCCE) is available on health risks and border control at PoE and in border communities proximate to key border crossing. (IOM)**	28,000	73,440	101,440	31000
Activity 3.2.1	Through three local workshops and a national workshop, to develop and consolidate RCCE messaging and materials, coordinating closely with MoPH and consulting with community committees and PoE officials.	-	17,000	17,000	8,000
Activity 3.2.2	Conduct RCCE ToT at national level	-	5,000	5,000	2,000
Activity 3.2.3	Print/procure IEC materials	16,000	-	16,000	-

Activity 3.2.4	Roll out messaging, via billboards, social media, pamphlets, etc	12,000	-	12,000	4,000
Activity 3.2.5	Conduct awareness raising and orientation sessions	-	29,440	29,440	12,000
Activity 3.2.6	Visibility activities of the project	-	22,000	22,000	5,000
Total for Outcome 3 (Outputs 3.1 + 3.2 + 3.3…etc.)		***569,190***	***414,840***	***984,030***	***317,750***
OUTCOME 4: Strengthened cross-border cooperation enhances early detection and response capacities at PoE and target communities					
Output 4.1:	**Coordination and communication mechanisms exist at PoE for reliable early detection and response, including cross-border agreements. (IOM)**	52,480	122,000	174,480	56,500
Activity 4.1.1	Multi-sectoral coordination team meetings	22,080	17,000	39,080	14,000
Activity 4.1.2	Organize stakeholder mapping of existing cross-border coordination engagements and opportunities	15,200	8,000	23,200	5,000
Activity 4.1.3	Support the development of a ToR, SOP or protocol on cross-border engagement and information sharing with cross-border PoE/provincial level partners	15,200	17,000	32,200	7,500
Activity 4.1.4	Support cross border meetings, table top exercises and joint trainings	-	40,000	40,000	20,000
Activity 4.1.5	Joint cross-border trainings with Pakistan and Iran	0	40,000	40,000	10,000
Total for Outcome 4 (Outputs 4.1 + 4.2 + 4.3…etc.)		***52,480***	***122,000***	***174,480***	***56,500***
TOTAL PROGRAMMATIC BUDGET: (Outcomes 1 + 2 + 3…)		**800,741**	**809,040**	**1,609,781**	**511,030**

GENDER BUDGET: % of total budget reserved for GEWE (indicative) in the programmatic budget.	*32%*

PERSONNEL, OPERATIONAL, M&E BUDGET	**IOM**	**WHO**	**TOTAL**
Personnel costs if not included in activities above	**490,975**	**239990**	**730,965**
Operational costs if not included in activities above	**83,834**	**200000**	**283,834**

Monitoring and evaluation (must include provision for final independent evaluation) - minimum 3% of total budget	**45,000**	**40700**	**85,700**
TOTAL PERSONNEL, OPERATIONAL, M&E BUDGET:	**619,809**	**480,690**	**1,100,499**

SUB-TOTAL PROJECT BUDGET: (Programmatic + Personnel, Operational and M&E)	**1,420,550**	**1,289,730**	**2,710,280**
Indirect support costs (7%):	**99,439**	**90,281**	**189,720**
TOTAL PROJECT BUDGET:	**1,519,989**	**1,380,011**	**2,900,000**

Annex 3b: Budget – UNDG Budget Categories

CATEGORIES	IOM	WHO	JOINT PROGRAMME TOTAL
1. Staff and other personnel	490,975	323,990	814,965
2. Supplies, Commodities, Materials	139,364	62,500	201,864
3. Equipment, Vehicles, and Furniture (including Depreciation)	21,126	114,000	135,126
4. Contractual services	639,930	122,100	762,030
5.Travel	73,531	66,200	139,731
6. Transfers and Grants to Counterparts	-	-	
7. General Operating and other Direct Costs	55,624	600,940	656,564
Sub-Total Project Costs	1,420,550	1,289,730	2,710,280
8. Indirect Support Costs (must be 7%)	99,439	90,281	189,720
TOTAL	1,519,989	1,380,011	2,900,000
First Tranche (70%)	**1,063,992**	**966,008**	**2,030,000**
Second Tranche (30%)	**455,997**	**414,003**	**870,000**

Annex 4: Workplan

Activities	Responsible Party	Timeframe							
		Year 1				Year 2			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.1.1 Form assessment team and tools for PoE assessment	WHO	X							
1.1.2 Conduct field assessments and de-briefs	WHO	X							
1.1.3 Draft the assessment report and organize events to discuss findings and recommendations	WHO	X							
1.1.4 Organize key stakeholder meetings to develop contingency plans	WHO		X						
1.2.1 Form the committee of advisors and public health experts and recruit one legislation expert for 4 months	WHO		X						
1.2.2 Conduct national workshops on the review and formation of legislation, policy and recommendations	WHO		X						
1.2.3 Draft, publish and disseminate the legislation review assessment report and advocate for legal amendments based on the recommendations	WHO			X					
2.1.1 Review training needs component of the POE assessment	WHO			X					
2.1.2 Develop SOPs, capacity building plan and training curriculum on rights based IHR implementation at PoEs	WHO			X					
2.1.3 Organize trainings for MoPH, ABP and Customs officials	WHO				X	X	X	X	X

2.1.4 Run tabletop simulation exercise(s)	IOM			X		X			X
2.1.5 Print and distribute pocket reference guides	IOM			X	X	X	X	X	X
2.1.6 Mentorship activities and follow up to review efficacy of trainings	WHO			X	X	X	X	X	X
2.2.1 Hire engineer staff to design and oversee construction	IOM	X							
2.2.2 Field assessment of infrastructure needs jointly by WHO and IOM Engineers	IOM/WHO	X	X						
2.2.3 Hold meetings to review PoE assessment and agree upon design of construction plans for each PoE	IOM	X	X						
2.2.4 Construction and upgrading of PoE infrastructure	IOM		X	X	X	X	X		
2.2.5 Supporting upgrading of infrastructures in the vicinity of PoEs (transit center clinics)	IOM		X	X	X	X	X		
2.2.6 Procurement of additional office and medical supplies	IOM		X	X	X	X	X		
2.2.7 IT Equipment, Software and supplies - PoE	IOM	X				X			
2.2.8 Procurement of PPE	IOM	X				X			
3.1.1: Strengthen and tailor SOPs and other guidance within the overall surveillance system	WHO	X							
3.1.2: Conduct capacity building workshops on surveillance systems	WHO		X						
3.1.3: Establish screening/surveillance system at the PoE with functioning referral	IOM	X	X	X	X	X	X	X	X

management (inclusive of ambulance transport)									
3.1.4: Support the placement of a designated health official at each target PoE	WHO	X	X	X	X	X	X	X	X
3.1.5: Conduct Population Mobility Mapping exercises	IOM				X				X
3.1.6 Tablets for online data entry/updates in DHIS2 and mobile phones for communication of public health official to surveillance team	WHO	X							
3.1.7: Develop and roll-out community-based mechanism for feeding into overall surveillance system in targeted border communities	IOM/WHO	X							
3.1.8: Establishing vector surveillance system for POEs including international TA for developing guidelines/SoPs and trainings and equipment	WHO		X	X	X	X	X	X	X
3.2.1 Through three local workshops and a national workshop, develop and consolidate RCCE messaging and materials, coordinating closely with MoPH and consulting with community committees and PoE officials for effective means of communication	WHO	X	X						
3.2.2 Conduct RCCE ToT at national level			X						
3.2.3 Print/procure IEC materials	IOM		X	X					
3.2.4 Roll out messaging, via billboards, social media	IOM		X	X					
3.2.5 Conduct awareness raising and orientation sessions	IOM		X	X					

3.2.6 Visibility activities of the project	WHO/IOM	X	X	X	X	X	X	X	X
4.1.1: Form core multi-sectoral airport and land PoE planning and support coordination teams and support regular meetings	WHO/IOM	X	X	X	X	X	X	X	X
4.1.2: Conduct stakeholder mapping of existing cross-border coordination engagements	IOM		X						
4.1.3: For each land PoE, develop/tailor a ToR, SOP or protocol for national communication link and international communication link on cross-border engagement and information sharing with cross-border partners	WHO		X						
4.1.4 Provide logistical support to the organization of cross border meetings, table top exercises and trainings	IOM/WHO	X	X	X	X	X	X	X	X
4.1.5 Joint cross-border trainings with Pakistan and Iran	WHO		X	X	X	X	X	X	

Annex 5: Human Rights Marker Self-Assessment Matrix

Element of an HRBA	Yes/ No/ Not Applicable	Justification
1. A human rights-based situational analysis has been conducted to identify: a) the key human rights obligations of the State(s) in which you work/whose government's) you are supporting; and b) the key human rights issues of relevance to your intended target group, including a particular attention to migrants most vulnerable to human rights violations and abuses and/or most at risk of being left behind.	No	While there are existing human rights analyses related to key issues facing mobile populations and communities in areas of high mobility, as well as for the more general population in relation to medical care, these were not specifically undertaken for the purpose of this project.
2. Staff are aware of the human rights obligations of the government they are supporting.	Yes	IOM and WHO staff work closely with GoIRA, including on human rights, specifically relating to public health and the rights of migrants. As such, they are aware of such obligations and in strengthening the realization of these in practice.
3. Measures have been identified to mitigate any unintended negative human rights impacts identified in the situational analysis and their monitoring has been integrated in the project's Monitoring and Evaluation processes.	Yes	IOM and WHO acknowledge the heightened vulnerabilities that are faced by migrant populations in Afghanistan, including relative to access to medical care, and acknowledge the need to ensure high quality training and oversight of all officials and partners to ensure no unintended harm is done through the project. M&E will include monitoring of the efficacy of training for officials and staff, particularly at the PoE.
4. Monitoring processes are in place and evaluation processes are contemplated that make specific reference to relevant human rights and other relevant standards.	Yes	Strengthening the realization of human rights is at the core of IHR and within the parameters of this project. Monitoring processes are directly linked to measuring the progress of IHR implementation, and therefore the improved realization of human rights for migrants and affected communities.

5. Migrants, civil society, national human rights institutions and other stakeholders have been meaningfully engaged in the design and development of the Joint Programme.	Yes	Yes, the development of this project, and the larger effort from IOM and WHO to strengthen health outcomes at PoE and in mobility corridors, has been centrally informed by feedback from migrants, affected communities and key stakeholders.
6. A plan to ensure a meaningful consultation processes with all relevant stakeholders is in place and will be maintained throughout the duration of the Joint Programme and in the evaluation phase.	Yes	As noted in the project document, the project has been designed to include consultation and feedback mechanisms that include the participation of community leaders and civil society, and which take into account the experiences and needs of migrants. The evaluation will likewise ensure these voices are included.
7. Appropriate due diligence will be exercised throughout the duration of the joint programme, regarding partnerships with or support to State, non-State, civil society, employers' and workers' organizations and corporate actors.	Yes	IOM/WHO institutional due diligence mechanisms and in-depth knowledge of existing partners and the Afghan operating context will ensure appropriate due diligence is ensured throughout implementation.
8. A plan is in place to ensure that Joint Programme staffing is gender-balanced and staff are equipped to respond effectively to stakeholder and target group needs.	Yes	Both IOM and WHO have policies to ensure gender-balanced hiring practices. This is particularly important for frontline engagements with communities to ensure equal access to information and services.
9. Transparency and access to information by the intended target group and relevant stakeholders, including cultural, linguistic, and age-appropriate access, will be maintained throughout the duration of the joint programme.	Yes	This project includes specific components on ensuring equal and open access to information. The listed considerations are central to the development and roll out of these, in close consultation with local health shura.
10. Measures, including an effective complaint and remedy mechanism, will be put in place in order to provide redress for negative human rights impacts.	Yes	Feedback mechanisms will be reinforced at PoE and in communities in connection with programme activities. This will be particularly important at PoE, where there are heightened sensitivities relating to the conduct of border officials and ensuring access to

		proper medical care and services. This will include ensuring information on the AWAAZ call center and feedback mechanism are widely available (see proposal for more details).