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The development of Afghanistan's Integrated Package of Essential Health Services: Evidence, expertise and ethics in a priority setting process

Isabelle L. Lange [a,*], Ferozuddin Feroz [b], Ahmad Jan Naeem [b], Sayed Ataullah Saeedzai [b], Fatima Arifi [b], Neha Singh [a], Karl Blanchet [a,c]

[a] Department of Global Health and Development, London School of Hygiene & Tropical Medicine, London, WC1E 7HT, UK
[b] Ministry of Public Health, Kabul, Afghanistan
[c] Geneva Centre of Humanitarian Studies, University of Geneva, Switzerland

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ABSTRACT

Health systems in fragile states need to respond to shifting demographics, burden of disease and socio-economic circumstances in the revision of their health service packages. This entails making difficult decisions about what is and is not included therein, especially in resource-constrained settings offering or striving for universal health coverage. In this paper we turn the lens on the 2017–2021 development of Afghanistan's Integrated Package of Essential Health Services (IPEHS) to analyse the dynamics of the priority setting process and the role and value of evidence. Using participant observation of meetings and interviews with 25 expert participants, we conducted a qualitative study of the consultation process aimed at examining the characteristics of its technical, socio-cultural and organisational aspects, in particular data use and expert input, and how they influenced how evidence was discussed, taken up, and used (or not used) in the process. Our analysis proposes that the particular dynamics shaped by the context, information landscape and expert input shaped and operationalized knowledge sharing and its application in such a way to constitute a sort of "vernacular evidence". Our findings underline the importance of paying attention to the constellation of the priority setting processes in order to contribute to an ethical allocation of resources, particularly in contexts of resource scarcity and humanitarian need.

1. Introduction

Fragile states are having to reimagine, reconstruct and revise their health systems to respond to shifting demographics, burden of disease and socio-economic circumstances (Schmid and Raju, 2020). This entails making difficult decisions about what is and is not included in their health care packages, especially in resource-constrained settings offering or striving for universal health coverage (Norheim, 2016). In our increasingly globalised world, a variety of actors take part in this process and contribute to the outcomes – donors, academics, NGOs, clinicians, civil rights groups and politicians, among others. This can mean that different kinds of data and knowledge are elevated and subjugated. At the same time, the process remains extremely political (Kieslich et al., 2016), with a multitude of dynamics factoring into every step of the way and often intangible factors influencing the prioritization process.

While priority-setting activities in health services take place in many settings, a universal guideline to accompany these processes do not exist (Hipgrave et al., 2014). Authors have offered various approaches that reflect different end-goals and contextual particularities (Glassman et al., 2016; Baltussen et al., 2016). Based on decisions and trade-offs due to limited resources and infrastructure, certain health conditions will be prioritized while others (and the populations they are more likely to affect) will be sidelined (Sabin, 1998). Populations at risk due to vulnerabilities such as socio-economic status, geographic location, gender or other factors could be impacted negatively (Rosoff, 2017). Priority-setting is a complex and necessary step to ration service delivery in health systems but in the process of becoming normative may not be able to constructively capture the broader contextual problems or offer comprehensive solutions to deeper rooted challenges (Bump, 2019; Kenny and Joffres, 2008). As such, how one approaches priority-setting processes plays a fundamental part in assuring that identified health packages have a chance at being equitable and fair according to the resources at hand.

One key aspect of the priority-setting process includes what sorts of

* Corresponding author.
E-mail addresses: Isabelle.Lange@lshtm.ac.uk (I.L. Lange), drferozferoz@gmail.com (F. Feroz), ahmadjn@hotmail.com (A.J. Naeem), atasayedzai@gmail.com (S.A. Saeedzai), fatima.arefi@gmail.com (F. Arifi), Neha.Singh@lshtm.ac.uk (N. Singh), Karl.Blanchet@unige.ch (K. Blanchet).

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evidence are used to identify problems and applied to solve them. At the most basic level, the underpinning ideas that form the basis of evidence seeking and application can differ profoundly between societies, shaped by ethical values and deep rooted socio-practices (Stefanini, 1999). Recently, in the field of evidence-based decision making, there has been a shift in the hierarchy of evidence pyramid from placing the traditional context-free scientific knowledge at the coveted peak to also seeing the value in methodologies that embrace context-derived knowledge (Blanchet et al., 2020). This is particularly the case of humanitarian settings and fragile states, where contexts are dynamic, unpredictable and require methodological adaptations (Smith et al., 2020), while a large gap remains in evidence availability (Kohrt et al., 2019).

The literature on health service priority setting has frequently focused on key steps in the process, such as methodology, donor financing, political will and lobbying, disease group characteristics and resources, or on implementation though technical aspects have also more recently been documented (see, for example Eregata et al., 2020; Petit et al., 2013, Petricca et al., 2018). These technical activities that make up the actual priority-setting process in-country deserve to be unpacked further, as they form the arena in which data, evidence and national and international experts come together to make decisions toward the development of strong, revised, health systems. We ask: how does the nature of the priority-setting process influence how decisions are made and how evidence is used? What are the shaping factors beyond actual evidence, statistics and country-specific characteristics?

In this paper we turn the lens on the 2017–2021 development of Afghanistan's Integrated Package of Essential Health Services (IPEHS) to analyse the dynamics of the priority setting process and the role and value of evidence. We conducted a qualitative study of the consultation process which aimed to examine the characteristics of its technical, socio-cultural and organisational aspects, in particular data use and expert input, and how these dynamics influenced how evidence was discussed, taken up, and used (or not used) in the process. Our analysis proposes that the particular dynamics shaped by the context, information landscape and expert input shaped and operationalized knowledge sharing and its application in such a way to constitute a sort of "vernacular evidence".

1.1. Background

The focus of this paper is Afghanistan's first health system revision since their Basic Package of Health Services (BPHS) was devised in 2003 and the complementary Essential Package of Health Services (EPHS) in 2005. Both of these packages aimed at delivering effective, targeted, equitable, and sustainable health services to the Afghan population at a time of optimism that peace was a real prospect for the country (Mirzazada et al., 2020). The packages were designed as a development tool as part of the Afghan Ministry of Public Health (MoPH) national health strategy (2002–2004) which focused in particular on improving maternal and child health, and on the control of communicable diseases. At this time, high maternal mortality ratios caused Afghanistan to be considered "one of the worst places in the world for a woman to be pregnant" (UNICEF, 2002).

In the years following the implementation of the BPHS and EPHS, Afghanistan made substantial progress in population health, with an estimated 64 percent reduction in the maternal mortality ratio (Akseer et al., 2016), and an under five mortality rate that was reduced from 172/1000 in 2003 to 50/1000 in 2018 (UNICEF,). Furthermore, access to and utilization of primary health care services improved along with the supply of essential medicines (Mirzazada et al., 2020). The country's health information system became progressively functional with increased investment (Newbrander et al., 2014). However, given the emergency situation and slow progress in responding to other key health indicators, and in light of emerging health challenges, it became clear that the current packages were no longer meeting the needs of the population.

In 2017, the MoPH started to seriously consider developing a new health services package aligned with the changing health needs of the population and the capacity of the Afghan health system. There were clear mandates for this revision. First, the current package predominantly addressed the donor concerns in the early 2000s. Over the years, the country's burden of disease had changed, with an increase in non-communicable diseases (33%) due to longer life expectancies and lifestyle modifications, and a rise in trauma and injuries (21%) as a result of the resurgence of the conflict (percentages based on the 2010 mortality survey, Afghan Public Health Institute et al., 2011).

The consultation and revision process took about 18 months in 2017–2019 and another eight months in 2021 and resulted in the 2021 IPEHS, published by MoPH in August 2021 just before the take over of Kabul by the Taliban. By paying attention to the revision process of the IPEHS, in this study we examine the inputs and dynamics that shape the resulting health system package.

2. Methodology

2.1. Conceptual framework

Within health system development, priority setting processes reflect the environment within which specialist topics are enacted. They are synced with resource allocation, and undertaken in a landscape of scarcity or abundance of resources, technical developments, governance, communication, and competing interests, among other factors. Priority setting is often studied by ethicists, who debate the key principles of what constitutes ethical practices (Kieslich et al., 2016).

We grounded our study's approach of the IPEHS revision in the idea that conceptualizations of good practice and evidence vary and are not static. The role evidence plays is fluid according to the context in which it is employed. Our study seeks to understand what factors influence decision-making in the priority setting process and the role that evidence plays, also analyzing who in this context has the authority to interpret data and when and how it becomes validated, or considered evidence (Dobrow et al., 2004). Following the ideas of Hilhorst and Jansen (2010, 2018) we recognize that humanitarian spaces are socially negotiated. These sites are used to further projects and ambitions – be they of individuals or institutions. At the same time, humanitarian actors (agencies, individuals) need to legitimize themselves, just as aid beneficiaries do, and contributions – in the form of recommendations, expert input, funding, networking, and resources – will reflect these dynamics.

Overall, the study of these arenas in which decisions are made are attempts to understand how health care for particular services is rationed, and the interplay between values and resources. We turn the lens on the role of evidence and argue that a variety of aspects play a role in shaping how evidence is perceived, used and operationalized. To guide our analysis we used a framework by Barasa et al. (2015) designed to evaluate priority setting processes. They reviewed the literature on processes of resource allocation in health care and specified consequentialist outcomes and proceduralist conditions central to successful priority making. The organization of the analysis and the results of this study are guided by the seven proceduralist conditions, which are: stakeholder engagement; stakeholder empowerment; transparency; use of quality information; revisions; enforcement; and incorporation of community values (Barasa et al., 2015). As this study focuses on the process of priority setting, not its implementation, we do not include the consequentialist outcomes in our analysis.

3. Methods

3.1. Document review

The authors reviewed relevant documents including donor agency reports, government files, scientific publications, policy briefs, and external evaluations to place debates and perspectives within the

historical context of the BPPHS and other related activities.

3.2. Interviews and participant observation

We selected study participants based on their involvement in the consultation process, either as part of the international Expert Committee or Afghanistan Working Groups (these groups are explained in the results section). We chose interview participants based on our observation of the process and discussions with facilitators, receiving no refusals from approached individuals. Between October 2018 and March 2019, we interviewed 13 members and observers of the Expert Committee (of approximately 25), and 10 members of the Working Groups (of approximately 50 members). At least one member of each of the nine Working Groups was interviewed. Informants included academics (health systems researchers, epidemiologists, modellers, economists, and specialists in health domains such as maternal and mental health), clinicians, donors, policy makers and technical advisors.

ILL conducted semi-structured interviews with Expert Committee members in private (face-to-face or by phone), and followed-up with participants by email or phone for clarifications. One interview was conducted as a triad. PR[1] conducted interviews in Afghanistan with Working Group members. Interviews, done in English, lasted between 30 min and 2 h. We adapted topic guides for each interview to cover main themes and to allow for informants' own narratives and values to emerge. Most participants had been involved in the process for more than a year, and interviews required them to reflect back to the origins of their association with the project.

All authors observed or participated in either some or all of the expert meetings throughout the revision process, and contributed to logistical and scientific aspects of the execution of the revision between 2017 and 2021. The meetings offered the opportunity for informal conversations and for interactions to jog people's memories and present ideas that they might not have thought of in a one-on-one more structured setting. ILL took field notes, and we included the minutes of all meetings in the analysis. Presentations and conference proceedings where elements of the IPEHS revision were presented also informed the data base.

3.3. Analysis

All but two interviews were digitally recorded, then transcribed. ILL analyzed the data, supplemented by discussions with the wider research project team in London and Kabul. We adapted a thematic analysis approach, coding interview transcripts and observation notes on the basis of *a priori* topics – accountability, measurement, use of evidence, etc. – and arranged according to recurring themes that arose during analysis. Coding was then stratified by source of information (e.g. informant interview, observation). We employed a mix of iterative response and thematic analysis using a constant comparative method of coding and a systematic process to identify relevant emergent themes. The analysis was written-up according to the main research questions, the themes that emerged through readings, Barasa et al.'s conceptual framework (2015), and discussion between the researchers. We first produced a descriptive report of the revision process, which also served as an organizational tool to categorize participants' reflections during analysis.

3.4. Researcher positionality

The lead author of this study is a medical anthropologist who was an observer to the revision process, supported by co-authors who, as public and global health specialists, were a part of the consultation exercise and have expertise in health systems, economics, and clinical medicine, either from within Afghanistan and/or globally. As such, this paper is authored by scholars and practitioners both internal and external to priority setting practices, which allowed for the external perspective to be confronted by invested perspectives. This meant that intricacies of the process – from exchanges between participants observed in meetings to the politics of embarking on a health system revision – could be questioned and discussed. Co-authors were interviewed as part of data collection to document ideas surrounding the research questions and the role of evidence in the process in their eyes, which could then be mapped out and compared in relation to other participants' perspectives.

3.5. Confidentiality and informed consent

The Afghanistan Ministry of Public Health and London School of Hygiene & Tropical Medicine (LSHTM) ethical committees granted permission for this study to take place. Written informed consent was requested and received from all informants. Study participants were given the option to be named or not in any publication resulting from this research.

4. Results

We begin by describing the revision structure and timeline, main tasks and perspectives on its rationale. We then present the results according to the proceduralist conditions of the aforementioned framework. Given our particular focus on evidence use, the section on "use of quality information" is more in-depth.

4.1. Overview of consultation structure

The MoPH, led by the Minister of Public Health, Dr Ferozuddin Feroz, drove the revision process. In their role of overseeing this activity, the MoPH core team coordinated nine national Working Groups and obtained and integrated expert opinion from members of the Ministry and the local stakeholder community including international organisations such as United Nations agencies. A range of technical experts in the MoPH who carried out specialist tasks related to the BPHS/EPHS revision also reinforced the core team. These activities were supported by four main international partners: LSHTM coordinated the international aspects of the work and conducted a series of analyses on the burden of diseases, service delivery and health system assessment with the MoPH Monitoring and Evaluation and Health Information System Directorate. The World Health Organization (WHO) Geneva provided expertise on clinical aspects and general articulation of the interventions by health system level. University College London (UCL) took the lead on the health economics activities, carrying out allocative efficiency analyses in collaboration with the MoPH Health Economics and Financing Directorate (HEFD). At the time of the development of the new package of health services, the Disease Control Priorities (DCP) network was a global collaboration coordinated by the Department of Global Health at the University of Washington. The consultation activities were funded by the Bill and Melinda Gates Foundation (BMGF), and funds were managed by LSHTM.

In Afghanistan, nine multi-stakeholder Working Groups were set up according to health domains (reproductive, maternal, child and adolescent health; mental health; surgery; cardiovascular health; infectious disease; surgery; cancer; palliative care; rehabilitation; and intersectoral policy) to provide expertise in reviewing the shortfalls in the BPHS and EPHS.

An advisory mechanism in the form of an international Expert Committee was put in place to maximize the use of data and evidence, ensure the adequacy of the methodology, encourage creativity in data analysis, and provide accountability for use of the results by the Afghan government, as well as by national and global stakeholders. Committee participants were invited based on their expertise of the various disease domains and their knowledge of the Afghanistan health system. More

[1] Peter Reynolds of Rebuild Consultants.

specifically, the role of the 15 members of the Expert Committee were to provide advice on: the current evidence for specific health interventions; key criteria for selecting priority interventions in the revised BPHS and EPHS; the pre-selection of priority interventions; the relevance and feasibility of any proposed interventions; and how best to visualize and communicate results from the work to ensure their use.

Both the Working Groups and the international Expert Committee were tasked with prioritizing the interventions needed for Afghanistan. They shared the understanding that the revision should be led by the MoPH, and not directed by external actors. It was considered time for Afghanistan to be in control of the direction of its health system. One Afghan MoPH member spoke about past efforts in the country:

> UNICEF came to us to say maternal health is your priority. WHO says mental health and disability are your priorities. The World Bank was saying nutrition is your priority. Then WHO says immunization health is your priority. And postwar, we can put something about disability … They all came to the Ministry and defined the priority of the country. The international community came and based decisions on their own mandate. [EC10]

A timeline of the key steps in the process is outlined in Fig. 1.

The timing of stages 11 and 12 were determined by political developments. After May 2019, presidential elections were organized and Health Minister Dr Feroz was replaced. The IPEHS was put aside by the next minister who stayed in post for eight months after being dismissed. He was replaced by Dr Wahid Majrooh at the end of 2020 who received explicit instructions from the President of Afghanistan to finalise the IPEHS with the support of experts. The lead of the international expert group, Karl Blanchet, in the mean time based at University of Geneva, was called back by the Acting Minister to reinitiate discussions. Two rounds of national consultations were then organized in February and May 2021 in Kabul to review the 2019 version of the IPEHS. Around 70 people took part in the consultation process which included department directorss at the MoPH, international donors, UN agencies (WHO, UNICEF, UNFPA) and a few implementing partners managing provinces. This final round of consultation lead to the 2021 version of IPEHS released in August 2021 just before the arrival of the Taliban in Kabul.

4.2. Proceduralist conditions

4.2.1. Stakeholder engagement

Stakeholder engagement is influenced by structural factors such as which profiles and individuals constitute the participant list and how the task was organized (for example the nature, frequency and location of meetings).

The three international Expert Committee meetings took place in London, due to the security situation in Afghanistan. This meant that while three to five Afghan MoPH representatives (including the Minister) attended the Expert Committee meetings, fewer Afghan participants, e.g. from the Working Groups, could attend and that opportunities envisioned for joint working across actors were carried out by teleconference or not at all. Attendance at the international meetings varied, with a selection of experts present at each meeting. In addition to the members of the Expert Committee, LSHTM and UCL research team members involved in carrying out prioritization and costing exercises were invited to meetings as observers to be kept informed of the discussions taking place that would influence their calculations. Participants were not paid for their input throughout the 18 months beyond the reimbursement of their flight, accommodation and meals to cover their attendance at meetings. Each international Expert Committee meeting lasted two full days.

In general, Expert Committee members believed that the constitution of the group was appropriate for the task at hand. The "*right people were at the table*" with considerable expertise represented. An Afghan member of the expert committee highlighted the importance of making sure participants felt on board: "*Because, you know, if you develop policy and people are not feeling like they are part of the process they will not take it seriously.*" [EC3] A colleague agreed, "*It needs lots of meeting, lots of updating people, to get ownership. They've got to feel that they are involved, not just one-off meetings.*" [EC5]

Participants noted the presence of donors (World Bank and USAID) as observers at the international meetings, who were engaged, facilitators told us, to ensure transparency and future ownership by all stakeholders. While the revision was officially not considered a donor-driven process, by funding health system activities they were able to "*keep their fingers in the pie and make decisions*," one participant said. This raised

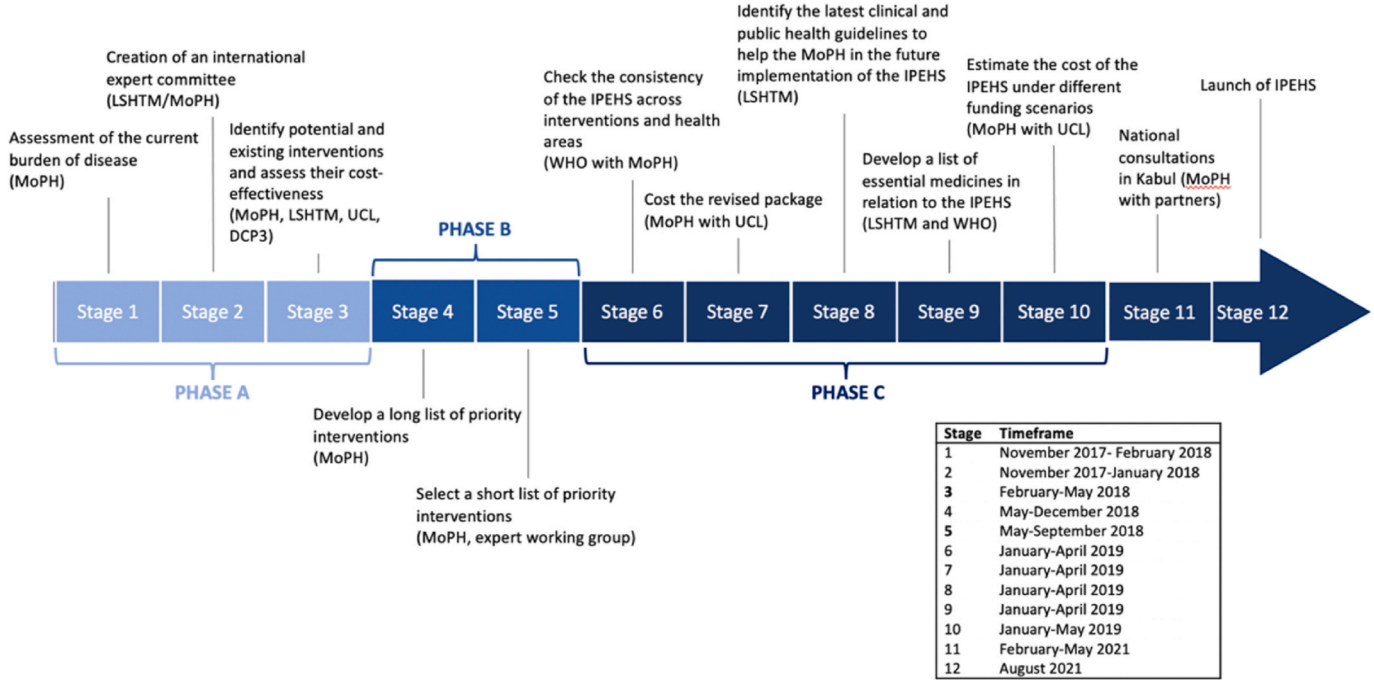

Fig. 1. Timeline of key activities in the IPEHS consultation.

questions surrounding the links between the amount of financial support and resources they provided and their input into the decision-making surrounding the configuration of services.

Facilitators had assembled a range of country-, disease-, and health system-expertise in the group, meaning that continuous negotiation between different aspects of health system building were on the floor for debate throughout the consultation. For example, clinical perspectives may have differed from financial perspectives, requiring negotiations between strategies and tensions around the possibilities for contribution.

Working Group members in Afghanistan assessed their own colleagues' involvement as "*hard working*" and engaged. While they valued their participation, some thought that they could have been used even more in the process, receiving more feedback about the revision, more contact with the Expert Committee and in general more exchange throughout the months of their consultation. As the security situation meant that international meetings were not held in Kabul as planned, the location of the international meetings will have contributed to an increased sense of separation from the place meant to be the focal point of the process. Ministry staff were aware of this issue, looking back, and suggested more meetings could have been held with these technical groups to further keep them informed along the way.

Throughout interviews, participants raised the disciplinary diversity of the group and the approaches presented. The task had been established as an interdisciplinary one, but more than one participant highlighted the struggle between health system development either being the domain of clinicians or of health service management and health system experts. One expert committee member laid out how they understood this tension:

> *For years you had a bunch of doctors running public health programs, and they were really shitty at it! It's not the same science, you know? And they weren't great at listening to people and they weren't great at teamwork and they weren't great at integrating lateral pieces of information. So … that was the problem. There was this real backlash about that, like, "You don't need doctors, you need people who understand the health system and you need MPHs [masters in public health]" …. which is all true but we've now gone kind of too far … Really: If you're doing services packages, the content is clinical service delivery … so your MPH [staff] probably should have started as a doctor 15 years ago*. [EC9]

This participant called for closer collaboration with clinical partners for input into the phases of the revision. However, an interview with a member of the Working Groups highlighted the difficulties of translating in-country clinical expertise into guidelines and policies, and underlined that even when complementary skills and training were present it could still be challenging to find the necessary common ground:

> Not to be offensive to anyone, but very few people know the medicine, the health care services. And there are very few people who know the medicine **and** have done public health. So there are two types of people – polarized: one with the curative medicine and health care services, and the other category are the public health. And there is a big gap between them. They don't want to understand each other. They don't want to delegate each other's expertise. [WG7]

Further discussion with this participant revealed that they believed the constellation of their subgroups and their repeated meetings offered the opportunity to cut across these disciplinary approaches. Notably, no representatives of patients' advocacy groups or other citizen and community members participated in this stage of the consultation process, either in Afghanistan or internationally, which is considered a core feature of stakeholder engagement.

4.2.2. Empowerment

In terms of feeling empowered to contribute to and influence decision-making, Expert Committee members believed that they could speak their minds and make their opinions known throughout the revision period. To do so, they sometimes chose indirect, non-public routes (for example, finding allies in the process with whom to exchange with, or initiating private calls with the facilitators to address issues).

Due to varying degrees of status, seniority and how vocal participants were, some voices were more dominant than others, which frustrated participants who may not have shared the same views on prioritization in the revision. "*It's a regular process of two steps forward, one back*," one programmatic expert told us.

Most Working Group participants believed the revision to be an important task and were overall hopeful that change would come about from the care and attention they put into their responsibilities. As the groups were separated by medical discipline, some participants felt that certain groups with renowned members had more clout and power than others when it came to the influencing the revision process. We heard from others that the Working Groups were well organized and it was helpful to have divided the tasks into smaller groups of expertise. "*Small groups are easy to control and to come in to one point. As you know, a big group cannot easily decide on one issue, because there are a lot of ideas and a lot of discussions. But generally, it was really nice, good dynamics. The meetings were chaired by the MoPH himself, then also the deputy.*" [WG2]

A condition of stakeholder empowerment includes clearly defining the roles of participants and assuring that they have adequate knowledge and resources to be able to contribute to the process – either from the start or through capacity building. Three Working Group participants told us that felt that they were not well-informed about how the process worked and what their role actually was. They attributed this to insufficient feedback of international level activity to the working groups so that they could be clearer on what they were supposed to be doing and why they were doing it.

4.2.3. Transparency and revisions

In general, Expert Committee members indicated that they felt the process was transparent and clear, even when decisions were taken that they did not necessarily agree with. Two participants said that decisions seemed to be taken in the "black hole" or "radio silence" between the three main meetings. Between these meetings, decisions were reversed or unexplained steps occurred – but these participants understood this perspective was likely due to *advising* rather than *running* an activity, in that they were peripheral to internal MoPH decisions made with the knowledge of the politics of the health system at heart.

Related to the concept of transparency, Expert Committee members noted participants' personal or institutional agendas behind priority setting. Some commented that "hot topics" in the global health landscape appeared to receive more attention in discussions according to trends and who was in attendance at the meetings. Gender was cited as being one such theme.

Two Working Group actors indicated that they were disillusioned by their past involvement in activities led or dominated by global actors and believed their opinions would be undervalued in this activity as well. The Working Group consultation was just a "tick-box exercise" done for the West and not done for Afghanistan, one said. These comments were indicative of historical processes that are important to be aware of in collaborations moving forward.

4.2.4. Use of quality information: evidence

Throughout the process, participants shared the understanding that "evidence was not enough" to develop the health package, and that in the absence of evidence, a combination of expert opinion, modelling, common sense, and core values would take their place. One expert committee member insisted that the consultation process as a whole was not actually about being evidence-based. She explained:

> *If you were to take only a set of randomised controlled trial-proven interventions, you would end up with kind of a Frankenstein health*

package. It wouldn't necessarily reflect all the things that work, it would reflect the scholarly research agenda *over the last x number of years, and what kind of things researchers are getting funded to do, and what kind of interventions are easily studyable. And that is very important … but that is only a small part of putting together a health delivery package.* [EC9]

Health systems like that of Afghanistan are poorly documented in the global health literature, meaning that you would need "*1000 systematic reviews*" and a large investment to be able to pull together the typical standards of evidence that generally input on healthcare decision-making, said another participant [EC2]. Instead, other factors – secondary data analysis, personal experience, small scale studies, local descriptive reports – were needed to take their place. The knowledge gap created by the lack of evidence on cost-effective interventions for Afghanistan created a space for negotiation.

4.2.4.1. Shared underpinning values. Before selection and application of evidence, facilitators decided that participants should agree upon a shared strategy within the priority setting exercise. The team adopted a multicriteria approach for transparent priority setting as follows: (i) use of the latest global and national evidence on burden of disease and cost–effectiveness of interventions (including the third edition of the disease control priorities); (ii) agreement by all stakeholders on well-defined selection criteria; (iii) transparent and documented process of selecting interventions; and (iv) recognition by all health systems actors that decisions made are reasonable, combining both analysis of evidence and expert discussions" (Blanchet et al., 2019).

Further shared values guided decision-making, including the fluid communication between decision-makers and researchers, the strengths of merging local and global expertise, and the recognition of the contributions of data analysis and modelling. In the second Expert Committee meeting, six months into the process, the facilitators proposed priority setting criteria to guide the group. The following points were to be at the forefront of each condition and health system decision placed on the table:

- Effectiveness: What has been proven to work?
- Local feasibility: Do local resources exist to deliver services? Is staff in place? Are they trained? Is the intervention supported by existing infrastructure?
- Affordability: Are new drugs and equipment required? Is there a large setup cost?
- Equity: Will it improve access to care? For whom?

To illustrate how these points have been operationalized in the meetings, we will detail the example of a discussion on the use of community health workers (CHWs) in the delivery of mental health services. The group deliberated which health services could be put in the hands of CHWs to provide, but this question exploded into a number of further considerations. If, during their community visits, CHWs are able to diagnose health problems but have nothing to offer families as treatment, it becomes ethically problematic. "*How do you answer to families if you can't offer any services?*" one participant asked. Another participant suggested that evidence did exist of CHWs and outreach nurses being able to offer certain aspects of mental health care, bringing in the example of neighboring Pakistan and short medical screening questions being delegated to CHWs rather than needing community members to travel to the health centre for screening. Furthermore, an academic participant added, "*It's complicated because do we even know whether we will have enough CHWs to carry out these tasks?*" Another brought up the issue of the profile of CHWs – are they literate? Is mental health an appropriate responsibility to task them with? They may be able to carry out screening, but what about decisions surrounding diagnosis and treatment that might be expected by the community? Some interventions to treat mental health will be medical and require clinical skills, but could some be delivered by CHWs? The discussion then evolved into discussing distinctive cadres of CHWs – those with different skill levels and training available at the other levels of the health system, and examples from other settings, such as Lady Health Workers in Pakistan. These discussions highlight how the analysis of interventions at one level of the system requires analysis of the rest of the system's capacity to deliver complementary interventions.

We have elaborated on this exchange here to demonstrate how in-depth discussion about any number of factors can derail a meeting agenda. This conversation on this single topic took 30 min, and was of course only one of the many areas that needed to be reviewed and unpacked. It shows how local knowledge and experience are indispensable and can – at the same time as they simplify processes – also add complexity to discussions as they bring to light the nuances and intricacies of real-life situations. The overall process of attributing services to specific areas of the health system was painstaking, much of it carried out away from the main meetings and discussed when smaller groups of participants came together. In this example, six spreadsheets for the different levels of the health system existed; make a change in one and the others would no longer be up-to-date to ensure the continuity of care.

Furthermore, the issue of mental health was already a contested one, and revealed the layers of value and attribution engrained into each health issue. In an exchange with MoPH officials one participant said *"[Donor participant] kept mentioning mental health because they are* funding. *But now we need to focus on: 'What is the need, what is the reality and what is the priority for the Ministry of Public Health?'"* [EC2] Another agreed: "*Rather than the donor* agenda*, there are priorities. There's a real battle to make sure it's the Ministry's –, it's the people's needs and priorities, not the donors'*." [EC13]

In the next two sections, we describe two backbones in the consultation activity – the use of DCP_3 data and adopting a mortality vs DALY driven rationale, to illustrate the complexity involved in filling evidence gaps.

4.2.4.2. The use of DCP_3 data. The 3rd edition of Disease Control Priorities published between 2015 and 2018 in nine volumes provides a review of evidence on cost-effective interventions to address the burden of disease in low- and middle-income countries (LMICs). It does so by drawing on systematic reviews of economic evaluations, epidemiological data, and clinical effectiveness studies, and on the expertise and time of over 500 authors (Jamison et al., 2017). While DCP_3 data is generally considered thorough and to have been constituted in a transparent manner, considerable adaptation must be undertaken when applying it at the country level, especially in those countries, like Afghanistan, where contextually adapted evidence is especially needed given the complexity brought about by sectarian violence and armed conflict. National health officials are advised by DCP_3 that its packages of interventions needed to be modified based on local priorities, and that country specific analyses as to costs and impact should be carried out. The needs for health system strengthening and implementation monitoring and evaluation also should also be considered.

To inform each health system building block, team members also consulted other sources, including the most recently available national health systems data and results from the Afghanistan mortality survey, mental health survey and other national surveys. To develop the list of interventions, Working Groups compared the DCP_3 list of interventions with the existing BPHS and the EPHS. The MoPH decided that the revised package of health services would be unique from community level to provincial level – instead of two distinct packages. This involved prioritizing the interventions in DCP_3 and assigning them to the different categories of health system level, categorized by health facility type. Contextual knowledge and specialist assessment as to which interventions would be possible given government and partner support at each level was critical for this task.

As they began their work, members in the Working Groups

mentioned that it was evident that the DCP_3 had been developed "*globally, and for other countries,*" so considerable care was needed in their review to contextually adapt the interventions. They stressed how important it was to move away from an academic mindset and ground the adaptation in the reality of the health professionals, public health actors, and communities living in the Afghan context each day. They also advised that the process should build on what did already work in the BPHS and EPHS.

The limitations of using DCP_3 data in Afghanistan became clear. As one participant also involved in the DCP_3 project acknowledged:

> *Afghanistan is a very unique place – a lot of the issues around the balance of interventions, epidemiology and health systems constraints and financial constraints I think are just unique even amongst low-income countries. As a first approximation, for the first model … the countries we had in mind for DCP audiences probably weren't a lot of conflict zones, to be quite honest. They were more like low, lower-middle income Africa and lower-income South Asia, is where we perceived there to be a lot of demand for the product and the most relevance. So, you take those epidemiologic settings and yes, there are some fragile states and some other sorts of – conflict. But we hadn't explicitly tried to tailor a package to a country that was on the very extreme end of things.* [EC13]

4.2.4.3. Mortality and DALY driven rationale. Disability-adjusted life years (DALYs) are a measure of the burden of disease accounting for the number of years lost due to ill health, disability or early death. DALYs "measure the gap between a population's health and a hypothetical ideal for health achievement" (Gold et al., 2002), and are used in setting health research priorities, identifying disadvantaged groups and targeting health interventions. While estimates, projections and modelling that are based on mortality – how many deaths could be averted due to a health service being offered – are popular and compelling, they underestimate morbidities such as chronic diseases, mental health, injuries and disabilities, that will have an impact on quality of life which DALYs can capture.

The Expert Committee took the decision to use DALYs for the analysis tools using context-specific data on burden of disease and intervention effectiveness to help stakeholders identify funding priorities and targets. The reference point of this consultation, the highest-priority package (HPP) published by DCP_3, is based on "value for money" which included three criteria: cost-effectiveness, equity, and financial risk protection (Watkins et al., 2017). There was therefore more cost-effectiveness data available than effectiveness data in the form of relative risk ratios – which would have allowed for outputs other than DALYs such as impact on disease incidence or mortality. Nonetheless, given the number of diseases and interventions considered, it is important to note that results might have been less clear to interpret if a variety of outputs were used. DALYs provided a single measure for which to compare interventions across the entire BPHS and EPHS packages.

These considerations were a point of debate for participants, particularly those in Afghanistan who were concerned about being able to make a case for their criteria setting in-country: mortality was an indicator that everybody could understand, and presented a persuasive argument. Furthermore, modelling – particularly an advanced or innovative method – required mental gymnastics on the part of some participants and was not a solution in itself. A technical expert emphasized this:

> *You can't just throw everything at the model and have the model tell you what to do, that is not the point of these models. These models are input to a policy conversation, not a replacement for a policy conversation, which is why, even if they become plug-and-play for countries, they have to have a policy discussion of their own first, decide what the list is – and that will be self-limiting, because no human is going to type a thousand of these things [variables] in, and lose the will to live at 250, when the model starts doing weird things.* [EC2]

As such, many of the discussions during the Expert Committee meetings fundamentally dealt with how to approach the hierarchization of decision-making regarding priority setting, with the acknowledgement that different methodologies would lead to different priorities, and, ultimately influence which health services and populations would be served.

4.2.5. Enforcement

At the time of writing, the IPEHS had not yet been implemented, but there are initial indications as to how it finds its place within the health system. We were told that the fact that the entire activity was led by the MoPH and not driven by outside actors played a substantial role in its reception by stakeholders (including health actors, citizen groups, and other ministries). Two Expert Committee members told us that attempts over the previous 14 years to redevelop the system had been scorned because they were driven by "out-of-touch" foreign actors who did not attempt to have local buy-in to the plans. The political nature of this process dominated participants' hopes and understandings for its potential. As one Working Group member said: "*Politics are a big issue especially in Afghanistan. But this time we hope we will get what the people want. What the health teams and the beneficiaries need from us. Everything will go where it should be.*" [WG2]

5. Discussion

Our study of the IPEHS development process shows that this complex exercise was conducted transparently with inclusion of experts from different disciplines and backgrounds, representing a mix of local and international voices. The process was structured so as to emphasize creating and tapping into a shared value base, continuously focusing on keeping the Afghanistan health system and the people it will serve at the center. The activity also brought out differences in experts' disciplinary approaches, notably around which methods and inputs should be prioritized to make decisions of resource allocation in a context of limitations and population health challenges. Furthermore, as seen in the comments of Working Group members whose disappointment with previous supposed-collaborations colored their views, and of expert members who had participated in similar exercises, past experiences shape current beliefs and practices, underlining that care must be taken to understand the expectations of participants and the dynamics that may enter into the group.

Facilitators made efforts to disrupt generations of practices reliant on what Abimbola titles "the foreign gaze" (2019), where ownership is placed in the hands of foreign "experts" who are given the power to frame the problems as well as the solutions. Efforts against this are part of the localisation agenda, signified by the shift towards local stakeholders directing the decision-making surrounding action, response, power distribution and the allocation of resources. We saw that previous attempts at a revision had faltered when led by outside actors who were not invested in finding the appropriate path forward. Nevertheless, the localization agenda has been "beset by the same power imbalances evident in the wider sector, despite its aspirations to upend" which are not "adequately recognized nor discussed" (Fast and Bennett, 2020, 18). Our interviews demonstrate that the legacy of such institutionalized colonization lingers on in the present day realities of project participants (such as having mistrust of international agencies), and active steps are needed to listen and communicate about past experiences, and to do things differently.

Our study also contributes to documenting interdisciplinary efforts in priority setting and the question of whether it is more suited as a clinician's domain or as a health systems management domain. This revision exercise was designed to include input from both (as well as from further experts), and to break down the silos within which actors often work. We witnessed tensions in the attribution of value to modelling, costing, and burden of disease calculations, and how and when expertise should step in to direct decision-making. Who receives a

platform shapes whether and which evidence is considered, its interpretation, and framing along the lines of particular disciplinary backgrounds, conceptual approaches, and learned hierarchies of evaluation. These findings emphasize the importance of carefully considering the structural aspects that form the scaffolding of the priority setting process (Liverani et al., 2018), as well as the details of how they are implemented and tended to throughout the consultation. The priority setting process is inherently an ethical one, and decisions about who has a seat at the table and which sources are used to inform decisions will have repercussions on the allocation of resources and the prioritization of health services (Pratt et al., 2018), especially in a setting that is hindered by limitations of funding and optimal security standards.

5.1. Vernacular evidence

Ethics, evidence and experts are still sometimes treated as static non-negotiables within health systems, as people clamour for "gold standard" evidence as solutions to ever complex problems. However, this tactic falls short in questions related to humanitarian contexts. Instead, these in-flux settings crystallize that evidence is shaped by the social context of its production: it is not neutral and objective as often claimed (Seaver, 2015). Evidence does not have a singular identity: we understand it to have different meanings, to come with different values, and not be as neatly defined in categories as seen validated by the literature and publishing practices.

The revision of the Afghanistan health system in 2017–2021 was the site of the molding, melding and creation of a particular blend of knowledge sharing and information use, creating a bank of evidence in a way that was unique to this particular process, and symbolic of similar processes undergoing similar dynamics. We refer to this as *vernacular evidence*.[2]

Some premises underline this conceptualization. We understand that evidence is socially embedded – influenced by authority relations and cultural contexts (Strassheim and Kettunen, 2014). It is shaped by the availability of traditional evidence as much as by the gaps and lacks in these data. Furthermore, data are important, but how they are included and how they are used depend on people's grasp and who is in charge. Vernacular evidence is also shaped by the specific questions and tasks at hand, in this case the Afghan IPEHS, with the security and resource constraints, and its own burden of disease, socio-demographics, and mandates to take into consideration. Studies have underlined that in humanitarian settings, data that have "user value" can be just as or more important than the acquisition and application of "better" data (Fast and Bennett, 2020), and we saw this in the questioning of the use of DALYs and DCP_3 data to respond to the questions of the Afghan revision.

Contexts and processes create vernacular evidence that are specific products of a place and time. Evidence is ascribed meaning as key information or debate brings new understandings and parameters to light. As Walls and colleagues write: "[…] evidence is not a uniform concept for which more is obviously better, but rather illustrates how different constructions and pieces of evidence become relevant in relation to the features of specific health policy decisions" (Walls et al., 2018). Keen and careful judgement is applied by experts, taking the micro and macro levels into account, guided by their experience and the dynamics of the group and discussions. While other global health contexts will require similar weighing and balancing of multiple variables, in humanitarian response in particular, decision-makers will have to use their professional judgement "amidst the uncertainty of whether the existing research evidence can be applied to their unique setting" (Khalid et al., 2020). The IPEHS is an example of this, where the decision-making surrounding available evidence often came down to discussions and experience, rather than published material.

As such, vernacular evidence is a blend of expertise, debate and applied knowledge, tweaked and layered and specific to particular circumstances. At times it is a compromise in light of absences, and shaped by consensus building, shared ethics and morality (as in the example of the agreed values of the Expert Committee and Working Groups). It is not less robust than other evidence, in fact, one could suggest that through its adaptations it is more explicit and tailored to the situation at hand. However, despite the "social" vetting of vernacular evidence, it is still at the mercy of authority, of those at the table with the most clout or voice, of who have the money and of the political directives, and perhaps whatever trends and catchphrases take center stage that distract or focus attentions (Cornwall, 2007).

Our findings have distinct implications for ethical and practical considerations in priority setting activities. The actual facilitation of the entire course of events is critical to shepherding its outcomes: the experts, dynamics of participant discusssions, locations, technology as engagement enabler, moments of dissemination and exchange are all as important as the sources and data consulted, the models used for estimations and predictions, the standards agreed upon for decision-making and the value based premises that drive the selection criteria. Informal modes of communication are important to facilitate different avenues for consultation and discussion, and different constellations that will allow for strategies, theories and solutions to be brainstormed and discussed. This is especially important in settings where standard evidence is lacking or perceived to be of uneven quality (Kapiriri, 2020), or when country situations are fluid and changing with security, stability and funding uncertainties. COVID-19 has highlighted that ruptures in communication and the possibility for in-person meetings can befall at any time, in any context, and more than ever the intangible aspects to creating context-specific evidence processes are important.

5.2. Limitations

While a strength of this study is the variety of embedded roles the authors had in the activity (e.g. observer, facilitator, expert, leader), it also meant that some interviewees may have held back in expressing their opinions lest it come across as criticism. However, the external observer carried out the interviews and stressed that the aim of the study was not to evaluate the quality or style of the facilitators and participants, but to be focused on the dynamics that inform the role of evidence in decision-making in this process. A further limitation is that due to the security situation, researcher observation was not carried out at the Working Group meetings in Afghanistan, and only at the Expert Committee meetings in the UK.

The validity of this research was strengthened by the observer's prolonged engagement in data collection (over a period of six months), allowing the opportunity to adapt lines of questioning depending on new interactions and events observed. Data were triangulated through the consultation of various sources: interviews, meeting notes, conference procedings and informal discussions. As with all qualitative studies, the aim was not to be generalizable, but to offer insight into the dynamics at play in a particular setting, which may have similarities to other activities taking place.

6. Conclusion

In August 2021, the MoPH began drafting the IPEHS implementation plan, which included an investment plan required to sync the health system's actors with the revised content of the package. The political turmoil created by the arrival of the Taliban interrupted the process. In November 2021, during consultations with WHO and UNICEF about a new round of humanitarian funding, several Afghan actors referred to the IPEHS as a benchmark, demonstrating the relevance of the consultation process and that its result makes sense to most decision makers

[2] Elaboration on this term can be found in: Duclos Diane, Roberts Bayard, Lange Isabelle, Palmer Jennifer, Lokot Michelle, Mehio Sibai Abla, Giacaman H. Rita and Blanchet Karl. Vernacular Evidence? Framing Evidence-Informed Humanitarian Action in the 'Localisation of Aid' Era. RECAP working paper.

concerned with the Afghanistan health system and population's health.

This study of the IPEHS underscores the importance of paying attention to the micro acts within greater ethical- and health systems questions pertaining to resource allocation, especially in contexts of fragility or scarcity. Public health is a social process, but if the social is only recognized in certain spheres of health services – for example in implementation but not in decision-making – a skewed, imbalanced and unrepresentative system will be created, with outputs that fail to address their mandates. Actors need to understand the particular challenges related to context in order to take on board the fundamental points of each priority setting process. We call for attention to the procedures involved and a scrutiny of the methods that ultimately create national and global level infrastructure in the field of evidence setting in health care.

Credit author statement

Isabelle L Lange: Conceptualization, Methodology, Investigation, Formal analysis, Writing – original draft; **Ferozuddin Feroz**: Writing – review & editing, Funding acquisition; **Ahmad Jan Naeem**: Writing – review & editing; **Sayed Ataullah Saeedzai**: Writing – review & editing; **Fatima Arifi**: Writing – review & editing; **Neha Singh**: Writing – review & editing; **Karl Blanchet**: Conceptualization, Writing – review & editing, Funding acquisition

References

Abimbola, S., 2019. The foreign gaze: authorship in academic global health. BMJ Global Health 4, e002068. https://doi.org/10.1136/bmjgh-2019-002068.

Afghan Public Health Institute, 2011. Afghanistan Mortality Survey 2010. Calverton. APHI/MoPH, CSO, ICF Macro, IIHMR and WHO/EMRO, Maryland, USA.

Akseer, N., Salehi, A.S., Moazzem Hossain, S.M., et al., 2016. Achieving maternal and child health gains in Afghanistan: a Countdown to 2015 country case study. Lancet Global Health 4, e395–413.

Baltussen, R., Jansen, M.P., Mikkelsen, E., Tromp, N., Hontelez, J., Bijlmakers, L., Van Der Wilt, G.J., 2016. Priority setting for universal health coverage: we need evidence-informed deliberative processes, not just more evidence on cost-effectiveness. Int. J. Health Pol. Manag. 5 (11), 615.

Barasa, E.W., Molyneux, S., English, M., Cleary, S., 2015. Setting healthcare priorities at the macro and meso levels: a framework for evaluation. Int. J. Health Pol. Manag. 4 (11), 719.

Blanchet, K., Allen, C., Breckon, J., Davies, P., Duclos, D., Jansen, J., et al., 2020. Using Research Evidence in the Humanitarian Sector: A Practice Guide. Evidence Aid, London School of Hygiene and Tropical Medicine and Nesta (Alliance for Useful Evidence), London, 2018.

Blanchet, K., Ferozuddin, F., Naeem, A.J.J., Farewar, F., Saeedzai, S.A., Simmonds, S., 2019. Priority setting in a context of insecurity, epidemiological transition and low financial risk protection, Afghanistan. Bull. World Health Organ. 97 (5), 374.

Bump, J.B., 2019. What really sets priorities?: method, context, and perspective from 150 Years of priority-setting. In: Global Health Priority-Setting. Oxford University Press, pp. 45–66.

Cornwall, A., 2007. Buzzwords and fuzzwords: deconstructing development discourse. Dev. Pract. 17 (4–5), 471–484.

Dobrow, M.J., Goel, V., Upshur, R.E.G., 2004. Evidence-based health policy: context and utilisation. Soc. Sci. Med. 58 (1), 207–217.

Eregata, G.T., Hailu, A., Geletu, Z.A., Memirie, S.T., Johansson, K.A., Stenberg, K., et al., 2020. Revision of the Ethiopian essential health service package: an explication of the process and methods used. Health Systems & Reform 6 (1), e1829313.

Fast, L., Bennett, C., 2020. From the Ground up: It's about Time for Local Humanitarian Action. ODI, London.

Glassman, A., Giedion, U., Sakuma, Y., Smith, P.C., 2016. Defining a health benefits package: what are the necessary processes? Health Systems & Reform 2 (1), 39–50.

Gold, M.R., Stevenson, D., Fryback, D.G., 2002. HALYS and QALYS and DALYS, Oh My: similarities and differences in summary measures of population Health. Annu. Rev. Publ. Health 23 (1), 115–134.

Hilhorst, D., Jansen, B.J., 2010. Humanitarian space as arena: a perspective on the everyday politics of aid. Dev. Change 41 (6), 1117–1139.

Hilhorst, T., 2018. Arenas. In: Allen, T., MacDonald, A., Radice, H. (Eds.), Humanitarianism: A Dictionary of Concepts. Routledge.

Hipgrave, D.B., Alderman, K.B., Anderson, I., Soto, E.J., 2014. Health sector priority setting at meso-level in lower and middle income countries: lessons learned, available options and suggested steps. Soc. Sci. Med. 102, 190–200.

Jamison, D.T., Gelband, H., Horton, S., et al. (Eds.), 2017. Disease Control Priorities, third ed. World Bank, Washington, DC.

Kapiriri, L., 2020. Does the narrative about the use of evidence in priority setting vary across health programs within the health sector: a case study of 6 programs in a low-income national healthcare system. Int. J. Health Pol. Manag. 9 (10), 448.

Kenny, N., Joffres, C., 2008. An ethical analysis of international health priority-setting. Health Care Anal. 16 (2), 145–160.

Khalid, A.F., Lavis, J.N., El-Jardali, F., Vanstone, M., 2020. Supporting the use of research evidence in decision-making in crisis zones in low-and middle-income countries: a critical interpretive synthesis. Health Res. Pol. Syst. 18 (1), 1–12.

Kieslich, K., Bump, J.B., Norheim, O.F., Tantivess, S., Littlejohns, P., 2016. Accounting for technical, ethical, and political factors in priority setting. Health Systems & Reform 2 (1), 51–60.

Kohrt, B.A., Mistry, A.S., Anand, N., Beecroft, B., Nuwayhid, I., 2019. Health research in humanitarian crises: an urgent global imperative. BMJ global health 4 (6), e001870.

Liverani, M., Chheng, K., Parkhurst, J., 2018. The making of evidence-informed health policy in Cambodia: knowledge, institutions and processes. BMJ Glob. Health 3 (3).

Mirzazada, S., Padhani, Z.A., Jabeen, S., Fatima, M., Rizvi, A., Ansari, U., Das, J.K., Bhutta, Z.A., 2020. Impact of conflict on maternal and child health service delivery: a country case study of Afghanistan. Conflict Health 14 (1), 1–13. https://doi.org/10.1186/s13031-020-00285-x.

Newbrander, W., Ickx, P., Feroz, F., Stanekzai, H., 2014. Afghanistan's Basic Package of Health Services: its development and effects on rebuilding the health system. Global Publ. Health 9 (S1), S6–S28.

Norheim, O.F., 2016. Ethical priority setting for universal health coverage: challenges in deciding upon fair distribution of health services. BMC Med. 14 (1), 1–4.

Petit, D., Sondorp, E., Mayhew, S., Roura, M., Roberts, B., 2013. Implementing a basic package of health services in post-conflict Liberia: perceptions of key stakeholders. Soc. Sci. Med. 78, 42–49.

Petricca, K., Bekele, A., Berta, W., Gibson, J., Pain, C., 2018. Advancing methods for health priority setting practice through the contribution of systems theory: Lessons from a case study in Ethiopia. Soc. Sci. Med. 198, 165–174.

Pratt, B., Sheehan, M., Barsdorf, N., Hyder, A.A., 2018. Exploring the ethics of global health research priority-setting. BMC Med. Ethics 19 (1), 1–11.

Rosoff, P.M., 2017. Drawing the Line: Healthcare Rationing and the Cutoff Problem. Oxford University Press.

Sabin, J.E., 1998. Fairness as a problem of love and the heart: a clinician's perspective on priority setting. Br. Med. J. 317, 1002–1004.

Schmid, B., Raju, E., 2020. Humanitarian crisis and complex emergencies–Burden of disease, response, and opportunities for global health. In: Haring, R., Kickbusch, I., Ganten, D., Moeti, M. (Eds.), Handbook of Global Health. Springer, pp. 1–36.

Seaver, N., 2015. The nice thing about context is that everyone has it. Media Cult. Soc. 37 (7), 1101–1109.

Smith, J., Whitehouse, K., Blanchet, K., 2020. Knowledge production in humanitarian crises: beware of the innovation trap. Lancet Global Health 8 (4), e481.

Stefanini, A., 1999. Ethics in health care priority-setting: a north–south double standard? Trop. Med. Int. Health 4 (11), 709–712.

Strassheim, H., Kettunen, P., 2014. When does evidence-based policy turn into policy-based evidence? Configurations, contexts and mechanisms. Evid. Policy A J. Res. Debate Pract. 10 (2), 259–277.

UNICEF, 2002. Afghanistan Is Among Worst Places on Globe for Women's Health, Say UNICEF and CDC. Press release available at: https://www.unicef.org/newsline/02pr59afghanmm.htm.

UNICEF Multi Indicator Cluster Survey (MICS) 2003 and Afghanistan Health Survey (AHS) 2018.

Walls, H., Liverani, M., Chheng, K., Parkhurst, J., 2018. The many meanings of evidence: a comparative analysis of the forms and roles of evidence within three health policy processes in Cambodia. In: Evidence Use in Health Policy Making. Palgrave Macmillan, Cham, pp. 21–49.

Watkins, D.A., Jamison, D.T., Mills, A., 2017. Chapter 3. Universal health coverage and essential packages of care. Disease control priorities 9.